State of Hawai'i
Department of Labor and Industrial Relations
DISABILITY COMPENSATION DIVISION
P.O. Box 3769, Honolulu, Hawai'i 96812-3769

FORM HC-5
(Rev. 12/03)

FOR CALENDAR YEAR 2004

EMPLOYEE NOTIFICATION TO EMPLOYER

Instructions to Employee: This form, to be completed in triplicate, is to be used for the following purposes as provided by the Hawai'i Prepaid Health Care Act and Administrative Rules: (A) If you work for two or more employers, you must notify each employer whether the employer is the principal employer (the employer responsible for providing health care coverage) by checking item 1, or the secondary employer by checking item 2. (B) If you are claiming exemption from health care coverage, indicate the reason in the appropriate block under item 3. (C) If you are changing your principal and/or secondary employer designation, or if you are terminating your exempt status, complete item 5.

NOTE: This form need not be filed if (1) you work for only one employer and your employer provides you health coverage, or (2) you work less than 20 hours per week for your employer.

To determine who would be the principal employer, Section 393-6 explains that (1) the principal employer shall be the employer who pays you the most wages; or (2) if one of the employers, who does not pay you the most wages, employs you for at least 35 hours a week, you shall determine which of the employers shall be your principal employer.

Employer Name	DOL Account Number
Address	Phone Number

In accordance with the provisions of the Hawaii Prepaid Health Care Act (Chapter 393, Hawaii Revised Statutes), this is to notify you that: (Check one block only):

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

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

☐ 3. I am **exempt** from health care coverage because I am (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 for healing upon prayer or other spiritual means.

☐ 4. I waive coverage from my employer's health care plan; in lieu I have obtained a plan from _____ (name of health care plan contractor) which satisfies the Hawaii Prepaid Health Care Act (attach copy of plan and send to the DC Division). I understand this individual waiver is binding for one year (Section 393-21).

☐ 5. The coverage exemption previously indicated in items 2, 3 or 4 is no longer applicable; you are therefore required to provide health care coverage for the undersigned (Section 393-18) effective _____ (give date).

PRINT NAME _____

Employee Signature	Address	Date	Phone No.

Instructions to Employer: Enter your firm's Department of Labor (DOL) Account Number in the space provided. Provide coverage as required by 1 and 5 above. Send original copy of notice to the address listed at the top of this form; second copy for employer; third copy for employee. **This notification must be renewed every December 31 for exemptions claimed under item 3 (Sections 393-17 and 393-22).**

Auxiliary aids and services are available upon request. Please call: (808) 586-9188, **TTY** (808) 586-8847, **TTY neighbor islands** 1 -888-569-6859. A request for a 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.