Prepared by the Personnel Management Office.
This replaces Administrative Procedure No. A9.690
dated July 1982

March 1986

SAFETY WELFARE AND BENEFITS

A9.690 HEALTH FUND BENEFITS

1. Purpose. To provide University personnel with the information necessary to process documents for coverage under the Hawaii Public Employees Health Fund in accordance with Chapter 87, HRS.

2. Objective. To provide Health Fund information on benefits and eligibility and to prescribe the procedures for enrollment and changes that are necessary.

3. Applicability/Responsibility.

   a. This procedure applies to all eligible employees of the University of Hawaii who are enrolled or who may elect to enroll during the open enrollment period in the Hawaii Public Employees Health Fund. The employee is responsible for making his/her benefit plan selection.

   b. Vice Presidents, Chancellors, Secretary of the Board of Regents, Associate Vice President, State Director for Vocational Education, Deans at Manoa, the University Librarian at Manoa or their designees (henceforth Administrative Officer) are responsible for processing enrollment and/or change actions that may be required and for maintaining the necessary records.

4. General Benefit and Eligibility Information.

   a. Coverage Available: The Health Fund provides medical, dental and life insurance coverage.

      1) The medical plan provides for hospitalization and medical service benefits. Refer to the current Health Fund brochure for details.

      2) The dental plan covers dependent children under 19 years of age. The coverage is free to the employee but enrollment is not automatic and coverage must be requested in the Enrollment

Application Form.

3) The group life insurance covers the employee and is free. Like the dental plan enrollment, it is not automatic and coverage must be requested in the Enrollment Application. As an alternative to enrolling in the Health Fund Plan, an employee may designate that the premium paid by the State be applied to an employee organization if the employee is enrolled in its group life plan.

b. Eligibility: To be eligible, an employee must be appointed for a period of at least three months at 1/2 time FTE or more. Lecturers at four year campuses must teach at least seven credit hours and lecturers at Community colleges must teach at least eight credit hours to meet the 1/2 time equivalent requirement. Also eligible are the surviving spouse and dependent children under age 19 of an active employee who is killed while performing his/her duty.

5. Procedures. The Board of Trustees of the Health Fund has adopted a comprehensive set of rules and regulations to administer the program. These are not included herein due to the large volume of material and its technical nature. The following, however, are the most common rules affecting eligibility, enrollment and changes. Information on situations not covered here may be obtained by reading the Health Fund Benefits booklet, or calling the appropriate administrative officer responsible for personnel matters. If further clarification is needed, call the University Personnel Management Office, Employee Welfare Section.

a. Forms

1) The Health Fund Office (HFO) requires the completion of a number of forms to maintain current, accurate and complete information of its subscribers. These forms, the use of which is described below, are available in the offices of the respective Administrative Officers.

2) Offices of the Administrative Officers are responsible for replenishing their supply of forms from the Health Fund Office by completing the Requisition Form (Attachment A).

3) Completed forms for employees are to be sent to

the Personnel Management Office for forwarding to the Health Fund by listing each employee alphabetically and checking the form being transmitted on the Health Fund Transmittal Report Form T-1 (Attachment B).

b. Initial Enrollment

1) To obtain Health Fund benefits, eligible new employees must indicate that they wish to enroll in the specific medical plan, dental plan and life insurance plan available by completing the form, Enrollment Application, Form E-1 (Attachment C).

2) Enrollment of a new employee must take place within thirty-one (31) calendar days from the eligibility date, which is the appointment date. If enrollment is not accomplished within this period, the HFO will accept late enrollment with the understanding that it must be accompanied by a justification for late submittal and that the final decision on actual enrollment rests with the HFO. The enrollment application forms E-1, D-63 and payment will be submitted 'Special" to the HFO. The forms are to be submitted intact with 2 copies of T-1.

3) Along with the Enrollment Application, Form E-1. the Medical Plan Insurance Deduction Authorization, Form D-63 (Attachment D) must also be completed to authorize the deduction of premiums from one's pay. However, if payroll deductions do not cover the initial period of the medical plan, the employee must include a payment (check) with the enrollment forms to the HFO for that period in order to be covered by the medical plan.

