RCUH Research Corporation of the University of Hawai'i
Human Resources Department

Employee Name (Last, First): _____
RCUH ID: _____

Open Enrollment FY22-23: RCUH Group Health Enrollment Form (OE B-5H)

(for Regular, Relief, and Non-Regular benefits-eligible status employees 50% FTE or greater for Plan Year: July 1, 2022 – June 30, 2023)

Upload form and supporting documentation to RCUH Employee Self Service via eUpload Section by May 13, 2022.

Section I: Medical Health Insurance (Pre-Tax)

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

Coverage Election: _____

Benefit Plan: _____

Coverage Code: _____

***If enrolling eligible dependents, please complete Section III and provide proof of relationship documentation.*

*HMSA HPH/HNP Only (If

Health Center: _____ Primary Care Physician: _____

SECTION II: Dental Insurance (Pre-Tax)

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

Coverage Election:

Benefit Plan:

Coverage Code: _____

***If enrolling eligible dependents, please complete Section III and provide proof of relationship documentation.*

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 III: Dependent Information

*****PROOF OF RELATIONSHIP DOCUMENTATION IS REQUIRED** when adding a dependent upon submission (i.e., Marriage Certificate, Civil Union Certificate, Birth Certificate, etc.) and subject to RCUH review.

ADD/ REMOVE	Med	Den	NAME (Last,First)	Social Security Number	Date of Birth	Relation-ship	Gender	PCP (HMSA HPH/HNP only)
ADD								
ADD								
ADD								
ADD								

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: _____

Policy 3.520 RCUH Health Plans

Form REVISED: 04/05/2022