| EC-2 Rev AUG 2010 | Hawai'i Employer-Union Health Benefits Trust Fund<br>**EC-2: Enrollment Form For Retirees** | **PLEASE SUBMIT THIS FORM EC-2 TO THE EUTF** |
|---|---|---|

**See Instructions BEFORE completing this form. Refer to your Reference Guide or our website for plan details.**

## SECTION 1: RETIREE DATA

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

Name (Last, First, Middle) _____

Home Phone (_____) _____

Mobile Phone (_____) _____

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

Retiree's Social Security Number (SSN) or EUTF ID Number _____

Marital Status ☐ Married ☐ Single
Marriage Date: (MM/DD/YYYY) ____/____/____

***If you are including your spouse or domestic partner in your health benefit plans, please complete Section 4***

☐ Mid- Year Qualifying Event: _____
Event Date: ____/____/____
Gender ☐ Male ☐ Female
Birth Date: (MM/DD/YYYY) ____/____/____

Domestic Partnership (DP Status)
☐ IRS Qualified ☐ Not Qualified
DP 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:_____ or
EUTF ID:_____

## SECTION 2: COVERAGE AND CONTRIBUTION START SELECTION

Skip this section if Retiree does NOT pay towards health plan benefits

**If events are filed within 30 days of qualifying event date, some events allow for a selection of the Coverage and Contribution Start Dates. If your event is listed below and *you pay towards your health benefits plan*, please select one of the three options; otherwise skip this section.**

**Qualifying Events for this Section**

Adoption, Birth, Marriage, New Domestic Partnership, Placement for Adoption, Guardianship, New Eligible Student

**Available Options for this Section**

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

☐ Coverage & premium contributions start first day of the first pay period* following event

☐ Coverage & premium contributions start first day of the second pay period* following event

*(1st or 16th of month)

## SECTION 3: PLAN SELECTION

Make your selection by checking the box for the appropriate benefit plans below. Select Self, 2-Party, Family or Cancel/Waive coverage. Choose only one box in each plan selection.

**Medical Plan** — **Choose only one box in each plan section**

| Type | Carrier Selection | Cancel/Waive | Self | 2-Party | Family |
|---|---|---|---|---|---|
| PPO | PPO-Health Management Associates **(HMA)** No Drug Coverage | ☐ | ☐ | ☐ | ☐ |
| | PPO-Hawai'i Medical Service Association **(HMSA)** No Drug Coverage | ☐ | ☐ | ☐ | ☐ |
| HMO | HMO-Kaiser Comprehensive Kaiser Drug Coverage Included | ☐ | ☐ | ☐ | ☐ |

**Other Plans**

| | | Cancel/Waive | Self | 2-Party | Family |
|---|---|---|---|---|---|
| Prescription Drug | InformedRx Prescription Drug (not a valid selection w/ the Kaiser medical plan) | ☐ | ☐ | ☐ | ☐ |
| Dental | Hawai'i Dental Service **(HDS)** | ☐ | ☐ | ☐ | ☐ |
| Vision | Vision Service Plan **(VSP)** | ☐ | ☐ | ☐ | ☐ |
| Life | Standard Insurance Company | ☐ | ☐ | | |

SSN or EUTF ID# _____

## SECTION 4: DEPENDENT INFORMATION AND PLAN SELECTIONS

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, DC=Disabled Child if your child is age 19 or over and is also disabled.

| Add | Delete | Dependent(s): Last Name (if different), First Name, Middle Initial | Birth Date (MM/DD/YYYY) | Social Security Number or EUTF ID Number | *Relationship | Gender M/F | Medical | Drug | Dental | Vision |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | | / / | | | | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | | / / | | | | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | | / / | | | | ☐ | ☐ | ☐ | ☐ |

Detailed eligibility information is available at www.eutf.hawaii.gov in the EUTF Administrative Rules, Chapter 87A, Hawai'i Revised Statutes. Dependent Certification and Student Certification– See Sections 4.6 and 4.7 of "Instructions for Completing Form EC-2"for more information.

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

**I certify that all of my dependent children ages 19 through 23, are full time students at an accredited scholastic institution.** _____ **(initials)**

Domestic Partner Certification – See Sections 4.8 and 4.9 of "Instructions for Completing Form EC-2" for specific instructions.

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

## SECTION 5: MEDICARE

Chapter 87A-23(4) requires eligible beneficiaries to enroll in Medicare Part B as a condition of receiving contributions and participating in the EUTF benefit plans. If you or your dependent(s) recently enrolled in Medicare Part B, or have not already done so, please submit a copy of the Medicare card and EUTF Direct Deposit Agreement Form to the EUTF without delay and complete this section to initiate quarterly reimbursement.

