

Employer name

accommodation(s).

Address

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 2016

DOL account number

Phone no.

Instructions to employer: See employee's selection below and take appropriate action. Keep this completed, signed form and give a copy to the employee. You must keep this form for 2 years. The employee's selection below is applicable only within calendar year 2016. If the employee will be renewing the selection after 2016, have the employee complete the form for the appropriate year.

| Instructions to employee : Keep a copy of your completed, signed employer. | d form for yourself. Give the com | pleted form to your |
|---|---|---------------------------|
| | n exemption or waiver from healt rour principal and/or secondary e | |
| **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 per week but that employer does not pay you the most wages, you choose the principal employer. | | |
| Do not use this form if either: • You work for only 1 employer at • You work less than 20 hours pe | | nealth care coverage |
| In accordance with the provisions of the Hawaii Prepaid Health C to notify my employer that: (Check appropriate box.) | are Act (Chapter 393, Hawaii R | evised Statutes), this is |
| 1. Of the two or more concurrent employers that I work for (a principal employer and are required to provide me health | | ve been selected as the |
| 2. Of the two or more concurrent employers that I work for (a the secondary employer and are therefore relieved of the you are otherwise notified (Section 393-16). | | |
| 3. I am exempt from health care coverage because I am: (Ch | eck appropriate box.) (Sections | 393-17 and 393-22) |
| a. covered by a Federally established health insurance or or medical care benefits provided for military dependent | | |
| $\hfill \square$ b. covered as a dependent under a qualified health care $\mathfrak p$ | olan. | |
| ☐ c. a recipient of public assistance or covered by a State-legis | slated health care plan governing | medical assistance. |
| d. a follower of a religious group who depends upon praye | er or other spiritual means for he | aling. |
| 4. I waive coverage from my employer's health care plan bed from the health care plan contra I understand this waiver is binding for the 2016 calendar years. | ctor named | |
| forward to the Dept of Labor and Industrial Relations with the | | . , . , . , . |
| 5. The coverage exemption/waiver previously indicated in ite required to provide me health care coverage (Section 393- Requested effective date of coverage: | | ble; you are therefore |
| Print employee name | Employee signature | |
| | . , , , , , , , , , , , , , , , , , , , | Date |
| Call (808) 586-9188 with any questions about this form. | | |

Important Notice about Language Assistance: This document contains important information. If you need language assistance at no cost to you, please contact us by phone or in person immediately.

569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed

Auxiliary aids and services are available upon request. Please call: (808) 586-9188; TTY (808) 586-8844; TTY neighbor islands (888)

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.