RCUH Research Corporation of the University of Hawai'i

Human Resources Department

RCUH Group Health Enrollment Form (ACA Eligible Non-Recruited Hires – HMSA COMP MED BASIC ONLY)

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

In compliance with the Patient Protection and Affordable Care Act (also known as the Affordable Care Act (ACA)), we have determined that you have met the definition of a "Full Time Employee" under the ACA (worked at least 30 hours/week or 130 hours/month). Under the ACA, RCUH must offer you and your dependents (as defined under the ACA – see definition highlighted below) its lowest costing health plan (HMSA Comprehensive Medical Basic) provided you maintain your "Full Time Employee" status.

Medical Insurance Coverage – HMSA COMPREHENSIVE MEDICAL BASIC – Select an option below:

☐ New Enrollment (select coverage type below): ☐ Add ☐ Drop Dependent Effective Date:_____

- ☐ Employee Coverage Only (Pre-Tax)
- ☐ Employee (Pre-Tax) + 1 Dependent (Pre-Tax)
- ☐ Employee (Pre-Tax) + 2 or more Dependents (Pre-Tax)

The ACA defines "Dependents" as the employee's (1) Biological Child (BC) OR (2) Adopted Child (AC) through the end of the month in which the employee turns 26 years of age. It is RCUH's policy for you to provide proof of dependent status as listed below.

Dependent's Name	SSN / ITIN (Required for 12 months or older)	Date of Birth (mm-dd-yyyy)	*Dependent Relationship	Gender
			☐ BC ☐ AC	☐ F ☐ M
			☐ BC ☐ AC	☐ F ☐ M
			☐ BC ☐ AC	☐ F ☐ M
			☐ BC ☐ AC	☐ F ☐ M

IMPORTANT: Please read terms and conditions below before signing and dating this form.

- I certify that any dependent(s) listed above are legally recognized dependents (Biological or Adopted Child) under the ACA. I understand that it is the RCUH's policy 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, health plan regulations, and ACA/IRS 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 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 will only accept WET SIGNATURES and will validate the information prior to processing.

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				