Name of Enrollee:

Medicare Claim #: (ID number listed on the blue and red Medicare Card)

**Non-EUTF Medicare Part D**

If you or your dependent(S) are enrolled in a non-EUTF Medicare Part D prescription drug plan, please read Section 5 on the instruction form and enter the name(s) of those enrolled in a non-EUTF Medicare Part D plan.

Name(s):

## SECTION 6: OTHER INSURANCE INFORMATION

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, etc).

| Type of Plan | Name of the Plan (Carrier's Name) | Subscriber's Name | Effective Date | Health Plan Coverage Self | 2-Party | Family |
|---|---|---|---|---|---|---|
| | | | / / | ☐ | ☐ | ☐ |
| | | | / / | ☐ | ☐ | ☐ |

## SECTION 7: RETIREE SIGNATURE

I am eligible for the coverage requested and declare that the individuals listed on the enrollment form are also eligible. 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.

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.

Retiree Signature: _____ Date Signed: _____

**Please submit your signed and completed form via mail to:**

**EUTF**
**P. O. Box 2121**
**Honolulu HI 96805-2121**

- **Or you may fax it to: 808-586-2161**
- **Or hand deliver at: EUTF, 201 Merchant St., Suite 1520, Honolulu HI 96813**

**Customer Service:**

**Oahu (808) 586-7390**
**Toll Free 1(800) 295-0089**

A. Print or type clearly. If this form is unreadable, incomplete, or does not contain all information required, it may be sent back to you without action.
B. This form is effective for changes made on or after August 1, 2010.

## SECTION 1 - RETIREE DATA

1. Enter your full legal name as recorded on your Social Security card.
2. Enter your address information. If your mailing address differs from your residential address, you need to enter both addresses to ensure that correspondence reaches you timely.
3. Enter EUTF ID#; if you are enrolling for the first time, you must enter your social security number.

*** Section 7(b), of the Privacy Act of 1974 (Public Law 93—579) requires that any federal, state, or local governmental agency which requests an individual to disclose their Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) requests each employee-beneficiary's Social Security account number on a voluntary basis. However, it should be noted that due to the use of Social Security account numbers by other entities for identification purposes, the EUTF may be unable to verify eligibility for benefits without the Social Security account number. The EUTF uses Social Security account numbers for the following purposes: 1. Employee-beneficiary identification for eligibility processing and eligibility verification; 2. Payroll premium deduction from paychecks for state/county employees; 3. Eligibility file to carriers; 4. Completion of 1099's for employee-beneficiaries with domestic partners. ***

4. Event - Please describe the event:
   I. Mark the Open Enrollment box **only** during the annual or special Open Enrollment period.
   II. Mark the Mid-Year Qualifying Event box if you have made any changes during the year and its description. The following are the most common events: Address Change, Retirement, and Death. If there are simultaneous events, please describe the most prevalent event; for example, if the event is a death and an address change, enter Death in the event section.
      a. Enter the date the event took place.
5. Enter EUTF ID # of Spouse or Domestic Partner if your spouse of Domestic Partner is a State or County Employee or Retiree. Be sure to complete section 4, if you want to cover your spouse or domestic partner.

## SECTION 2 – COVERAGE AND CONTRIBUTION START SELECTION --*Complete this section only if you pay towards health plan benefits*

1. If the "Qualifying Event" that applies to you is listed in Section 2 (adoption, birth, marriage, new domestic partnership, placement for adoption, guardianship, new eligible students), you have three choices of when your coverage and premium contributions begin. Select one of the three.
2. If no selection is made, the first option (coverage starts day of the event and premium contribution starts first day of the pay period in which the effective date of coverage occurs) will be the default option selected.

## SECTION 3 – PLAN SELECTION

Only one plan from the Medical plans and self, 2-party, or family may be selected. If you choose a PPO medical plan, you now have the option to select or not to select InformedRx if you also want prescription drug coverage. If you do not want any plan coverage, mark the "Cancel/Waive" box.

1. Carefully review each selection that you make. You can choose ONE Medical, ONE dental, and ONE vision plan. Your choice of the prescription drug plan will depend on the MEDICAL plan that you select. If you select an HMO, your medical selection also will include a prescription drug plan. If you select a PPO plan, you must select the prescription drug plan if you want drug coverage. If you don't make a selection, you will not have any prescription drug coverage.
2. You may now choose to elect only the Medical PPO plan without the Prescription Drug plan or vice versa. If you want both the medical and drug plans, please mark the appropriate boxes. Select one plan from the Medical plans and the appropriate coverage for you. If you do not want any plan coverage, mark the "Cancel/Waive" box. If you do not make a selection or check the "waive" box, you will be considered as "waiving" the selection(s).
3. If you have other health plan coverage and do not want to participate in the EUTF plans, mark the Cancel/Waive box for each plan that you choose not to select.
4. Life Insurance is provided for the retiree only.

