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 2025

Use this form if the employee works at least 20 hours per week and:

- Works for 2 or more employers** or
- Claims an exemption or waiver from health care coverage or
- Terminates an exemption or
- Changes principal and/or secondary employer designation**

THIS SECTION IS FOR THE EMPLOYER TO COMPLETE.

Employer name _____ DOL account number _____

Address _____ Phone no. _____

See employee's selection below and take appropriate action. **Give a copy of this completed form to the employee**. Keep this completed, signed form on file for 2 years. **The employee's selection below is applicable only within calendar year 2025.** If the employee will be renewing the selection after 2025, have the employee complete the form for the appropriate year.

FOR THE EMPLOYEE TO COMPLETE:

Do **not** use this form if:

- You work for only 1 employer and that employer provides you with health care coverage or
- 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.)

☐ 1. Of the two or more concurrent employers that I work for (at least 20 hours a week), you have been selected as the **principal**** employer and are required to provide me health care coverage (Section 393-6).

**The principal employer is the employer who pays the employee the most wages. However, if the employee works for 1 employer at least 35 hours per week and that employer does not pay the employee the most wages, the employee chooses the principal employer.

☐ 2. Of the two or more concurrent employers that I work for (at least 20 hours a week), you have been selected as the **secondary**** employer and are therefore relieved of the responsibility to provide me health care coverage until you are otherwise notified (Section 393-16).

☐ 3. I am **exempt** from health care coverage because I am: (Check appropriate box.) (Sections 393-17 and 393-22)

- ☐ a. covered by a Federally established health insurance or prepaid health care plan, such as Medicare, Medicaid or medical care benefits provided for military dependents and military retirees and their dependents.
- ☐ b. covered as a dependent (e.g. spouse, child, etc.) under a qualified health care plan.
- ☐ c. a recipient of public assistance or covered by a State-legislated health care plan governing medical assistance (e.g. MedQuest).
- ☐ d. a follower of a religious group who depends upon prayer or other spiritual means for healing.

☐ 4. I waive coverage from my employer's health care plan because I have obtained the plan named _____ _____ from the health care plan contractor named _____.
I understand this waiver is binding for the 2025 calendar year. I submitted a copy of my plan to my employer to forward to the Department of Labor and Industrial Relations with this form. (Section 393-21).

☐ 5. The coverage exemption/waiver previously indicated in items 2, 3 or 4 is no longer applicable; you are therefore required to provide me health care coverage (Section 393-18).
Requested effective date of coverage: _____.

Print employee name _____ Employee signature _____

Address _____ Phone no. _____ Date _____

Keep a copy of your completed, signed form for yourself. **RETURN COMPLETED FORM TO EMPLOYER.**

Call (808) 586-9188 with any questions about this form.

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.

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