STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

FORM HC-5 EMPLOYEE NOTIFICATION TO EMPLOYER FOR CALENDAR YEAR 2015

Instructions to employee: Keep a copy of your completed, signed form for yourself. Give the completed form to your employer.

Use this form if any of these apply to you:

- You work for 2 or more employers**
- You are claiming an exemption or waiver from health care coverage
- You are terminating your exemption
- You are changing your principal and/or secondary employer designation**

Do **not** use this form if either:

- You work for only 1 employer and that employer provides your health care coverage
- You work less than 20 hours per week for your employer

**The principal employer is the employer who pays you the most wages. Or if you work for 1 of your employers at least 35 hours a week but that employer does not pay you the most wages, you choose which employer is the principal employer.

Employer name	DOL account number
Address	Telephone No. ( )

In accordance with the provisions of the Hawaii Prepaid Health Care Act (Chapter 393, Hawaii Revised Statutes), this is to notify my employer that: (Check appropriate box.)

☐ 1. Of the two or more concurrent employers that I work for (at least 20 hours a week), you have been selected as the **principal** employer and are therefore required to provide me health care coverage (Section 393-6).

☐ 2. Of the two or more concurrent employers that I work for (at least 20 hours a week), you have been selected as the **secondary** employer and are therefore relieved of the responsibility to provide me health care coverage until you are otherwise notified (Section 393-16).

☐ 3. I am **exempt** from health care coverage because I am: (Check appropriate box.) (Sections 393-17 and 393-22)

- ☐ a. covered by a Federally established health insurance or prepaid health care plan, such as Medicare, Medicaid or medical care benefits provided for military dependents and military retirees and their dependents.
- ☐ b. covered as a dependent under a qualified health care plan.
- ☐ c. a recipient of public assistance or covered by a State-legislated health care plan governing medical assistance.
- ☐ d. a follower of a religious group who depends upon prayer or other spiritual means for healing.

☐ 4. I waive coverage from my employer's health care plan because I have obtained a_____ _____ (name of plan) plan from_____ (name of health care plan contractor) which satisfies the Prepaid Health Care Act. I understand this waiver is binding for the 2015 calendar year (Section 393-21).

☐ 5. The coverage exemption/waiver previously indicated in items 2, 3 or 4 is no longer applicable; you are therefore required to provide me health care coverage (Section 393-18). Requested effective date of coverage: _____ _____.

Print employee name	Employee signature	
Address	Phone number ( )	Date

Call (808) 586-9188 with any questions about this form.

Instructions to employer: Provide coverage as required by 1 and 5 above. Keep the completed, signed form and give a copy to the employee. You must keep this form for 2 years. **DO NOT SUBMIT** this form to the State Department of Labor & Industrial Relations, unless it is requested. (Form must be renewed every December 31.)

Auxiliary aids and services are available upon request. Please call: (808) 586-9188; TTY (808) 586-8847; TTY neighbor islands (888) 569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall, on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation, be subjected to discrimination, excluded from participation in, or denied the benefits of the Department's services, programs, activities, or employment.