4) Once the enrollment application is received by the Health Fund Office, the employee will not be permitted to change his/her original enrollment request.

c. Changes

1) Relocation to Another Area

Changes between carriers may b e made if an employee

relocates or moves from the ge ographic/service area of his/her medical insurance carrier or int o another area where his/her current plan is no t available but other Health Fund plans ar e available. For specific details and instructions, employees should refer to the Health Fund booklet.

2) Loss of Eligibility Due to Change in FTE

Changes in employment status to less than half-time require completion of Form N-1 (Attachment E) and Form D-63 (Attachment D) to cancel Health Fund Benefits. Medical benefits, however, will continue at no additional cost for 31 days after the date of change in FTE.

3) Authorized Leave Without Pay

a) When an employee is granted an authorized Leave of Absence Without Pay (LWOP), the administrative officer will send to the employee a "Notice of Benefits Changes or Terminations Due to Personnel Action" Form N-1 (Attachment 8). As stated in Part B of the form, an employee must make premium payment directly to the Health Fund Office on or before the 10th day of each month. The Health Fund Office will cancel the medical plan enrollment when an employee on LWOP does not pay the medical insurance premiums on a timely basis. If this occurs, the employee will not be able to re-enroll until the Health Fund's next open enrollment period.

b) If, however, an employee oh authorized LWOP was provided medical insurance coverage that was fully paid by an educational grant or government program, upon his/her return he/she may re-enroll within 31 days of his/her reappointment date. In this situation the Health Fund Office requires a signed letter from the grant official to certify that the medical insurance coverage was fully paid by the grant during the employee's leave.

4) Open Enrollment

Once each year (May 15 to June 14) the Health Fund Office authorizes an open enrollment period to permit changes in plan selection or to permit enrollment by those who had not done so during their initial eligibility period. Enrollment instructions are provided at that time.

5) Election of Primary Medical Plan Carrier

Employees between 65 through 69 years of age who continue to work may choose a primary health insurance coverage by completing the form, Election of Primary Medical Plan Insurance Carrier for Active Employees Age 65-69 Only, Form EF-1 (Attachment F). This form may be duplicated as necessary.

6) Enrollment in Medicare Supplemental Plan

An employee or dependent who becomes 65 years of age may obtain supplemental medical coverage by completing the form, Enrollment Application--Medicare Supplemental Plan, Form E-5 (Attachment G), provided the employee or spouse has applied for and received the medicare card.

7) Changes to Employee’s Data on File

The following changes are to be reported on the form, Notice to Health Fund, Changes to Employee's Data on File, Form DC-1 (Attachment H):

a) New address

b) Dependent data changes (include incorrect data on file and the correct data)

c) Employee name change (provide former name and new name)

d) Social security number (indicate the incorrect number and the correct number)

8) Disability of Dependent Child(ren)

Physician's certification of disability of dependent child is to be reported in the form, Disability Certification for Dependent Children,

Form D-1 (Attachment I), if the child reaches 19 and will continue to be a dependent.

9) Foster Child

Care of a foster child is to be reported in the Foster-Child Statement, Form F-1, in duplicate (Attachment 3).

d. Refunds

Any claim for refund is to be submitted by completing the Refund Claim Application, Form RC-1 (Attachment K), including the reason for the refund.

e. Appeals

A person may appeal an action of the Health Fund by completing the Employee Appeal Statement, Form EA-1 (Attachment L) .

6. Other Information of Importance/Interest.

a. Retirement

1) Employees who retire must pay their medical insurance premiums as follows:

If your last day worked is between:	You must pay the monthly premium for:	State begins full payment on:
lst thru 15th	first half	16th of the month and thereafter
16th thru end of month	full month	lst of the the following month and thereafter

2) If an employee's retirement does not become effective within the next pay period after leaving active employment, the University will terminate the employee's Health Fund benefits. The employee is then required to re-enroll within 31 days of his/her effective retirement date in order to receive benefits.

3) The State will pay the medical, dental and life insurance plan premiums for eligible employees who

retire after June 30, 1984 with ten (10) or more years of service.

4) Employees who retire after June 30, 1984 with less than ten (10) years of service and who wish to continue their medical coverage must pay their medical insurance premiums and may have the amount, as determined by the Health Fund, deducted from their pension payments. However, the State will continue to pay the dental and life insurance plan premiums for eligible retirees.

b. Death of Employee

Medical insurance continues for 31 days after the employee's date of death.

