

**CITY AND COUNTY OF HONOLULU
PREMIUM CONVERSION PLAN
BENEFIT ELECTION FORM**

This form is to be used to elect to participate in or terminate from the Premium Conversion Plan (PCP) and must be submitted during the following periods:

1. Within 90 days of the effective date of becoming a newly eligible employee (a new hire, change in benefits eligibility, or transfer from BWS); or
2. Within annual open enrollment period.

Required fields (*) must be completed or the form will be returned without action.

***Required: Select only 1 choice below:**

- Open enrollment
- Newly eligible employee - *Effective Date: _____

*Name (Last, First, Middle)	*Employee ID or Last 4 SSN:	BU Code
*Department	Division	

***Required: Select only 1 check box below:**

- 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.

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