



RCUH Group Health Enrollment/Change Form

Employee Name: _____ RCUH Employee ID #: _____

PRETAX Dental Insurance Coverage: Hawaii Dental Service (HDS) Select an option below:	
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Cancel Coverage Effective Date: _____
<input type="checkbox"/> Add <input type="checkbox"/> Drop Dependent Effective Date: _____	

PRETAX Medical Insurance Coverage Select an option and a plan below:	
<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Cancel Coverage Effective Date: _____
<input type="checkbox"/> Add <input type="checkbox"/> Drop Dependent Effective Date: _____	
<i>*If you are cancelling medical coverage through RCUH, you need to review, complete, and submit the RCUH Health Insurance Waiver Form B5-Wa.</i>	

<p>Available To Hawaii Residents Only.</p> <input type="checkbox"/> Kaiser A Plan <input type="checkbox"/> Kaiser B Plan <input type="checkbox"/> HMSA Preferred Provider Plan (PPO) <input type="checkbox"/> HMSA Comprehensive Medical (CompMED) <input type="checkbox"/> HMSA Health Plan Hawaii Plus* (HPHP) <input type="checkbox"/> HMSA Health Plan Hawaii-Basic* (HPH)	<p>Available To BOTH Hawaii and Out of State Residents.</p> <input type="checkbox"/> HMSA Preferred Provider Plan (PPO) <input type="checkbox"/> HMSA Comprehensive Medical (CompMED)
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***HPH/HPHP Health Center:** _____ ***Primary Care Physician (PCP):** _____

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

*The 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 .*

Dependent's Name	SSN / ITIN <small>(Required for 12 month or older)</small>	Date of Birth <small>(mm-dd-yyyy)</small>	*Dependent Relationship	Gender	Med	Den	Health Center <small>(Required for HMSA HPHP/HPH)</small>	PCP
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> CU <input type="checkbox"/> DP	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> CU <input type="checkbox"/> DP	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> CU <input type="checkbox"/> DP	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> CU <input type="checkbox"/> DP	<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/>	<input type="checkbox"/>		

***Relationship Code: S – Spouse C – Child CU – Civil Union DP – Domestic Partner** Domestic Partnership enrollment requires additional forms. See Policy 3.520 Health Plans for form.

- I certify that any dependent(s) 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/partner (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.
- 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:** _____

Submit via email: RCUH_Benefits@RCUH.com or Fax: 808-956-5022

RCUH USE ONLY Authorized By:	Coverage Start	Input By / Date	Edit By / Date
Health Plan			