

- NEW
- AMEND
- CONTINUATION
- CANCELLATION

STATE OF HAWAII
DEPARTMENT OF LABOR & INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

DATE RECEIVED

PREPAID HEALTH CARE PLAN APPLICATION (Form HC-7)

INSTRUCTIONS

Select New if the plan has not been filed with DCD previously.
 Select Amend if the plan was filed as New, but you need to change your response(s) in the fields below.
 Select Continuation if the plan was approved and you are seeking continued approval of the amended plan.
 Select Cancellation if the plan will no longer be available to employers/employees.

PLAN INFORMATION	
PLAN NAME	PLAN REQUESTED EFFECTIVE DATE
BENEFIT LEVEL (HMO, PPO, Comprehensive, Basic Major Medical, Other)	HAWAII REVISED STATUTES (HRS) SECTION <input type="checkbox"/> 393-7(a) or <input type="checkbox"/> 393-7(b)* *Must include certification that the employer has agreed to contribute at least one-half of the cost of the coverage for dependents.
IF OTHER, PLEASE SPECIFY	HEALTH CARE CONTRACTOR NAME
POINT OF CONTACT INFORMATION	
POINT OF CONTACT NAME	POINT OF CONTACT EMAIL ADDRESS
POINT OF CONTACT ADDRESS	POINT OF CONTACT PHONE NUMBER
POINT OF CONTACT CITY	Will you be able to have a representative present when the Council is discussing your plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
POINT OF CONTACT STATE	How many days' notice do you require?
POINT OF CONTACT ZIP CODE	
REQUIRED DOCUMENTS	
<p>Please submit the following digital copies to DLIR.DCD.PLANS@hawaii.gov Hard copies shall be delivered to:</p> <p style="text-align: center;"> Department of Labor and Industrial Relations Disability Compensation Division 830 Punchbowl Street #209 Honolulu, HI 96813 </p> <p>(a) Digital copy of Prepaid Health Care Plan Application. (b) Digital copy of Cover Letter. (c) Digital copy of the HC-16 and/or HC-17 as applicable. (d) Digital copy of red-lined and clean plan. (e) 8 hard copies-colored. For Continuation plans provide 8 hard copies of the red-lined version of health care plan. (f) Digital copy of network directory of the PPO, EPO, or HMO network. (g) Hawaii State Insurance Commissioner's approval or signed statement that the plan does not require approval.</p> <p>New contractor plans: (a) through (g) are required. New employer-sponsored plans: (a) through (f) are required. All continued plans: (a) through (e) are required.</p>	

AGREEMENT

The Hawaii Prepaid Health Care (PHC) Act, Chapter 393, HRS, requires employers to provide coverage to eligible employees. An employee is deemed eligible if the employee works at least twenty hours per week and earns a monthly wage of at least 86.67 times the Hawaii minimum hourly wage. Coverage commences after four consecutive weeks of employment. Employers/Contractors are not allowed to deny eligible employees coverage based upon other factors, such as, pre-existing health conditions.

As an Employer/Contractor of Approved Health Care Plans we agree to abide by the following:

1. Health information on employees, if requested, may not be used to deny coverage nor retroactively cancel coverage.
2. Approved plans(s) must be offered to all employers/regular employees as defined in section 393-3, HRS.
3. Approved plans purchased/offered by employer/contractor will remain in effect until such time when the health care contractor files a notice to terminate with and receives approval from the Department of Labor and Industrial Relations (DLIR) or the plans are revoked by the DLIR for noncompliance with the PHC Act or its related administrative rules.
4. The Health Care Contractor/Employer will permit the DLIR Director or authorized representative access to the premises and records for the purpose of conducting audits and/or investigations in the enforcement of the PHC Act.
5. Health Care Contractors/Employer will comply with all provisions of the PHC Act, Chapter 393, HRS and its Related Administrative Rules, Chapter 12, Title 12. (Chapter 12, Title 12, Subchapter 3 specifically applies to health care contractor requirements, which can be referenced on DLIR's website at labor.hawaii.gov/dcd/)

SIGNATURE

I declare under penalty of law that all the information provided herein is true and correct to the best of my knowledge and belief.

SIGNATURE	TITLE	DATE
EMAIL	PHONE NUMBER	
ON BEHALF OF	EMAIL	



ENGLISH	This document contains important information. If you need language assistance at no cost to you, please contact us by telephone or in person immediately.
ILOKANO	Daytoy nga dokumento ket addaan ti importante nga impormasyon. No masapul mo ti mangipatarus nga libre, pangngaasim ta awagan na kami ti telepono wenno umay na kami kitaen nga daras.
TAGALOG	Ang dokumentong ito ay naglalaman ng importanteng impormasyon. Kung nangangailangan kayo ng libreng tulong para maintindihan ito, mangyaring makipag-ugnay sa amin sa pamamagitan ng telepono o makipagkita kagaad sa amin.
CHINESE SIMPLIFIED	此文件有重要信息。如果您需要免费的语言协助服务，请您立刻给我们打电话或来我们办公室请求帮助。
CHINESE TRADITIONAL	此文件有重要信息。如果您需要免費的語言協助服務，請您立刻給我們打電話或來我們辦公室請求幫助。
SPANISH	Este documento contiene información importante. Si necesita los servicios de un intérprete sin costo alguno para usted, por favor llame de inmediato por teléfono o contacte con alguna persona de nuestra oficina.
JAPANESE	この書類には重要な情報が含まれています。無償で日本語の支援を受けたい場合は、早急に電話あるいは直接窓口にて申込を行ってください。
CHUUKESSE	Mei auchea met masowan ei taropwe. Ika pwe ke mochen aninis ren noumw chon chiaku esap kamo, kose mochen kokori kich won tengwa ika fen pusin chuto rech.
MARSHALLESE	Ilo pepa in ewor melele ko aorok. Ne kwoj aikuj jiban na ukok ilo ejjelok wonen, jouj im kokkeitaak kem ilo talboon ak ilo wobij e ien eo emakaaj tata.
KOREAN	이 문서는 중요한 정보가 포함되어 있습니다. 무료로 언어 도움이 필요하시면, 바로 전화 하시거나 오셔서 상담하십시오.
VIETNAMESE	Tài liệu này bao gồm các thông tin quan trọng. Nếu bạn cần hỗ trợ ngôn ngữ miễn phí, xin vui lòng đến gặp trực tiếp chúng tôi hoặc liên lạc qua điện thoại ngay lập tức.