



STATE OF HAWAII PREMIUM CONVERSION PLAN
ELECTION CHANGE FORM (Form PCP-2)

Premium Conversion Plan (PCP) is a voluntary benefit plan, administered by the State Department of Human Resources Development (DHRD) that allows employees to pay for their health benefit plan premiums on a pretax basis. Premium conversion plans are governed by Section 125 of the Internal Revenue Code (IRC). Changes/cancellations must be "on account of and consistent with" the change of status event indicated and shall become effective on a prospective basis from the date received. Submit this form directly to your Human Resources Office (HRO) designee within ninety (90) calendar days of a qualifying event together with the EUTF EC-1/EC-1H Enrollment Form.

EMPLOYEE COMPLETES: Full Name (Last, First, Middle), Last 4-digits of Social Security Number, Date of Qualifying Event
Check Benefit Plans Affected: Medical/Prescription Drug/Chiropractic Plan, Vision Plan, Dental Plan

I elect to CHANGE the amount of the PCP reduction of my pay due to:

From 2-party to Family Enrollment, From Family to 2-party or Self-Only Enrollment, From Self-Only to 2-party or Family Enrollment, From 2-party to Self-Only enrollment
Open Enrollment (non-EUTF, e.g., spouse's employer's open enrollment), Birth, adoption, or placement for adoption of a child, My Marriage, My eligible dependent (re-) joined my household, My dependent's loss of eligibility for coverage under a health benefits plan, My spouse's health benefits plan is significantly changed or terminated, My dependent(s) satisfies the eligibility requirements of the plan (e.g., full-time student, etc.)
Other IRS Qualifying Reason (I have attached a written explanation)

Change of health benefits plan insurance carrier because new residence is out of service area of my present carrier
Change to new employment classification where other component plans have become available or where my carrier's plan is not available

I elect to PARTICIPATE in the Premium Conversion Plan due to:

Self-Only, 2-Party, Family Enrollment
My being out-of-state during the entire Open Enrollment Period, My return from a leave without pay status, Birth, adoption, or placement for adoption of a child, My loss of health benefits plan coverage because of the involuntary termination of my enrollment or my spouse's enrollment due to: Death, Divorce/annulment of my marriage, Eligibility/employment termination
Other IRS Qualifying Reason (I have attached a written explanation)

I elect to TERMINATE my participation in the Premium Conversion Plan due to:

Open Enrollment (non-EUTF, e.g., spouse's employer's open enrollment), My transfer to a non-eligible employment classification, My loss of eligibility for coverage under a component plan, I will be covered under my new second employer's health benefits plan, or a new health benefits plan offered by my second employer, My marriage. I will be covered under my spouse's employer's plan, I will be covered as a dependent under my spouse's new employer's plan or retiree health benefits plan, My spouse, who is also a State employee, changed his/her health plan enrollment to family coverage due to the birth/adoption of our child, I will be placed on a leave without pay status
Other IRS Qualifying Reason (I have attached a written explanation)

I have read the PCP materials, understand the limitations and qualifications of the PCP program, and agree to abide by the terms and conditions of the Plan. I understand that I am making an election that is binding for the remainder of the plan year. I also understand that during this period I may not modify my reduction in pay unless (1) the plan is terminated, (2) there is an increase in the amount required employee contributions for the coverage which I have elected in conjunction with this current Election Change Form, (3) there is a change in my personal status that qualifies under the Internal Revenue Code.

Employee Signature _____ Date _____

HRO DESIGNEE: Complete this section and mail/email this form to DHRD-EAO or fax to 808-587-1107

Department, Division/School, Bargaining Unit, HRO phone/fax number
Employer's Receipt in Office Date, PCP Effective Date
HRO (or employer designee) PRINT Name, HRO (or employer designee) SIGNATURE