



**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.**

<b>EMPLOYEE COMPLETES:</b>	Full Name (Last, First, Middle)	Last 4-digits of Social Security Number:	Date of Qualifying Event
Check Benefit Plans Affected:	<input type="checkbox"/> Medical/Prescription Drug/Chiropractic Plan	<input type="checkbox"/> Vision Plan	<input type="checkbox"/> Dental Plan
			Date entered in the EUTF Member Self-Service Portal:

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

<input type="checkbox"/> From 2-party to Family Enrollment	<input type="checkbox"/> From Family to 2-party or Self-Only Enrollment
<input type="checkbox"/> From Self-Only to 2-party or Family Enrollment	<input type="checkbox"/> From 2-party to Self-Only enrollment
<ul style="list-style-type: none"> <li><input type="radio"/> Open Enrollment (non-EUTF, e.g., spouse's employer's open enrollment)</li> <li><input type="radio"/> Birth, adoption, or placement for adoption of a child</li> <li><input type="radio"/> My Marriage</li> <li><input type="radio"/> My eligible dependent (re-) joined my household</li> <li><input type="radio"/> My dependent's loss of eligibility for coverage under a health benefits plan</li> <li><input type="radio"/> My spouse's health benefits plan is significantly changed or terminated</li> <li><input type="radio"/> My dependent(s) satisfies the eligibility requirements of the plan (e.g., full-time student, etc.)</li> </ul> Other IRS Qualifying Reason (I have attached a written explanation)	<ul style="list-style-type: none"> <li><input type="radio"/> Open Enrollment (non-EUTF, e.g., spouse's employer's open enrollment)</li> <li><input type="radio"/> My Divorce/annulment of my marriage</li> <li><input type="radio"/> Death of my dependent(s)</li> <li><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.)</li> <li><input type="radio"/> My spouse/dependent child becoming eligible for and electing coverage under other health benefits plan</li> </ul> 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"> <li><input type="radio"/> My being out-of-state during the entire Open Enrollment Period</li> <li><input type="radio"/> My return from a leave without pay status</li> <li><input type="radio"/> Birth, adoption, or placement for adoption of a child</li> <li><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"> <li><input type="radio"/> Death</li> <li><input type="radio"/> Divorce/annulment of my marriage</li> <li><input type="radio"/> Eligibility/employment termination</li> </ul> </li> </ul> 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"> <li><input type="radio"/> Open Enrollment (non-EUTF, e.g., spouse's employer's open enrollment)</li> <li><input type="radio"/> My transfer to a non-eligible employment classification</li> <li><input type="radio"/> My loss of eligibility for coverage under a component plan</li> <li><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</li> <li><input type="radio"/> My marriage. I will be covered under my spouse's employer's plan</li> <li><input type="radio"/> I will be covered as a dependent under my spouse's new employer's plan or retiree health benefits plan</li> <li><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</li> <li><input type="radio"/> I will be placed on a leave without pay status</li> </ul> Other IRS Qualifying Reason (I have attached a written explanation)
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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:	