



**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 2023

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

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

THIS SECTION IS FOR THE EMPLOYER TO COMPLETE.	
Employer name _____	DOL account no. _____
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 2023. If the employee will be renewing the selection after 2023, 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.)

<input type="checkbox"/>	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 therefore 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.
<input type="checkbox"/>	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).
<input type="checkbox"/>	3. I am exempt from health care coverage because I am: (check appropriate box.) (Section 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 (e.g. spouse, child, etc.) 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 (e.g. MedQuest).
<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; because I have obtained the plan named ___ from the health care contractor named ___. I understand this waiver is binding for the 2023 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).
<input type="checkbox"/>	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 393-8). 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.

Auxiliary aids and services are available upon request. Please call: (808) 586-9188; TTY (808) 586-8844; TTY neighbor islands (888) 569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

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.

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.