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
- 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: Worldwide Travel Staffing, Limited
DOL account number: 0007355378
Address: 2829 Sheridan Drive, Tonawanda, NY 14150
Phone no.: 716-821-9001

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.

Auxiliary aids and services are available upon request. Please call (808) 586-9188; 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.

Worldwide Travel Staffing

2829 Sheridan Drive, Tonawanda, NY 14150 | Toll Free: 866.633.3700 | Toll Free Fax: 877.375.2450 | www.WorldwideTravelStaffing.com

Waiver of Coverage

Employee Name:

Please check all that apply:

☒ I waive my employer's group Health insurance coverage for myself and my dependents (if any).

☒ I waive my employer's group Dental insurance coverage for myself and my dependents (if any).

Special Enrollment Notice and Certification
Please review and sign below:

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any.

If I am *declining* my employer's group health insurance or dental coverage, I affirm that I have alternate coverage. By declining coverage offered by Worldwide Travel Staffing, Limited, I understand my dependents and I may not be eligible to enroll for benefits until the next open enrollment period. I and/or my dependents may become eligible to enroll if there is a qualifying event, and I request enrollment within 30 days of the eligible qualifying event. I understand that to request special enrollment or obtain more information, I should contact my group administrator.

If I am *accepting* my employer's group health insurance or dental coverage, I acknowledge that failure to submit properly completed enrollment forms prior to my first day of work shall constitute an automatic and continuing waiver of coverage until the required enrollment forms are submitted.

Employee Signature: **Date:**