## SECTION 4 – DEPENDENT INFORMATION AND PLAN SELECTIONS

1. Check "Add" box to add dependent, check "Delete" box to delete dependent.
   Enter your Dependent(s) data. If enrolling your dependent for the first time, enter his/her birth date and social security number. Otherwise, you may leave the birth date blank and list your dependent's EUTF ID number. If making changes to your dependent's data, enter the corrected item. If listing more than 3 dependents, write/type "Continued" on the last line of the Dependent section. Attach a separate sheet of letter size white paper to list additional dependent(s) information.

2. Use the following Relationship codes:

| | | |
|---|---|---|
| SP = Spouse | CH = Child | DC = Disabled Child√√ |
| DP = Domestic Partner√ | DPC = Domestic Partner Child√ | GC = Guardianship or Foster Child√√√ |

3. **For Relationship codes with √ or √√ or √√√, please see item #9 below for further instructions and other required forms.**
4. Gender - Mark either M (male) or F (female.)
5. Plan Selections. YOUR DEPENDENTS CAN BE ENROLLED ONLY IN THE SAME PLANS IN WHICH YOU ARE CURRENTLY ENROLLED. If you do not want any plan coverage for any of your dependents, mark the "Self" box in Section 3.
6. Dependent certification. Your initials confirm that you are certifying that all of your dependent children are eligible to be enrolled under your enrollment. You confirm that you will provide a copy of your child(ren)'s birth certificate and/or social security card if/when requested by the EUTF.
7. Student certification. Your initials confirm that you are certifying that all of your dependent children ages 19 through 23, are eligible to be enrolled under your enrollment as full-time students. You further confirm that you will provide proof of student status if/when requested by the EUTF.
8. If you are enrolling a domestic partner (and children), you are required to complete all required forms in accordance with the instructions for Domestic Partners. You are responsible to obtain, complete and submit all necessary documentation to the EUTF. Failure to do so will result in denying your domestic partner coverage. You may add your Domestic Partner at anytime outside of Open Enrollment provided all required documents have been received. Visit the EUTF website at eutf.hawaii.gov for detailed instructions regarding domestic partnership.
9. If you are adding a disabled child, domestic partner and child or an adopted child, please contact the EUTF at 808-586-7390 or toll free, 1-800-295-0089 or visit our website at eutf.hawaii.gov for more information. Other EUTF forms to include with EC-2 (if applicable):
   - √ EUTF Declaration of Domestic Partnership or EUTF Declaration of Termination of Domestic Partnership
   - √ Affidavit of "Dependency" for Tax Purposes (For Domestic Partnerships)
   - √ DHRD Domestic Partnership Acknowledgement Form (State Employees with PCP enrolling Domestic Partners)
   - √ DHRD PCP 2 form (For State Employees Only)
   - √√ Disability Certification For Dependent Children (Form D-1) for enrolling a disabled child
   - √√√ Legal documents for guardianship or foster child

## SECTION 5 – MEDICARE

**IMPORTANT: If you or your dependent(s) are Medicare eligible and are enrolled in a Non-EUTF Medicare Part D prescription drug plan, please provide the name(s) of those enrolled in the Non-EUTF plan. Please ensure that you carefully read the implications of being enrolled in a Non-EUTF Medicare Part D prescription drug plan. Additional information is included in your Retiree Reference Guide. You can obtain detailed information regarding Medicare Part D at the Medicare website, www.medicare.gov.**

**IMPORTANT NOTICE: When you or your spouse or domestic partner become eligible for Medicare Part B, you or your spouse or domestic partner must enroll in Medicare Part B and forward a proof of enrollment to the EUTF. Failure to comply may result in loss of all health benefits coverage.** If you or your dependents have recently enrolled with Medicare Part B, please complete this section and submit this EC-2 form right away with a copy of your Medicare card and a direct deposit agreement form to the EUTF.

## SECTION 6 – OTHER INSURANCE INFORMATION

If you or any of your dependents have health benefit coverage through another employer's health plan(s), you are required to complete this section.

## SECTION 7 – RETIREE SIGNATURE

Your signature certifies that the information provided in this application is true and complete. Retiree agrees to abide by the terms and conditions of the benefit plans selected. Retiree affirms that any listed dependent child, aged 19 through 23, is attending a college, university as a full-time student and is also unmarried. Please enter date of Retiree's signature.

You must submit the EC-2 to the EUTF office. You may send it by mail, fax, or hand delivery. The address and number are printed at the bottom of page 2 of the enrollment form.