STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM HC-4
HEALTH CARE COVERAGE QUESTIONNAIRE

Instructions

Please completely fill out the HC-4 HEALTH CARE COVERAGE QUESTIONNAIRE FORM.

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail

Department of Labor and Industrial Relations, Disability Compensation Division
P.O. Box 3769, Honolulu, Hawaii 96812-3769

Delivery In-Person

Department of Labor and Industrial Relations, Disability Compensation Division
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-9188

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FORM HC-4 HEALTH CARE COVERAGE QUESTIONNAIRE

Employer Information

Employer Name (Last, First, Middle)			DOL Account No. - -
DBA Name, if any	Nature of Business		
Address	City	State	Zip Code
Place of Business, if different from above	City	State	Zip Code

HEALTH CARE PLAN(S) – (Chapter 393, Hawaii Revised Statutes)

If health care coverage is not required, please state reason:

Indicate the type(s) of plan(s) you already have or will have:

TYPE 1 – A service type plan which requires the prepaid health care plan contractor, such as Kaiser, to furnish the required health care benefits.		
Name of Health Care Plan Contractor		
Plan Name	Group No.	Effective Date
If not under your name, give employer's or association's name under which your health care is registered		
Classes of Employees Covered by the Plan	No. Covered	

TYPE 2 – A reimbursement type plan which requires the prepaid health care contractor, such as HMSA, to defray or reimburse the expenses of health care. If coverage is by an insurance company, attach a complete copy of the plan for review by the department.		
Name of Health Care Plan Contractor		
Plan Name	Group No.	Effective Date
If not under your name, give employer's or association's name under which your health care is registered		
Classes of Employees Covered by the Plan	No. Covered	

TYPE 3 – A plan in which health care benefits are provided according to a collective bargaining agreement. If more than one union, enter this information in the Additional Information section at the end of the form.	
Name of Union	
Name of Health Care Plan Contractor	
Name or Number of Plan	No. Covered

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TYPE 4 – A self-insured plan with satisfactory proof of solvency and financial ability to defray or reimburse health care benefits. Attach copies of the plan and employer's audited financial statements.		
Name of Health Care Plan Administrator		
Plan No. or Name	Group No.	Effective Date
Classes of Employees Covered by the Plan	No. Covered	

Indicate the number of employees you feel will be exempted from coverage and the reason(s) for their exemption.

No. of Employees	Reason for Exemption
	Works less than 20 hours a week
	Covered as a dependent under a qualified health care plan
	Covered by primary employer
	Covered by a State or Federal health care plan
	Covered by State-governed medical assistance or the employee is a public assistance recipient
	Other coverage obtained from _____ (name of health care contractor) which meets the Prepaid Health Care (PHC) Law (attach copy of plan and send to Disability Compensation Division).
	Other _____

If applicable, indicate your share and the employee's share of the premium cost. (Note: You cannot deduct more than 1.5% of the employee's gross wages up to one-half of the monthly premium. If the employee's share is less than half, you must pay the remaining portion.)

Total monthly premium cost per employee for employee only coverage $	Employee Pays $	Employer Pays $
Total monthly premium cost for employee and dependents coverage $	Employee Pays $	Employer Pays $

Additional Information (if more space is needed, please attach another sheet)

Signature	Title		Date
Print Name	Telephone No. ( )	Fax No. ( )	