Document #2: HEALTH INSURANCE/FLEXIBLE SPENDING ENROLLMENT FORM

IMPORTANT NOTES ON HEALTH INSURANCE / VOLUNTARY INSURANCES:

1. If you do not want to make any changes to your medical or dental insurances, you do NOT need to submit this form.
2. Complete the V/SI section ONLY if you are enrolling or canceling a V/SI Plan. If you are currently enrolled in a V/SI Plan your coverage will CONTINUE into the next Plan Year.
3. The deadline to submit enrollments/changes for this Open Enrollment period is WEDNESDAY, MAY 19, 2010. Changes will be processed effective July 1, 2010.
4. Refer to the Open Enrollment article in the Current News Section at www.rcuh.com for more information and for RCUH's Open Enrollment meeting schedule.

IMPORTANT NOTES ON FLEXIBLE SPENDING PLAN ACCOUNT (FSPA):

1. There are important IRS-mandated changes pertaining to the Flexible Spending Plan that may affect your elections for the upcoming 2010-11 plan year. Please review the Instructions sheet and Document #6 – Flex Highlights for details BEFORE submitting your Health Insurance/Flexible Spending Enrollment form.
2. You MUST complete this form if you wish to participate in a FSPA for the next Plan Year (7/1/2010 to 6/30/2011). FSPA is an annual contract. ***Current accounts will NOT carry over to the next Plan Year.***

Name: _____ **Birth Date:** _____
Address: _____ **Daytime Phone:** _____
City: _____ **State:** _____ **Zip:** _____ **Email:** _____

HEALTH INSURANCE ENROLLMENT

Health Insurance – Check off ALL that Apply.

- ☐ New Medical Plan Enrollment
- ☐ New Dental Plan Enrollment
- ☐ Add Dependents (Indicate dependents to be added in Dependent Information section below)
- ☐ Cancel Dependents (Indicate dependents to be cancelled in Dependent Information section below)
- ☐ Cancel Medical Plan
- ☐ Cancel Dental Plan

☐ *Check here if you would like your Medical & Dental Insurance Deducted on a Post-tax basis & you do NOT want the tax savings of Pretax selection.*

MEDICAL Plans – Check One:

- ☐ HMSA Health Plan Hawaii Plus (HPHP)* - Pretax
- ☐ HMSA Health Plan Hawaii-Basic (HPH)* - Pretax
- ☐ HMSA Preferred Provider Plan (PPO)- Pretax
- ☐ HMSA Comprehensive Medical (CompMED) – Pretax
- ☐ Kaiser A Plan – Pretax
- ☐ Kaiser B Plan - Pretax

Medical Plan # of Participants – Check One:

- ☐ Self Only
- ☐ Self + 1
- ☐ Self + 2 or more

***Health Plan Hawaii Plus and Health Plan Hawaii-Basic Participants must complete the following**:

Health Center: _____ Primary Care Physician: (PCP) _____

** Note: Employees electing Health Plan Hawaii Plus or Health Plan Hawaii must select a Health Center and Primary Care Physician. If you do not designate a Health Center and a Primary Care Physician for you & your dependents, HMSA will automatically assign it for you.*

HDS DENTAL Plan: Number of Participants:

☐ Self Only - Pretax ☐ Self + One – Pretax ☐ Self + 2 or more – Pretax

Dependent Information						✓ To Enroll		Required for HMSA HPHP or HPH	
#	Full Name	SSN	Birth Date	Domestic Partner (DP), Spouse (S) or Child (C)	Sex (M/F)	Cover Medical	Cover Dental	Health Center	PCP
1.				☐ DP ☐ S ☐ C		☐	☐		
2.				☐ DP ☐ S ☐ C		☐	☐		
3.				☐ DP ☐ S ☐ C		☐	☐		
4.				☐ DP ☐ S ☐ C		☐	☐		
5.				☐ DP ☐ S ☐ C		☐	☐		
6.				☐ DP ☐ S ☐ C		☐	☐		
7.				☐ DP ☐ S ☐ C		☐	☐		

