



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

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.

Table with 2 columns: Employer name, DOL account number, Address, Phone no.

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 terminating your exemption
You are claiming an exemption or waiver from health care coverage
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.)

Five checkbox options for health care coverage selection, including principal/secondary employer, exemption reasons, waiver, and non-applicable exemptions.

Table for employee information: 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.