Subject: Delegation of Authority to Provosts for all Health Fund Personnel Transactions

A. References:


3. Hawaii Administrative Rules, Title 6, Health Fund Benefits.

4. Hawaii Administrative Rules, Title 14, Premium Conversion Plan.

B. Background and Purpose:

By memo dated April 6, 1990, James H. Takushi, Director of Personnel, delegated to the Senior Vice President and Chancellor for Community Colleges (hereinafter Chancellor), authority to process Health Fund transactions for all categories, including executive and managerial personnel. Accordingly, to expedite personnel actions relating to Health Fund benefits, the Chancellor is redelegating the authority to Provost for all categories of employees.

C. Responsibilities and Procedures:

1. Chancellor:

   a. Through designated staff, provides assistance in the administration of Health Fund benefit programs.

   b. Acts as a liaison between the Community College campuses and the Health Fund Office on all matters that have system-wide impact.

   c. Assists campuses in the resolution of problematic situations.

   d. Supplies campuses with all Health Fund Forms/Brochures as required.

2. Provosts, Director of Employment Training Center, or Designee:

   a. Initiates, audits, and processes all Health Fund forms for all categories of employees. (See Attachment 1 for sample case scenarios and forms required)
b. Transmits to the Health Fund original forms/documents by listing each employee alphabetically on the Transmittal Report, Form T-1. (Attachment 2)

c. For Civil Service employees, forward pink copy (Department copy) to UH Personnel Management Office - Civil Service Sections. For all other employees each campus will maintain the pink copy for recordkeeping.

d. Corresponds directly with the Health Fund Office to resolve routine discrepancies/errors. (Attachment 3)

e. Requests for additional supplies of Health Fund Forms through the Chancellor's Office. (Attachment 4)

1. Benefits Plan Booklet and/or New Bulletin

2. Form E-1 - Health Fund Enrollment Application

3. Form N-1 - Notice of Benefits Change or Termination Due to Personnel Action

4. Form N-2 - Notice of Temporary Extension of Health Fund Insurance Coverage

5. Form DC-1 - Changes to Employee's Date on File

6. Form D-1 - Disability Certification for Dependent Children

7. Form F-1 - Foster Child Statement

8. Form RC-1 - Refund Claim Application


10. Form D-67 - Premium Conversion Plan (PCP) Benefit Election Change Form

11. DPS/PCP-2 - Premium Conversion Plan Election Change Form

12. Form T-1 - Transmittal Report

13. Certificate of Group Life Insurance
14. Premium Conversion Plan Brochure

D. Revisions:

None

Joyce S. Tsunoda, Senior Vice President
and Chancellor for Community Colleges

Attachments 4
CASE SCENARIOS AND FORMS TO BE PROCESSED

NEW EMPLOYEE

· E1
· D66 OR D67 (PCP)
· Check (if necessary for first month's premium)

TRANSFER IN EMPLOYEE

· E1
· Copy of N1 (from releasing agency/department)
· D66/D67 (if from City & County employment)
· PCP2 (if PCP and from City & County employment)

SPOUSE LOST COVERAGE, EMPLOYEE NOW WANTS COVERAGE

· E1
· D66 or D67
· PCP2 (if PCP)
· Letter from spouse's employer; notification of lost benefits
· Check (if necessary for first month's premium)

ADDITION DUE TO MARRIAGE/BIRTH

· E1
· D66/D67 (if changing from self-plan)
· PCP2 (if PCP)
· Check (if necessary for first month's premium)

note: if employee already has family plans, only submit the E1.

DELETION DUE TO DIVORCE/DEATH/LAST CHILD REACHES AGE 19

· E1
· Divorce Decree
· D66/D67 (if changing plan)
· PCP2 (if PCP)
· RC1 (if changing plan and refund due)

note: if employee already has self plans, only submit the E1 and divorce decree.

CHANGING PLANS TO SELF/LAST CHILD REACHED AGE 19
· E1
· D66 OR D67
· PCP2 (if PCP)
· RC1 (if necessary, refund claim form)

CANCELLATIONS

· E1
· D66 OR D67
· PCP2 (IF PCP)

LEAVE WITHOUT PAY

· N1

TRANSFER OUT EMPLOYEE

· N1
· D66 or D67 (if to City & County Employment)

RETIREMENT

· N1
· D66 or D67

SEPARATIONS/TERMINATIONS

· N2
· D66 or D67

CHANGING BENEFICIARIES

· E1

CHANGING ADDRESS

· DC1 (or E1, if changing additional information)
TO: HEALTH FUND - ENROLLMENT SECTION

FROM: University of Hawaii, Community College

SUBJECT: Employees Being Denied/Claims Rejecting/No Carrier Cards

EMPLOYEE: __________
SSN: __________

KAISER/HMSA/HMO PRESCRIPTION DRUG
__ Family __ Family
__ Self __ Self

VSP HDS DENTAL
__ Family __ Self
__ Self __ Self & Spouse

____ The above employee has had their claim rejected by insurance carrier. Please verify with carrier that this employee is covered.

____ The above employee's dependent has had their claim rejected by insurance carrier. Please verify with carrier that this employee's dependent date of birth _/_/_, is covered.

____ The above employee has not received their HMSA/Kaiser/HDS card as of yet. Please verify with carrier that this employee is covered and issue a card.

____ The above employee has retired, but since returned to work on an emergency hire/casual appointment basis. When their paycheck was generated, a deduction/reduction was taken. Please make correction and refund; attached is a Refund Claim form.
<table>
<thead>
<tr>
<th>QUANTITY</th>
<th>DESCRIPTION OF FORMS</th>
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<tbody>
<tr>
<td>___</td>
<td>BENEFITS PLAN BOOKLET</td>
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<tr>
<td>___</td>
<td>NEWS BULLETIN</td>
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<tr>
<td>___</td>
<td>FORM E1 - HEALTH FUND ENROLLMENT APPLICATION</td>
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<tr>
<td>___</td>
<td>FORM N1 - NOTICE OF BENEFITS CHANGE OR TERMINATION DUE TO PERSONNEL ACTION</td>
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<tr>
<td>___</td>
<td>FORM N2 - NOTICE OF TEMPORARY EXTENSION OF HEALTH INSURANCE COVERAGE</td>
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<tr>
<td>___</td>
<td>FORM DC1 - CHANGE TO EMPLOYEE’S DATE ON FILE</td>
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<tr>
<td>___</td>
<td>FORM D1 - DISABILITY CERTIFICATION FOR DEPENDENT CHILDREN</td>
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<tr>
<td>___</td>
<td>FORM F1 - FOSTER CHILD STATEMENT</td>
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<tr>
<td>___</td>
<td>FORM RC1 - FUND CLAIM APPLICATION</td>
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<tr>
<td>___</td>
<td>FORM D66 - HEALTH BENEFITS PLAN DEDUCTION AUTHORIZATION</td>
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<tr>
<td>___</td>
<td>FORM D67 - PREMIUM CONVERSION PLAN BENEFIT ELECTION FORM</td>
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<td>DPS/PCP2 - PREMIUM CONVERSION PLAN ELECTION CHANGE FORM</td>
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<td>___</td>
<td>FORM T1 - TRANSMITTAL REPORT</td>
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<tr>
<td>___</td>
<td>CERTIFICATE OF GROUP LIFE INSURANCE</td>
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<td>___</td>
<td>PREMIUM CONVERSION PLAN - BROCHURE</td>
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SEND FORMS TO: ______________________________________________________
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