RCUH Research Corporation of the University of Hawai'i *'Ahahuina Noi'i O Ke Kulanui O Hawai'i*

Employee Name: _____

RCUH ID: _____ RESET Form

RCUH Health and Dental Enrollment/Change Form (B5H-Reg)

(for Regular, Relief, and Non-Regular benefits-eligible status employees 50% FTE or greater for Plan Year: July 1, 2024 – June 30, 2025)

Upload form and supporting documentation to RCUH Employee Self Service via eUpload link.

Section 1: Qualifying Event and Effective Date

A. Qualifying Event: Please choose one option (form must be received within 30 days of qualifying event, if applicable).

- ☐ New Hire
- ☐ Birth/adoption of child (add child)
- ☐ Marriage (add spouse)
- ☐ Loss of insurance coverage (add employee, add qualified dependents)
- ☐ Meeting the eligibility requirements for civil union partner status
- ☐ Voluntary Drop Dependent – no qualifying event necessary
- ☐ Voluntary Cancel/Waive – no qualifying event necessary
- ☐ Other

B. Requested Date of Effective Change (future date): _____ (if applicable)

Form and supporting documentation must be received no later than the 20th of the month prior for the effective date of change on the 1st. RCUH HR reserves the right to adjust effective date,

Section 2: Medical Health Insurance (Pre-Tax) RCUH Policy 3.520

Check one box only. If no boxes are checked, no changes will be made to an employee's current enrollment.

	Employee New/Change Enrollment	2-Party* New/Change Enrollment	Family (3+)* New/Change Enrollment	NO CHANGE to current enrollment	Cancel/ Waive
HMSA Comprehensive Medical Basic	☐ $258.09	☐ $516.16	☐ $903.64	☐	☐ Submit Waiver on eWaive Form via eUpload in ESS.
HMSA Comprehensive Medical	☐ $296.39	☐ $592.74	☐ $1,037.67		
HMSA Preferred Provider	☐ $375.36	☐ $750.71	☐ $1,314.14		
HMSA HMO Hawaii Residents only PCP:	☐ $343.58	☐ $687.16	☐ $1,202.86		
Kaiser HMO Plan A – Standard Hawaii Residents only	☐ $199.33	☐ $398.67	☐ $697.67		
Kaiser HMO Plan B - Comprehensive Hawaii Residents only	☐ $231.16	☐ $462.32	☐ $809.05		

Employee share of monthly premium shown only: Refer to Rate Sheet for TOTAL monthly premium cost information

*If enrolling eligible dependents, please complete Section 4 and provide proof of relationship documentation.

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SECTION 3: Dental Insurance (Pre-Tax) RCUH Policy 3.520

Check one box only. If no boxes are checked, no changes will be made to an employee's current enrollment.

	Employee New/Change Enrollment	2-Party* New/Change Enrollment	Family (3+)* New/Change Enrollment	NO CHANGE to current enrollment	Cancel/ Waive
Hawaii Dental Service (HDS)	☐ $14.12	☐ $28.24	☐ $46.40	☐	☐

Employee share of monthly premium shown only: Refer to Rate Sheet for TOTAL monthly premium cost information

*If enrolling eligible dependents, please complete Section 3 and provide proof of relationship documentation.

SECTION 4: 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)	Date of Birth	Relation-ship	Gender	Primary Care Physician (HMSA HMO only)

SECTION 5: Employee Certification

While a signature (manual or electronic) is preferred, if form is submitted via Employee Self Service eUpload feature, the electronic submittal may serve as employee approval and certification of this form's content.

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand that the benefit elections made on this application are in effect as long as I continue to meet RCUH's eligibility requirements, or until I elect to change them subject to the provisions of the plan rules. I authorize my employer to make the deductions, adjustments, or cancellations from my compensation in accordance with applicable laws, rules, and regulations. This form supersedes all forms and submissions previously made for benefit coverage with the RCUH.

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. Please contact RCUH HR Employee Benefits to enroll in post-tax health insurance deductions.

Medical Enrollment: If enrolling, 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. I will contact RCUH HR if electing post-tax deduction. If waiving, 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). Information provided on this form is true and complete to the best of my knowledge.

Employee Signature: _____ **Date:** _____

Questions? Contact RCUH Employee Benefits: Phone: (808) 956-6979 or (808) 956-2326 or Email: rcuh_benefits@rcuh.com