- **Domestic Partnership/Reciprocal Beneficiary** (DP/RB) enrollment requires additional documentation to confirm DP/RB status (email rcuhhr@rcuh.com or call 808/956-3100 for forms)
- **Spouse/Child** new enrollments requests require documentation to confirm dependent status (e.g., official marriage certificate, birth certificate, adoption documents)
- **Student/Disability Certification** – Proof of Full-Time Student Status Due to RCUH Human Resources by August 25, 2010.

FLEXIBLE SPENDING PLAN ENROLLMENT - Check to Elect Benefits Listed Below ✓

☐ Medical Expense Reimbursement (Pretax) $_____ **Per Pay Period** (For 4 or more years of service w/ RCUH, Annual Maximum Contribution=$4,500.00)

$_____ **Per Pay Period** (For less than 4 years of service with RCUH, Annual Maximum Contribution=$2,400.00)

☐ Dependent Care Expense Reimbursement (Pretax) $_____ **Per Pay Period** (Maximum Annual Contribution=$5,000.00)

VOLUNTARY/SUPPLEMENTAL INSURANCE PLANS

☐ Enroll in Supplemental Long Term Care (After-Tax)	☐ Enroll in Voluntary Cancer Care Plan (Pretax)	☐ *CANCEL Voluntary Cancer Care Plan (Pretax)*
☐ Cancel Supplemental Long Term Care (After-Tax)	☐ Enroll in Voluntary AD&D Plan (Pretax)	☐ *CANCEL Voluntary AD&D Plan (Pretax)*
	☐ Enroll in Voluntary Group Life (After-Tax)	☐ *CANCEL Voluntary Group Life (After-Tax)*
	☐ Enroll in Voluntary Accident Guard (Pretax)	☐ *CANCEL Voluntary Accident Guard (Pretax)*
	☐ Enroll in Voluntary Critical Care (Pretax)	☐ *CANCEL Voluntary Critical Care (Pretax)*

I have read and acknowledge the Enrollment conditions for my Health Insurance, Flexible Spending Plan Accounts and/or Voluntary/Supplemental Insurance Plans as stated on the backside of this form.

Signature of Employee _____ Date _____

HEALTH INSURANCE/FLEXIBLE SPENDING ENROLLMENT FORM (Page 2)

HEALTH INSURANCE ENROLLMENT UNDERSTANDING (Reference Policy 3.520 Health Plan Policy):

Enrolling Dependents (Documentation required) – If you are requesting to add eligible dependents onto your health plan(s), documentation (e.g., official marriage certificate, birth certificate, adoption documents) to confirm the dependent status must be submitted along with this enrollment form.

Student/Disability Certification (for child dependents ages 19-24) – I certify that my son and/or daughter are between the age(s) of 19 to 24 and are either enrolled as a full-time student at an accredited University/College or are disabled and qualifies for continued coverage due to this disability. I agree to notify RCUH immediately of any changes to eligibility. Proof of Full-Time Student status is due to the RCUH Human Resources Department by Aug. 25, 2010.

Enrollment Information – I certify that the information on this application is given to obtain insurance and is true and complete to the best of my knowledge and belief. I authorize my employer to set my effective dates of coverage and deduct monthly employee contribution for each benefit plan from my salary, wages, or other compensation including any contribution increase, decrease, adjustment or cancellation as required by the Health Plan Agreement under applicable laws, policies, and procedures. I and any listed dependent agree to abide by the provisions of the service agreement and/or medical insurance contract and health plan regulations. I agree to abide by the terms and conditions of the Group Plan Contract(s) issued to the Research Corporation of the University of Hawaii. I have read the COBRA notice posted at www.rcuh.com and understand that I must inform my spouse and any dependents covered under my health insurance of their rights. I understand that my Employer makes no guarantee that any benefit I elect under this Flexible Spending Plan will be excludable from my gross income for Federal or State income tax purposes. I understand that I am electing to have my portion of the health insurance premiums deducted on a pretax basis unless I request otherwise in writing (Post-tax option).