Children's dental insurance terminates on the last day of the month in which death occurred.

c. Cost of Benefits

The monthly medical plan rates are in the Health Fund Benefits booklet together with details of health benefits provided. The information in the booklet is updated yearly and made available to all eligible employees prior to the open enrollment period each year. Copies of the booklet are available for reference in the respective offices of the administrative officer.

A9.690
Attachment A

HAWAII PUBLIC EMPLOYEES HEALTH FUND
P. O. Box 2121
Honolulu, HI 96805

Quantity Requested	Description of Forms
	BENEFITS BROCHURE - Information About the Medical, Children's Dental and Life Insurance Programs and Notice of Open Enrollment Period
	FORM E-1 - Health Fund Enrollment Application
	FORM E-5 - Medicare Information/Reimbursement
	FORM N-1 - Notice of Benefits Changes or Terminations
	FORM DC-1 - Changes to Employee's Data on File
	FORM F-1 - Foster Child Statement
	FORM D-1 - Disability Certification
	FORM RC-1 - Refund Claim Application
	FORM T-1 - Transmittal and Report Form
	Life Insurance Certificate and Description

SEND FORMS TO: DEPARTMENT _____

ADDRESS _____

_____

ATTENTION: _____

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Attachment B

TRANSMITTAL REPORT
HAWAII PUBLIC EMPLOYEES HEALTH FUND

1. Name of employing agency

Agency State Code No. 01

Dept. UH-(Coll., School, etc) Code No. 022

2. This report covers the period _____

_____ _____
Signature of Agency Official Date

3. LIST EMPLOYEES IN ALPHABETICAL ORDER:

NAME	E-1	CHECK	E-5	D-63	DC-1	D-1	F-1	N-1	RC-1

REFER TO THE HEALTH FUND PROGRAM MANUAL FOR INSTRUCTIONS

E1 49758

HAWAII PUBLIC EMPLOYEES HEALTH FUND
ENROLLMENT APPLICATION

A9.690 Attachment C

PART A Applicant must complete this part. Please print or type

01 Your Soc. Sec. No. | 02. Name (Last) (First) (Middle Initial)

03 Address (Number & Street) | 04. City and State | 05 Zip Code

06. Date of Birth (Use numbers) / / | 07. Sex: 1 ☐ Male 2 ☐ Female | 08. Are you now married? 1 ☐ Yes 2 ☐ No

PART B Complete items in this part to report **CHANGES** which have occurred since your most recent enrollment application.

List the names and birthdates of your spouse and any unmarried child under the age of 19 (including an adopted child, stepchild, foster child or legalized natural child who lives with you in a regular parent-child relationship) Indicate relationship code (R.C.): 1, spouse; 2, son; 3, daughter; 6, twins; and 9, disabled child. (To delete a family member, enter name, birthdate and relationship code.)

NAMES OF FAMILY MEMBERS — FIRST	INITIAL	LAST (If Different)	Birthdate Mo.	Day	Yr.	R.C.	NAMES OF FAMILY MEMBERS — FIRST	INITIAL	LAST (If Different)	Birthdate Mo.	Day	Yr.	R.C.
09			10.			11.	09.			10.			11.
09.			10.			11.	09.			10.			11.
09			10.			11.	09			10.			11.

12. Your spouse's Social Security Number
☐ State, County Employee or Retiree
☐ Other — Private, Federal, etc. ___ ___ ___

13. Your former name if different than your present name on Health Fund records
LAST FIRST INITIAL

PART C Indicate only **ONE** enrollment action in **EACH** benefit plan. Place an "X" in items B, C or D if applicable.

ENROLLMENT ACTION REQUESTED	MEDICAL PLAN	DENTAL PLAN	LIFE INSURANCE PLAN
A. **Enroll me** in or change my present enrollment to (Plan).	☐ Self Only ☐ Family	☐ Children Only	
B. **Cancel** my present enrollment.	☐	☐	☐
C. I **elect not to enroll** or am ineligible at this time.	☐	☐	☐
D. **Do not change** my enrollment at this time.	☐	☐	☐

PART D Complete only if you select the **HEALTH FUND LIFE INSURANCE PLAN.**

The beneficiaries of my Health Fund life insurance plan and their addresses are:

Primary beneficiary _____

Secondary beneficiary _____

PART E Applicant must sign this part.

