STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
830 Punchbowl Street, Princess Keelikolani Building, Room 209, Honolulu, Hawaii 96813
Mailing Address: P O Box 3769, Honolulu, Hawaii 96812-3769
Telephone Number: (808) 586-9239

INSTRUCTION SHEET FOR FORM HC-6
EMPLOYER'S REQUEST FOR PREMIUM SUPPLEMENTATION

SMALL EMPLOYERS (THOSE WITH LESS THAN 8 ELIGIBLE EMPLOYEES) SUBJECT TO HAWAII'S PREPAID HEALTH CARE (PHC) ACT, CHAPTER 393*, HAWAII REVISED STATUTES (HRS)

A special fund for health care premium supplementation is available to employers who meet the criteria established under Section 393-45, HRS. Please Note: Due to federal funding restrictions, claims for premium supplementation will only be processed for health plan years beginning on or after January 1, 2017.

Section 393-45(HRS) along with Sections 12-12-70 and 12-12-71 (Hawaii Administrative Rules) of the PHC Act specify that an employer is entitled to premium supplementation if the employer satisfies **all** of the following qualifying conditions:

1. Employer employs less than eight employees entitled to PHC coverage.
2. Employer's health care plan is approved under Section 393-7(a) of the PHC Act.
3. Employer's share of the premium cost for eligible employees (single coverage only) exceeds 1.5% of the total wages payable to such employees and the amount of such excess is greater than 5% of the employer's income before taxes directly attributable to the business.
4. Employer must be in business for profit and the request for supplementation must be filed within two years after the end of the employer's taxable year.

The fund will not supplement the employee's share of the premium, dependent's coverage and the additional premium cost of the more expensive plan should the employer have more than one plan.

Please complete Form HC-6, Employer's Request for Premium Supplementation, and return the form along with the following documents:

1. Individual payroll records and quarterly payroll tax reports (Forms UC-B6 and 941)
2. Copy of the State of Hawaii income tax return for the business certified by the Department of Taxation
3. Copy of the U.S. income tax return for the business
4. W-2 forms
5. Health care contractor's monthly medical billing statements and health plan rate exhibits
6. Additional records/documents may be requested when necessary

***Please visit http://labor.hawaii.gov/dcd for forms, instructions, and a complete text of Chapter 393, HRS.

Auxiliary aids and services are available upon request. Please call: (808) 587-8778; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for 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.

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FORM HC-6 EMPLOYER'S REQUEST FOR PREMIUM SUPPLEMENTATION

Employer Name	DOL Account No. - -	Federal I.D. No./Social Security No.

Address	City	State	Zip Code

Health Care Contractor Name	Plan Name / Plan Year(s) - MM/DD/YR - MM/DD/YR	
Total Number of Employees Eligible for PHC Coverage	Total annual wages paid to employees eligible for **and** covered under employer's PHC plan	$

To Calculate Premium Supplementation:

A. Total annual premium cost for providing single PHC coverage to eligible employees (per billing statements from health care contractor)	$
B. Employees' share of premium cost (1.5% of employee's wages not to exceed 50% of premium cost)	$
C. Employer's share of the premium cost (A minus B)	$
D. 1.5% of total wages paid to covered eligible employees	$
E. Difference (Note: Stop here if E is not a positive number. You are not entitled to premium supplementation.) (C minus D)	$
F. 5% of employer's adjusted income before taxes directly attributable to the business (Leave blank if not known.)	$
G. This is an approximate amount of premium supplementation claimed (If G is a positive number, you may be entitled to premium supplementation.) (E minus F)	$
Taxable year for which premium supplementation is covered	Mo / Day / Year to Mo / Day / Year (taxable year)

Attached with my application are individual payroll records and quarterly payroll tax reports (Forms UC-B6 and 941), a certified copy of the State of Hawaii income tax return, U.S. income tax return for the business, W-2 forms, the health care contractor's monthly medical billing statements, and the health plan rate exhibits.

I certify that the information submitted above is true and correct to the best of my knowledge. I understand that the Department of Labor and Industrial Relations, Disability Compensation Division, reserves the right to audit company records in considering our request.

Authorized Signature (Owner/Member/Corporate Officer)	Date
Print Name and Title	Email
Telephone No. ( )	Fax No. ( )

Visit our website at http://labor.hawaii.gov/dcd forms and instructions.