HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
AUTHORIZED LEAVE OF ABSENCE WITHOUT PAY (L-1)

Employee's Name (Last, First, M.I.) & Address	**EUTF ID or Social Security #**
	Dates of authorized leave of absence without pay **From:** **To:**

Monthly Employee Contributions	
Medical (includes Chiropractic)	$_____
Prescription Drug	$_____
Dental	$_____
Vision	$_____
Total	$_____
Effective through* ___ /___/____	

NOTE: Please look at your pay statement each pay period to check whether premiums were deducted.

For questions regarding your account balance, contact EUTF Accounting at 586-7390 or toll free at 1-800-295-0089.

* Rates and contributions may change effective 07/01/2013.

As long as you are on an authorized leave of absence without pay and you pay your portion of your premiums, your employer will continue to pay their share of contributions for health benefits .

You have two options to choose from:

(1) Voluntarily cancel your health benefit plan enrollments at the end of the most current pay period after your personnel officer receives the appropriate forms from you.
   a. You will need to complete an EC-1 or EC-1H and PCP-2 (if applicable) forms to cancel your plans.
   b. You may re-enroll in the same benefit plans upon return to work. You may not make any changes.

(2) Continue your enrollments during your leave by paying the following premiums:
1st payment:

$_____ on or before _____1, 201____ and,

Subsequent payments:

$_____ on or before the 1st of each succeeding month until you return to active pay status. You may send multiple monthly payments in advance of your payment due dates. Make checks payable to "EUTF" and be sure to indicate your EUTF ID# and applicable month(s) on your check. Send your payments to:

EUTF
P.O. Box 30700
Honolulu, Hawaii 96820-0700

NOTE: Failure to promptly pay your premiums may result in administrative cancellation of health plans. You will be ineligible for COBRA Continuation Coverage. If your enrollments are cancelled by the EUTF during your leave due to non-payment of premiums, you may re-enroll ONLY:

1. during the next open enrollment period and will suffer a break in coverage, or
2. You must pay all past due premiums and shall suffer no break in coverage

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For DPO USE: Please route the completed Form L-1 by intra-office courier or mail to EUTF at P.O. Box 2121, Honolulu, Hawaii 96805-2121.

Employer STATE Agency/Department UH / College of Natural Sciences

DPO Signature _____ Date _____ Phone _____