



STATE OF HAWAII PREMIUM CONVERSION PLAN ELECTION CHANGE FORM (Form PCP-2)

Premium Conversion Plan (PCP) is a voluntary benefit plan, administered by the State Department of Human Resources Development (DHRD) that allows employees to pay for their health benefit plan premiums on a pretax basis. Premium conversion plans are governed by Section 125 of the Internal Revenue Code (IRC). **Submit this form to your Human Resources Office within 90 calendar days of a qualifying event.** Changes/cancellations must be consistent with the "change of status" event indicated as defined by Section 125, IRC and shall become effective on a PROSPECTIVE basis from the "Employer's Receipt in Office date"

Employee Information	Full Name (Last, First, Middle)	Last 4-digits of Social Security Number	Date of Qualifying Event
Please Check Benefit Plans Affected:	<input type="checkbox"/> Medical/Prescription Drug/Chiropractic Plan	<input type="checkbox"/> Vision Plan	<input type="checkbox"/> Dental Plan

I elect to **CHANGE** the amount of the PCP reduction of my pay from:

<input type="checkbox"/> From 2-party to Family Enrollment <input type="checkbox"/> From Self-Only to 2-party or Family Enrollment <ul style="list-style-type: none"> <input type="radio"/> Open Enrollment (non-EUTF; e.g. spouse's employer's open enrollment) <input type="radio"/> Birth or adoption <input type="radio"/> My Marriage <input type="radio"/> My eligible dependent (re-) joined my household <input type="radio"/> My dependent's loss of eligibility for coverage under a health benefits plan <input type="radio"/> My spouse's health benefits plan is significantly changed or terminated <input type="radio"/> My dependent(s) satisfies the eligibility requirements of the plan (e.g., full-time student, etc.) Other IRS Qualifying Reason (I have attached a written explanation) _____	<input type="checkbox"/> From Family to 2-party or Self-Only Enrollment <input type="checkbox"/> From 2-party to Self-Only enrollment <ul style="list-style-type: none"> <input type="radio"/> Open Enrollment (non-EUTF; e.g. spouse's employer's open enrollment) <input type="radio"/> My Divorce/annulment of my marriage <input type="radio"/> Death of my dependent(s) <input type="radio"/> My dependent(s) no longer satisfies the eligibility requirements of the plan (e.g., attainment of age, loss of student status, marriage, etc.) <input type="radio"/> My spouse/dependent child becoming eligible for and electing coverage under other health benefits plan Other IRS Qualifying reason (I have attached a written explanation) _____
<input type="checkbox"/> Change of health benefits plan insurance carrier because new residence is out of service area of my present carrier	
<input type="checkbox"/> Change to new employment classification where other component plans have become available or where my carrier's plan is not available	

I elect to **PARTICIPATE** in the Premium Conversion Plan due to:

<input type="radio"/> Self-Only	<input type="radio"/> 2-Party	<input type="radio"/> Family Enrollment
<ul style="list-style-type: none"> <input type="radio"/> My being out-of-state during the entire Open Enrollment Period <input type="radio"/> My return from a leave without pay status <input type="radio"/> Birth of a child <input type="radio"/> My loss of health benefits plan coverage because of the involuntary termination of my enrollment or my spouse's enrollment due to: <ul style="list-style-type: none"> <input type="radio"/> Death <input type="radio"/> Divorce/annulment of my marriage <input type="radio"/> Eligibility/employment termination Other IRS Qualifying Reason (I have attached a written explanation) _____		

I elect to **TERMINATE** my participation in the Premium Conversion Plan due to:

<ul style="list-style-type: none"> <input type="radio"/> Open Enrollment (non-EUTF; e.g. spouse's employer's open enrollment) <input type="radio"/> My transfer to a non-eligible employment classification <input type="radio"/> My loss of eligibility for coverage under a component plan <input type="radio"/> I will be covered under my new second employer's health benefits plan or a new health benefits plan offered by my second employer <input type="radio"/> My marriage. I will be covered under my spouse's employer's plan <input type="radio"/> I will be covered as a dependent under my spouse's new employer's plan or retiree health benefits plan <input type="radio"/> My spouse, who is also a State employee, changed his/her health plan enrollment to family coverage due to the birth/adoption of our child <input type="radio"/> I will be placed on a leave without pay status Other IRS Qualifying Reason (I have attached a written explanation) _____

I have read the PCP materials, understand the limitations and qualifications of the PCP program and agree to abide by the terms and conditions of the Plan. I understand that I am making an election that is binding for the remainder of the plan year. I also understand that during this period I may not modify my reduction in pay unless (1) the plan is terminated, (2) there is an increase in the amount required employee contributions for the coverage which I have elected in conjunction with this current Election Change Form, (3) there is a change in my personal status that qualifies under the Internal Revenue Code.

Employee Signature _____

Date _____

Human Resources Office (HRO) Use Only

Department	Division/School	Bargaining Unit	HRO phone/fax number
Employer's Receipt in Office Date		PCP Effective Date	
Human Resources Officer (or employer designee) PRINT Name		Human Resources Officer (or employer designee) SIGNATURE	