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 2017

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 2017. If the employee will be renewing the selection after 2017, have the employee complete the form for the appropriate year.

Employer name Honolulu Community Action Program	DOL account number 0000781061
Address 1132 Bishop Street, Suite #100, Honolulu, HI 96813	Phone no. (808) 521-4531

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**

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

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 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 the plan named _____ _____ from the health care plan contractor named _____.
I understand this waiver is binding for the 2017 calendar year. I submitted a copy of my plan to my employer to forward to the Dept of Labor and Industrial Relations with this form. (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 no.	Date

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

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

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.

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.