RCUH Research Corporation of the University of Hawai'i

RCUH Group Health Enrollment Form (B-5Ha) Instructions

Open Enrollment Deadline: May 15, 2019

Section I: Dental Insurance

- Section A: Select if Dental Insurance is for **new enrollment** or **change in coverage**. The effective date for all Open Enrollment changes is 07/01/2019.
- Section B: Select new level of coverage.
- **Note:** There is no Waiver of Coverage needed for Dental Insurance

Section II: Medical Insurance

- Section A: Select if Medical Insurance is for new enrollment or change in coverage. The effective date for all Open Enrollment changes is 07/01/2019.
- Section B: Select new level of coverage at enrollment.
- Section C & D: Choose from the following plans, and provide HNP/HPH Health Center and Physician name. For details on each plan, plan comparisons, and rate sheets, please refer to Policy 3.520 RCUH Health Plans, Section VII. Relevant Documents.
- **Note:** If you are electing to waive medical coverage, or currently waiving medical coverage, you are required to submit the RCUH Group Health Plan Waiver form (B-5Wb).

Section III: Dependent Information

- Complete the information of each dependent being added or removed. Please refer to Relationship Code when filling out "Dependent Relationship."
- Attach proof of relationship document (i.e., marriage certificate, civil union certificate, birth certificate, etc.) for each dependent that is being **added**.
- Employee Signature: RCUH will only accept WET SIGNATURES for the RCUH Group Health Enrollment Form.

I would like to:	Action Needed From Employee
Keep my current medical and/or dental coverage.	No action needed.
Enroll in medical and/or dental coverage as I am currently waived.	Complete and submit the **RCUH Group Health Plan Enrollment Form (B-5Ha)** Section IA/IIA: Select New Enrollment
Change my current medical and/or dental coverage.	Complete and submit the **RCUH Group Health Plan Enrollment Form (B-5Ha)** Section IA/IIA: Select Change in Coverage
Add dependents to my medical and/or dental coverage.	Complete and submit the **RCUH Group Health Plan Enrollment Form (B-5Ha) and include required documentation for dependent coverage (i.e., birth certificate, adoption document, marriage certificate, etc.)** Section IA/IIA: Select Change in Coverage
Cancel my medical and/or dental coverage.	Complete and submit the **RCUH Group Health Plan Enrollment Form (B-5Ha)** and **RCUH Group Health Plan Waiver Form (B-5Wb)** Section IA/IIA: Select Cancel Coverage
Continue waiving medical coverage.	Complete and submit the **RCUH Group Health Plan Waiver Form (B-5Wb) ONLY. **NEW for plan year 2019-20: RCUH must receive a new signed waiver for the plan year 2019-2020 if you currently waive medical coverage.**

RCUH Research Corporation of the University of Hawai'i

RCUH Group Health Enrollment Form (B-5Ha)

OPEN ENROLLMENT

FY 2019 - 2020
3.520 RCUH Health Plans

Employee Name: _____ **RCUH Employee ID #:** _____

NOTE: You are able to cancel coverage for you and/or your dependents at any time of the year. If you elect to cancel coverage at this time, your cancellation of coverage will be effective July 1, 2019. If you, the EMPLOYEE, elect to cancel medical coverage, you MUST submit a waiver form per the Affordable Care Act (ACA).

Section I: PRE-TAX Dental Insurance Coverage: Hawai'i Dental State (HDS) (Select an option below):

A. ☐ New Enrollment
☐ Change in Coverage
☐ Cancel Coverage

Effective Date: 07/01/2019

B. Indicate new level of coverage:
☐ Employee Only
☐ 2-party
☐ Family (3 dependents or more)

Section II: PRE-TAX Medical Insurance Coverage (Select an option and plan below):

A. ☐ New Enrollment
☐ Change in Coverage
☐ Cancel Coverage*

**Waiver of Coverage form must be submitted no later than 5/15/19.*

Effective Date: 07/01/2019

RCUH USE ONLY: Waiver?
Y N N/A

B. Indicate new level of coverage:
☐ Employee Only
☐ 2-party
☐ Family (3 dependents or more)

C. Available to Hawai'i Residents Only
☐ Kaiser Permanente - Plan A
☐ Kaiser Permanente - Plan B
☐ HMSA Health Plan Hawai'i Plus* (HPH)
☐ HMSA Health Plan Hawai'i Basic* (HNP)

D. Available to Both Hawai'i and Out-of-State Residents
☐ HMSA Preferred Provider Plan (PPO)
☐ HMSA Comprehensive Medical
☐ HMSA Comprehensive Medical Basic

***HPH/HNP Health Center:** _____ **Primary Care Physician:** _____

*If you do not designate a Health Center and Primary Care Physician for you and your dependents, HMSA will automatically assign one 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 a 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 (☐) and initial:_____.

RCUH Research Corporation of the University of Hawai'i

RCUH Group Health Enrollment Form (B-5Ha)

Employee Name: _____ **RCUH Employee ID #:** _____

Section III: Dependent Information (Please complete the below information for each dependent being added or removed)

A. Addition or Removal of Dependents ***PROOF OF RELATIONSHIP DOCUMENTATION IS REQUIRED when adding a dependent upon submission***
(i.e., Marriage Certificate, Civil Union Certificate, Birth Certificate, etc.)

+/-	Dependent's Name	SSN/ITN (required if 12 months or older)	Date of Birth (mm-dd-yyyy)	*Dependent Relationship	Gender (M/F)	Med	Den	Primary Care Provider (Required for HMSA HNP/HPH)
				☐ S ☐ C ☐ CU ☐ DP		☐	☐	
				☐ S ☐ C ☐ CU ☐ DP		☐	☐	
				☐ S ☐ C ☐ CU ☐ DP		☐	☐	
				☐ S ☐ C ☐ CU ☐ DP		☐	☐	
				☐ S ☐ C ☐ CU ☐ DP		☐	☐	
				☐ S ☐ C ☐ CU ☐ DP		☐	☐	

***Relationship Code: S — Spouse; C — Child; CU — Civil Union; D — Domestic Partner (Domestic Partnership enrollment requires additional forms. See Policy 3.520 Health Plan for forms.)**

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. Any listed dependent and I 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 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.

Employee Signature: _____ **Date:** _____

RCUH will only accept WET SIGNATURES and will validate the information prior to processing.

Deadline to Submit Form: May 15, 2019

RCUH is committed to protecting the security of your personal information.
Please submit via encrypted email to: rcuh_benefits@rcuh.com or FAX: 808-956-5022

RCUH USE ONLY	Proof of relationship document? Y N	Coverage Start	Input By / Date	Edit By / Date
Health Plan		**07/01/2019**		