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 (HRO) designee or Department of Education- Employee Benefits Unit (DOE-EBU) 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:	☐ Medical/Prescription Drug/Chiropractic Plan	☐ Vision Plan	☐ Dental Plan

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

From 2-party to Family Enrollment
From Self-Only to 2-party or Family Enrollment (indicate reason below)
- o Open Enrollment (non-EUTF, e.g. spouse's employer's open enrollment)
- o Birth, adoption, or placement for adoption of a child
- o My Marriage
- o My eligible dependent (re-) joined my household
- o My dependent's loss of eligibility for coverage under a health benefits plan
- o My spouse's health benefits plan is significantly changed or terminated
- o 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)

From Family to 2-party or Self-Only Enrollment
From 2-party to Self-Only enrollment (indicate reason below)
- o Open Enrollment (non-EUTF, e.g. spouse's employer's open enrollment)
- o My Divorce/annulment of my marriage
- o Death of my dependent(s)
- o My dependent(s) no longer satisfies the eligibility requirements of the plan (e.g., attainment of age, loss of student status, marriage, etc.)
- o 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)

☐ **Change of health benefits plan insurance carrier because new residence is out of service area of my present carrier**
☐ **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:

- o **Self-Only**
- o **2-Party**
- o **Family Enrollment (indicate reason below)**

- o My being out-of-state during the entire Open Enrollment Period
- o My return from a leave without pay status
- o Birth, adoption, or placement for adoption of a child
- o My loss of health benefits plan coverage because of the involuntary termination of my enrollment or my spouse's enrollment due to:
  - o Death
  - o Divorce/annulment of my marriage
  - o 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:

- o Open Enrollment (non-EUTF, e.g. spouse's employer's open enrollment)
- o My transfer to a non-eligible employment classification
- o My loss of eligibility for coverage under a component plan
- o I will be covered under my new second employer's health benefits plan or a new health benefits plan offered by my second employer
- o My marriage. I will be covered under my spouse's employer's plan
- o I will be covered as a dependent under my spouse's new employer's plan or retiree health benefits plan
- o 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
- o 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_____

HRO designee or DOE-EBU Use Only

Department: _____ *Division/School:* _____ *Bargaining Unit:* _____

Employer's Receipt in Office Date: _____ *PCP Effective Date:* _____

HRO or DOE-EBU (or employer designee) PRINT Name: _____ *HRO or DOE-EBU SIGNATURE:* _____