RCUH
Research Corporation of the University of Hawaiʻi
Human Resources Department

Employee Name: ______________________________
RCUH ID: _______________

Open Enrollment 2022-2023:
RCUH ACA Health Enrollment/Waiver Form (OE B-5A)

(for employees offered health insurance under the ACA only – non-recruited 75% FTE or greater, and other ACA coverage for Plan Year: July 1, 2022 – June 30, 2023)

Upload form and supporting documentation to RCUH Employee Self Service via eUpload Section by May 17, 2022.

SECTION I: Medical Health Insurance (Pre-Tax)

*If you choose ELECT, complete Section II (if applicable) and IV. **If you choose to WAIVE, please complete Section III and Section IV.*

Coverage Begin: 07/01/2022
Change Reason: Open Enrollment

Coverage Election: ____

Benefit Plan: ____

Coverage Code: _________________________

***The ACA defines dependents as the employee's (1) Biological child or (2) Adopted child through the end of the month in which the individual reaches 26 years of age.*

OPTIONAL: The IRS requires that we provide 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. I elect post-tax payroll deduction of my health insurance premiums. Initials: ________.

SECTION II: Dependent Information

*****PROOF OF RELATIONSHIP DOCUMENTATION IS REQUIRED** when adding a dependent upon submission (i.e., Birth Certificate, Certification of Adoption) and subject to RCUH review.

ADD/ REMOVE	NAME (Last, First)	Social Security Number	Date of Birth	Relationship	Gender

SECTION III: Waiver – Please complete only if you are waiving coverage.

In compliance with the Patient Protection Affordable Care Act (ACA) and as an RCUH condition of employment, I am required to complete this section within two weeks of offer if you have decided to WAIVE health care coverage with RCUH. Individuals can obtain coverage in many ways, including by participating in RCUH's medical plans, purchasing insurance in the Federal Health Insurance Marketplace (HealthCare.gov), or by obtaining government health insurance such as Medicare Part A, Medicare Advantage plans, or Medicaid. I understand that RCUH has given me an opportunity to enroll in RCUH's Medical Plan for my eligible beneficiaries and myself, and if I am voluntarily declining enrollment as indicated above, I can only enroll in the future during RCUH's Open Enrollment Period or due to a Qualifying Event as defined by RCUH's Policy 3.520 RCUH Health Plans. I understand that I and (if applicable) eligible dependents will be ineligible for the Premium Tax Credit (PTC), since medical coverage was offered through RCUH (employer-sponsored coverage).

I am waiving coverage because: ____.

SECTION IV: Employee Certification

Information provided on this enrollment form is true and complete to the best of my knowledge. I authorize RCUH to set my effective dates of coverage and to deduct monthly employee contributions for each benefit plan from my salary. I understand my rights for continuation of health coverage under COBRA and am responsible to inform my dependents covered under my health insurance of their rights.

Employee Signature: ______________________________

Date: ___________________

Questions? Contact RCUH Employee Benefits: Phone: (808) 956-6979 or (808) 956-7055 or Email: rcuh_benefits@rcuh.com

Policy 3.520 RCUH Health Plans