



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-5  
EMPLOYEE NOTIFICATION TO EMPLOYER  
FOR CALENDAR YEAR 2010

**Instructions**

**Instructions to Employee:** This form, to be completed in triplicate, is to be used for the following purposes as provided by the Hawaii Prepaid Health Care Act and Administrative Rules: (A) If you work for two or more employers, you must notify each employer whether the employer is the principal employer (the employer responsible for providing health care coverage) by checking item 1, or the secondary employer by checking item 2. (B) If you are claiming exemption from health care coverage, indicate the reason in the appropriate block under item 3. (C) If you are changing your principal and/or secondary employer designation, or if you are terminating your exempt status, complete item 5.

**Note:** This form need not be filed if (1) you work for only one employer and your employer provides you health coverage, or (2) you work less than 20 hours per week for your employer.

To determine who would be the principal employer, Section 393-6, Hawaii Revised Statutes explains that (1) the principal employer shall be the employer who pays you the most wages; or (2) if one of the employers, who does not pay you the most wages, employs you for at least 35 hours a week, you shall determine which of the employers shall be your principal employer.

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

**Delivery via Fax**

Department of Labor and Industrial Relations, Disability Compensation Division  
(808) 586-9219



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FORM HC-5 EMPLOYEE NOTIFICATION TO EMPLOYER  
FOR CALENDAR YEAR 2010

Employer Information

Employer Name	DOL Account No. - -
Address	Telephone No. ( )

In accordance with the provisions of the Hawaii Prepaid Health Care Act (Chapter 393, Hawaii Revised Statutes), this is to notify you that: (Check one block only):

<input type="checkbox"/> 1. Of the two or more concurrent employers that the undersigned works for (at least 20 hours a week), you have been selected as the <b>principal</b> employer and are therefore required to provide health care coverage for the undersigned (Section 393-6).
<input type="checkbox"/> 2. Of the two or more concurrent employers that the undersigned works for (at least 20 hours a week), you have been selected as the <b>secondary</b> employer and are therefore relieved of the responsibility to provide health care coverage for the undersigned until you are otherwise notified (Section 393-16).
<input type="checkbox"/> 3. I am <b>exempt</b> from health care coverage because I am (Sections 393-17 and 393-22):
<input type="checkbox"/> 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.
<input type="checkbox"/> b. Covered as a dependent under a qualified health care plan.
<input type="checkbox"/> c. A recipient of public assistance or covered by a State-legislated health care plan governing medical assistance.
<input type="checkbox"/> d. A follower of a religious group who depends upon prayer or other spiritual means for healing.
<input type="checkbox"/> 4. I waive coverage from my employer's health care plan; in lieu I have obtained a plan from _____ (name of health care plan contractor) which satisfies the Hawaii Prepaid Health Care Act (attach copy of the plan and send to the Disability Compensation Division). I understand this individual waiver is binding for one year (Section 393-21).
<input type="checkbox"/> 5. The coverage exemption previously indicated in items 2, 3 or 4 is no longer applicable; you are therefore required to provide health care coverage for the undersigned (Section 393-18) effective _____ (give date).

Print Name \_\_\_\_\_

Employee Signature	Date
Address	Telephone No. ( )

**Instructions to the Employer:** Enter your firm's Department of Labor (DOL) Account Number in the space provided. Provide coverage as required by 1 and 5 above. Send the original copy of the notice to the address listed at the top of this form; retain a copy for employer; and provide a copy to the employee. **This notification must be renewed every December 31 for exemptions claimed under item 3 (Sections 393-17 and 393-22).**

Auxiliary aids and services are available upon request. Please call: (808) 586-9188; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall, on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation, be subjected to discrimination, excluded from participation in, or denied the benefits of the Department's services, programs, activities, or employment.

Visit our Website at [www.hawaii.gov/labor/dcd](http://www.hawaii.gov/labor/dcd) for ALL interactive and downloadable forms.