CITY AND COUNTY OF HONOLULU
PREMIUM CONVERSION PLAN

BENEFIT ELECTION FORM

1. Name (Last, First, Middle)	2. Employee ID number	3. BU Code
4. Department	5. Division	
6. Business Phone	7. Email Address	

☐ I elect to participate in the Premium Conversion Plan (PCP). I authorize my employer to reduce my pre-tax pay by the total amount of the required employee contribution for the health coverage for which I have elected.

☐ I elect **not** to participate in the Premium Conversion Plan.

If you have been reemployed by the City and County of Honolulu within the same plan year, you may continue your PCP enrollment under certain conditions. Please answer the question below.

Were you previously employed by the City and County of Honolulu with the past two years?

☐ YES ☐ NO

If Yes,

(a) What was your date of termination? _____

(b) What was your last department or agency? _____

(c) Coverage must be identical to enrollment prior to termination, otherwise attach completed Election Change Form.

I have received and read printed materials explaining the City and County of Honolulu's Premium Conversion Plan and my options thereunder. I understand that I am making an election that is binding for the 12 months beginning on the next July 1 (or, if I am a new employee, for the period beginning on the date I am eligible to participate in this plan) and ending when I submit an election change form. I understand that if I elect **not** to participate at this time, I may not enroll in this plan until the following July 1, unless I am permitted to change from an election of no coverage under any health plan to an election for such coverage, and I timely remit an Election Change Form (DF-A-79). I further understand that during this coverage period I may **not** terminate or otherwise modify my reduction in pay unless (1) the plan is terminated, (2) there is a change in the amount of required employee contributions for the health coverage which I have elected, or (3) there is a change in my personal status (marriage, birth, death, adoption, etc.). In the case of item (3), I understand I must complete and timely submit an Election Change Form in order to terminate or otherwise modify my reduction in pay under this plan.

Employee Signature:	Date:

EXCEPT AS STATED ABOVE, THIS ELECTION CANNOT BE CHANGED UNTIL THE END OF THE PLAN YEAR DURING OPEN ENROLLMENT. This form must be returned to your department personnel office no later than the deadline indicated in the accompanying material.