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: 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813
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, specify that an employer is entitled to premium supplementation if the employer satisfies all of the following qualifying conditions:

1. Employer employes not more than seven (7) employees entitled to PHC coverage.
2. Employer's health care plan is approved under Section 393-7(a), HRS.
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 for all employees, listing the employee's name, pay period, pay date, gross wages, hours, deductions, and net pay. The payroll records must include one month prior to the tax year and the tax year claimed.
2. Record of daily hours worked or employee affidavit of hours worked for salaried employees
3. Quarterly payroll tax reports (Forms UC-B6 including wage detail sheet and Form 941)
4. Copy of the State of Hawaii income tax return for the business certified by the Department of Taxation
5. Copy of the U.S. income tax return for the business
6. W-2 forms
7. Health care contractor's detailed monthly medical billing statements and health plan rate exhibits for all of the employer's plans offered to employees
8. Additional records/documents (such as cancelled payroll checks, Form HC-5) may be requested

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

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with Disabilities. TDD/TTY Dial 711 then ask for (808) 586-9239

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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 an 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	MM/DD/YR to MM/DD/YR	(taxable year)

Attached with my application are individual payroll and hourly records, 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 for all employer plans.

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. I understand that my request may be denied if all the required documentation are not submitted.

Authorized Signature (Owner/Member/Corporate Officer)	Date

Print Name and Title	Email
Telephone Number	Fax Number