RCUH Group Health Enrollment Form (B-5H)

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

Qualifying Event: N/A *Please provide proof of qualifying event within 30 days.*

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

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

Effective Date: _____

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

Section II: PRETAX Medical Insurance Coverage (Select an option and plan below):

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

Effective Date: _____

Waiver of Coverage form must be submitted* ***no later than the 15th of the month preceding the date of cancellation/waiver of coverage.*

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.

Optional: 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-5H)

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.

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				