FLEXIBLE SPENDING ACCOUNTS ENROLLMENT UNDERSTANDING (Reference Policy 3.530 Flexible Spending Plan Policy):

I understand that my Employer makes no guarantee that any benefits I elect under this Plan will be excludable from my gross income for federal or state income tax purposes. I understand that it is my obligation to determine whether or not each payment made under this Plan is excludable from my gross income for federal and state income or Social Security tax and to notify my Employer if I am aware that any particular payment may not be excludable. I agree that if I receive one or more reimbursements under this Plan that are not excludable from income under the Internal Revenue Code, I will indemnify and reimburse my Employer for any tax that may be due on such reimbursement.

By signing below, I acknowledge that I have reviewed the options available to me for my Employer's Flexible Spending Plan. If I make Flexible Spending Plan elections, I am electing to participate in the Plan for the entire plan year and authorize my Employer to reduce my salary and contribute the corresponding amount to the Flexible Spending Plan as indicated on this Election Agreement. Should my premiums change in the future, I authorize my Employer to adjust my reduction and corresponding contribution as permitted by the Internal Revenue Code to reflect the change.

I understand that once these elections are made, I cannot change them during the plan year, except as permitted by the Plan in accordance with Internal Revenue Service regulations. Following an unpaid leave of absence, I understand that I will be required to "catch up" on any missed Medical Expense Plan or voluntary benefit deductions while on leave. For Voluntary and Supplemental Insurance Plans, I authorize my employer to set my effective dates of coverage and deduct monthly employee contribution for each benefit plan from my salary, wages, or other compensation including any contribution increase, decrease, adjustment or cancellation as required by the Plan Agreement, under applicable laws, policies, and procedures.

SUPPLEMENTAL LONG TERM CARE ENROLLMENT UNDERSTANDING:

To enroll in Supplemental Long Term Care, SUBMIT this form and the UNUM Benefit Election Form to RCUH Human Resources Office, and Group LTC Insurance Application-Evidence of Insurability (medical questionnaire) form, if applicable, to UNUM by May 19, 2010. To obtain plan information, Application Packet & Instructions go to UNUM's website at http://w3.unumprovident.com/enroll/rcuh/. If you have any questions about the LTC plan you can call (800) 227-4165. Policy No.: 536066

VOLUNTARY INSURANCE ENROLLMENT UNDERSTANDING:

To enroll in any of the Voluntary Insurances, SUBMIT this form to RCUH Human Resources Office and the Voluntary Cancer Care, AD&D & VGL, Critical Care, and/or Accident Guard application form(s) to Benefits Services of Hawaii, Inc. by May 19, 2010. All additional documents requested/required by BSHI must be submitted to BSHI by July 23, 2010. Failure to submit required documents will result in denial of coverage. For Informational Packets with application forms, please call RCUH at (808) 956-8953. If you have any specific questions about the Voluntary plans, please call BSHI directly at (808) 538-8906 or toll free at (800) 490-3956.

For employees currently enrolled in the Voluntary Cancer Care, Voluntary AD&D, Voluntary Life Insurance, Voluntary Accident Guard, and/or Voluntary Critical Care plan(s) you do NOT need to complete/submit this form unless you want to cancel your plan(s). Your benefits will continue (with possible rate changes) into the next plan year.

RCUH Use Only:					
Plan	**#**	**Coverage Start**	**Deduction Start**	**Input by/Date:**	**Edit by/Date:**
Medical		7/01/2010	6/16/2010		
Dental		7/01/2010	6/16/2010		
FSPA		7/01/2010	7/01/2010		

Filed By/Date: