

EC-1: Enrollment Form for Active Employees

SECTION 1: EMPLOYEE DATA

Please complete all applicable fields below. Social Security numbers are required to process new hires and dependent enrollments. **

Name (Last, First, Middle) _____ New Hire _____ Mid-Year Qualifying Event (describe) _____
 Date of Hire (MM/DD/YYYY) ____/____/____
 Home Phone (____) _____
 Mobile Phone (____) _____
 Work Phone (____) _____
 Email _____
 Residence Address (Check this box if your address has changed)
 Street _____
 Line 2 _____
 City _____ State _____ Zip Code _____
 Mailing Address (if different from above)
 Street _____
 Line 2 _____
 City _____ State _____ Zip Code _____

Open Enrollment
 Termination
 Date of Termination (MM/DD/YYYY) ____/____/____

Employee's Social Security Number (SSN) or EUTF ID Number _____
 Domestic Partner (DP Status)
 IRS Qualified Not Qualified
 DP Date: (MM/DD/YYYY) ____/____/____
 Check this box if status change

Gender Male Female
 Birth Date: (MM/DD/YYYY) ____/____/____

Special Note: If your Spouse or Domestic Partner is a State or County Employee or Retiree and is not being enrolled in your plans, please provide his/her SSN: _____

Section 2: COVERAGE AND DEDUCTION START SELECTION

If events are filed within 30 days of qualifying event date, some events allow for a selection of the Coverage and Premium Contribution Start Dates.

If your event is listed below, please select one of the three options, otherwise skip this section.

Qualifying Events for this Section

Adoption, Birth, Guardianship, New Eligible Student, Marriage, Domestic Partner, New Hire, Newly Eligible, Placement for Adoption, Reinstatement in Employment, Return from Authorized Leave of Absence (if not currently enrolled)

Available Options for this Section

- Coverage starts day of the event & premium contributions start 1st day of the pay period in which the effective date of coverage occurs (if no selection is made, this option will be used)
- Coverage and premium contributions start 1st day of the **first** pay period following event
- Coverage and premium contributions start 1st day of the **second** pay period following event

Completed by DPO → Effective Date of Coverage: _____ Premium Contribution begins: _____

SECTION 3: PLAN SELECTION

Make your selection by checking the all the boxes of the appropriate benefit plans below. Select Self, Two-Party, Family or Cancel/Waive coverage. Choose only one box in each plan selection. If you do not make a selection, you will be considered as "waiving" coverage.

Medical Plan Type	Carrier Selection	Choose only one box in each plan selection			
		Cancel/Waive	Self	2-Party	Family
PPO	PPO-90/10 HMSA Medical, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	PPO-80/20 HMSA Medical, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Drug	Prescription Drug (Not a valid selection w/ HMO, HDHP, or Supplemental plans)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HMO	HMO-HMSA Medical, Prescription Drug Coverage, Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HMO-Kaiser Basic, (Includes Prescription Drug Coverage), Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HMO-Kaiser Comprehensive, (Includes Prescription Drug Coverage), Chiro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HDHP	HDHP-High Deductible Health Plan HMSA (Includes Prescription Drug Coverage)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supplemental	Supplemental-HMSA (Includes Supplemental Prescription Drug Coverage), Chiro ***	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Supplemental-Royal State National Insurance Company (Includes Supplemental Prescription Drug Coverage), Chiro ***	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*** To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group health plan (private/Federal)

Other Plans		Cancel/Waive	Self	2-Party	Family
Dental	Hawaii Dental Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	Vision Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Life	Royal State National	<input type="checkbox"/>	<input type="checkbox"/>		

For STATE Employees ONLY: Premium Conversion Plan Enroll Change Amount Cancel PCP Do NOT Enroll

For COUNTY Employees ONLY: Premium Conversion Plan – Please contact your DPO for more information on available options.

SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS Please list all dependents enrolled or who you want to add/delete from your plan.

List all eligible dependents you wish to cover and check the plan selections desired. Relationship* Key: SP=Spouse, DP=Domestic Partner, CH=your Child or your Spouse's Child, DPCH= Domestic Partner's Child, GC=Guardianship/Foster child, SC = Step Child, DC=Disabled Child if your child is age 19 or over and is also disabled. Social Security Number **: Social Security Number is not a required field when submitting an initial EC-1 for new birth. Please be sure to submit an EC-1 to update our records for your newborn once the information received/issued by SSA.

Add	Delete	Dependent:	Birth Date	Social Security Number**	Relationship *	Gender	Medical	Drug	Dental	Vision
		Last Name (if different), First Name, Middle Initial	(MMDDYYYY)			M / F				
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		/ /				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Detailed eligibility information is available at <http://eutf.hawaii.gov> in the EUTF Administrative Rules & Chapter 87A, Hawaii Revised Statutes.

Dependent Certification – See Section regarding Dependent Certification on "Instructions for Completing Form EC-1" for more information.

I certify that my dependent children meet eligibility requirements for enrollment in the EUTF plans. _____ (initials)

Domestic Partner Certification – See Section regarding Domestic Partner Certification on "Instructions for Completing Form EC-1" for specific instructions.

I have attached all documentation as required in the Domestic Partner Enrollment Instructions. _____ (initials)

SECTION 5: OTHER INSURANCE INFORMATION

*** To be eligible for coverage under any Supplemental Health Benefit Plan, you and your eligible dependent(s) must be covered under another employer group health plan (private/Federal)

If you or any of your dependents are covered through another employer's health plan(s), please provide the type of plan, name of the plan, subscriber's name, effective date of the plan, and the health plan coverage (self, two-party, family).

Type of Plan	Name of the Plan (Carrier's Name)	Subscriber's Name	Effective Date	Health Plan Coverage		
				Self	2-Party	Family
			/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 6: EMPLOYEE AUTHORIZATION AND SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand if I do not make a selection or check the "waive" box, it will be considered a "waive." I understand that the benefit elections made on this application are in effect for as long as I continue to meet EUTF's eligibility requirements, or until I elect to change them subject to the provisions of EUTF's plan rules. I have read the benefit materials, understand the limitations and qualifications of the EUTF benefits program and agree to abide by the terms and conditions of the benefit plans selected. I authorize my employer or finance officer to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.

A person who knowingly makes a false statement in connection with an application for any benefit may be subject to imprisonment and fines. Additionally, knowingly making a false statement may subject a person to termination of enrollment, denial of future enrollment, or civil damages. This form supersedes all forms and submissions I previously made for EUTF coverage. I hereby declare that the above statements are true to the best of my knowledge and belief, and I understand that I am subject to penalty for perjury.

Employee Signature: _____ Date Signed: _____

Department ID#	Department	Division/School	Bargaining Unit
Date EC-1 Received in Employing Office	/ /	DPO Phone Number	DPO Fax Number
DPO (or employer designee's) Printed Name	DPO (or employer designee's) Signature:		Date of DPO (or employer designee's) Signature
Remarks:			