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). Changes/cancellations must be "on account of and consistent with" the change of status event indicated and shall become effective on a prospective basis from the date received. **Submit this form directly to your Human Resources Office (HRO) designee within ninety (90) calendar days of a qualifying event together with the EUTF EC-1/EC-1H Enrollment Form.**

EMPLOYEE COMPLETES:	Full Name (Last, First, Middle)	Last 4-digits of Social Security Number:	Date of Qualifying Event
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* Family *to* 2-party or Self-Only Enrollment
☐ *From* Self-Only *to* 2-party or Family Enrollment	☐ *From* 2-party *to* Self-Only enrollment
○ Open Enrollment (non-EUTF, e.g., spouse's employer's open enrollment) ○ Birth, adoption, or placement for adoption of a child ○ My Marriage ○ My eligible dependent (re-) joined my household ○ My dependent's loss of eligibility for coverage under a health benefits plan ○ My spouse's health benefits plan is significantly changed or terminated ○ 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)	○ Open Enrollment (non-EUTF, e.g., spouse's employer's open enrollment) ○ My Divorce/annulment of my marriage ○ Death of my dependent(s) ○ My dependent(s) no longer satisfies the eligibility requirements of the plan (e.g., attainment of age, loss of student status, marriage, etc.) ○ 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:

○ Self-Only	○ 2-Party	○ Family Enrollment

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

○ Open Enrollment (non-EUTF, e.g., spouse's employer's open enrollment)
○ My transfer to a non-eligible employment classification
○ My loss of eligibility for coverage under a component plan
○ I will be covered under my new second employer's health benefits plan, or a new health benefits plan offered by my second employer
○ My marriage. I will be covered under my spouse's employer's plan
○ I will be covered as a dependent under my spouse's new employer's plan or retiree health benefits plan
○ 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
○ 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: Complete this section and mail/email this form to DHRD-EAO or fax to 808-587-1107

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