RCUH GROUP BENEFITS ENROLLMENT/CHANGE APPLICATION

(Regular, 50-100% FTE Employees)

PART A: EMPLOYEE DATA

Last Name:	First Name:	Middle Initial:
Address:		
City:	State:	Zip:	Sex: ☐ Male ☐ Female
Social Security #:	Married ?: ☐ Yes ☐ No	Email Address:	Date of Birth:

PART B: HEALTH INSURANCE ENROLLMENT/CHANGES (50-100% FTE) *Check all that apply*

☐ New Health Enrollment
☐ I Decline Medical Enrollment at this time
☐ I Decline Dental Enrollment at this time
☐ Add Dependent(s)
(Indicate dependents to be added in Dependent Information section below)

☐ Cancel Medical Plan Effective: ____/____/____
☐ Cancel Dental Plan Effective: ____/____/____
☐ Cancel Dependents Effective: ____/____/____
Explanation: ______________________
(Indicate dependents to be cancelled in Dependent Information section below)

Medical Plans – (Check Medical Plan to Enroll):

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

*HPH / HPHP Health Center: ______________________

*Primary Care Physician: ______________________

*If you do not designate a *Health Center* and *Primary Care Physician* for you & your dependents, HMSA will automatically assign it for you.

Dental Plan Selection (check to enroll into dental insurance):

☐ HDS Dental Plan - Pre-tax

IRS requires that we give employees an option to deduct health insurance premiums on a pre-tax (tax savings to employee) or post-tax (no tax savings to employee) basis. If you do NOT wish to obtain tax savings from a pre-tax payroll deduction of your health insurance premium, please check here: ☐

DEPENDENTS (You must complete this to obtain coverage for Spouse, Civil Union Partner, Domestic Partner, &/or dependent children; Proof of dependent status is required)

#	Full Name	SSN	Birth Date	Spouse, Civil Union Partner, Domestic Partner, or Child	Sex	☑ to Enroll: Medical	☑ to Enroll: Dental	*Required for HMSA HPH/HPHP: Health Center*	*Required for HMSA HPH/HPHP: PCP*
1.				☐S ☐CU ☐DP ☐C	☐M ☐F	☐	☐		
2.				☐S ☐CU ☐DP ☐C	☐M ☐F	☐	☐		
3.				☐S ☐CU ☐DP ☐C	☐M ☐F	☐	☐		
4.				☐S ☐CU ☐DP ☐C	☐M ☐F	☐	☐		
5.				☐S ☐CU ☐DP ☐C	☐M ☐F	☐	☐		
6.				☐S ☐CU ☐DP ☐C	☐M ☐F	☐	☐		
7.				☐S ☐CU ☐DP ☐C	☐M ☐F	☐	☐		

Domestic Partnership (DP) enrollment requires additional forms. Please visit www.rcuh.com, Policies & Procedures, Policy 3.520 Health Plans to download the necessary paperwork to properly enroll your DP. *By signing below, I certify that the dependents listed above are legally recognized dependents. (If a spouse or civil union partner is being covered), I certify that he/she is my legal spouse (consistent with the definition of marriage or civil union partnership as defined by the laws of the State of Hawaii). (If a DP is being covered), I certify that we meet the eligibility criteria for DP coverage (as recognized by the State of Hawaii). (If child dependent(s) are being covered), I certify that he/she is my or my civil union partner's natural/legally adopted/step/foster child and under the age of 26, or (if over age 26) cannot support themselves because of a mental or physical disability which occurred before his/her 26th birthday. I understand that proof of dependent status is* ***required*** *and agree to submit documentation by the established deadlines. I also agree to inform the RCUH if my dependent's eligibility status changes in the future. Failure to do so may result in cancellation of benefits, and may include termination of my employment.* ***SIGN BELOW ONLY IF DEPENDENTS WILL BE COVERED.***

Employee Signature: Date:

PART C: LIFE INSURANCE BENEFICIARY DESIGNATION (75% - 100% FTE)

The Beneficiaries of my RCUH life insurance plan provided through The Standard are as follows:

Primary Beneficiary: ______________________ Relationship: __________

Secondary Beneficiary (optional): ______________________ Relationship: __________

PLEASE NOTE: Life Insurance companies generally will not disburse payments directly to minor beneficiaries. Payment will normally be made to the legally recognized guardian of the minor beneficiary, executor of the estate, or The Standard who will retain the benefit amount until minor attains majority age. Your signature at the bottom of this form certifies the designation of the beneficiary(ies) listed above.

PART D: TIAA-CREF GROUP RETIREMENT ANNUITY PARTICIPATION (50-100% FTE)

	Check One:
Have you been or are you currently a participant in the TIAA-CREF Group Retirement Annuity Plan because of previous employment with the RCUH?	☐ Yes or ☐ No

PART E: FLEXIBLE SPENDING PLAN ELECTION & COMPENSATION REDUCTION SHEET (50-100% FTE)

IMPORTANT: Please read the Election Information Sheet and the information brochure for your Employer's Flexible Spending Plan before you complete this form.

Check One:
- ☐ Enrollment
- ☐ I Do NOT Wish To Enroll Into a Medical Expense Reimbursement and Dependent Care Expense Account
- ☐ Family Status Change Event:

	Fill in the your contribution:	
Medical Expense Reimbursement Account (Pretax): (Maximum annual contribution $2100 = $87.50 per pay period)	$	Per Pay Period
Dependent Care Expense Account (Pretax): (Maximum annual contribution $5000 = $208.33 per pay period)	$	Per Pay Period

PART F: PRETAX TRANSPORTATION BENEFITS PLAN (50-100% FTE)

IMPORTANT: Please read the RCUH Pre-tax transportation benefits plan policy (Addendum to 3.530 Flexible Spending Plan Policy) before you elect in this coverage. If you wish to enroll in this Benefits Plan, please complete the RCUH Pre-tax Transportation Benefit Program Individual Enrollment Form.

Check One:
- ☐ Enrollment (also submit the RCUH Pretax Transportation Benefits Program Individual Enrollment Form)
- ☐ I Do NOT Wish To Enroll in a Pretax Transportation Benefits Plan

PART G*:* EMPLOYEE CERTIFICATION (50-100% FTE)

- 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.
- I acknowledge that I have reviewed the options available to me for my Employer's Flexible Spending Plan. If I marked "Enrollment" to any of the 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 following an unpaid leave of absence, I will be required to "catch up" on any missed Medical Expense Plan deductions while on leave.
- 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.
- 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 to 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 General Notice and I understand my rights for Continuation of Health Coverage under COBRA. I also understand that I must inform my dependents covered under my health insurance of their rights.
- I understand that failure to comply with the above or providing inaccurate information or falsifying the information contained in this form may result in disciplinary action including termination of employment. Legal action may be brought against me and/or my Dependents/Spouse/Domestic Partner/Civil Union Partner for any losses, damages (including, but not limited to reasonable attorneys' fees and other legal expenses), financial or otherwise, due to false statements provided on this enrollment (or related) form or for failure to timely notify RCUH of changed circumstances as required. In addition, any health benefits (ex., monthly premiums, claims, etc.) paid by the RCUH health plans on behalf of the Employee's dependents will be reversed and become the responsibility of the Employee.

Employee Signature: **Date:**

RCUH USE ONLY		Coverage Start	Input by/Input Date	Authorized By:
Health Plan				
LTC/LTD/Life			Edit by/Edit Date	
Flex				