



STATE OF HAWAII  
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS  
DISABILITY COMPENSATION DIVISION  
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 and submit to the address in the Delivery Information section below.

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

**Delivery Information**

Department of Labor and Industrial Relations  
Disability Compensation Division  
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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**DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS**  
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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:**

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

<b>TYPE 1</b> - 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	
<b>TYPE 2</b> - 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	
<b>TYPE 3</b> - 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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<b>TYPE 4</b> - 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.