Information in this application is given to obtain insurance and is true and complete to the best of my knowledge and belief. I authorize my employer or finance officer to set my effective dates of coverage and to deduct my monthly employee contribution for each Health Fund benefit plan from my salary, wages, or other compensation including any contribution increase, decrease, adjustment or cancellation as required by the Health Fund under applicable laws, rules or regulations.

Applicant's Signature _____ Business Tel. No. _____ Date _____

FOR EMPLOYING AGENCY USE ONLY

AGENCY-DEPARTMENT NAME: State - U H. (Coll. school, etc.)

1. Enroll applicant in HEALTH FUND Plan Code.
2. Effective coverage date requested (MM/DD/YY).
3. Event Code which permits above enrollment.
4. Date of event (MM/DD/YY).

	MEDICAL PLAN	DENTAL PLAN	LIFE INSURANCE PLAN
1.	14.	18.	22.
2.	15. / /	19. / /	23. / /
3.	16.	20.	24.
4.	17. / /	21. / /	25. / /

I certify that the applicant is an eligible employee-beneficiary as defined in Chaper 87, HRS.

Authorized Signature _____ Date _____

Agency 26	Dept 27.	Div. 28.	B.U. 29.
01	022	—	

Use applicable block

	MM	DD	YY
DATE RECEIVED IN EMPLOYING AGENCY 30			
DATE EMPLOYED 31.			
TRANSFER IN DATE 32.			
DATE RETURNED FROM LEAVE 33.			

REMARKS.

CHECK ATTACHED
No.
Date ... / ...
Amt. $

Form E-1 (Rev. 5/84)

TO HEALTH FUND

OPPORTUNITIES AND TIME LIMITS TO ENROLL OR CHANGE ENROLLMENT

The following table shows the EVENTS or conditions which permit enrollment or changes in each STATE HEALTH FUND BENEFIT PLAN and the times within which you may file an enrollment application to make such changes.

EVENTS { You may file these enrollment changes within 31 days of the following event dates.	* CHANGE PERMITTED		
		If Enrolled	
	From not enrolled to enrolled	From Self Only to Family (or reverse)	From one carrier to another
Regular opportunity to enroll (Date of eligible employment, retirement, or re-employment, return from active military leave, return from LWOP — all costs paid by educational grant or government program, Dental Plan — first child, etc.)	10 Yes	Does not apply	Does not apply
Loss of your Health Fund Benefit Plan coverage (including children) because of termination of your spouse's enrollment	11 Yes	Does not apply	11 Yes
Loss of your Health Fund Benefit Plan coverage because your spouse changed his enrollment from Family to Self Only or deleted you from his Family enrollment	12 Yes	Does not apply	12 Yes
Loss of your non-Health Fund Benefit Plan coverage (including children) because of the INVOLUNTARY TERMINATION of your enrollment or your spouse's enrollment due to death, divorce, or termination of employment	13 Yes	Does not apply	Does not apply
Change in marital status (Marriage, divorce, annulment, death of spouse, etc.)	No	20 Yes	No
Change in family status (Birth or adoption of a child, acquisition of a foster child, last child reaches age 19, family members join your household, etc.)	No	21 Yes	No
When your spouse loses his Self Only Health Fund Benefit Plan coverage because of employment or eligibility termination	Does not apply	22 Yes	No
When your spouse loses his Self Only non-Health Fund Benefit Plan coverage (including children) because of employment termination	Does not apply	23 Yes	No
Open enrollment period (NOTE: Special filing time limits are set by the Board of Trustees)	19 Yes	29 Yes	39 Yes
When you move from the geographic/service area covered by your present carrier's plan or into an area where other Health Fund plans are available	Does not apply	No	30 Yes
Upon your retirement, you may change from the Health Fund Life Insurance Plan to your employee organization life insurance plan			33 Yes
If you are simultaneously enrolled in more than one employee organization life insurance plan when you cancel or terminate one of those enrollments, you may change to the remaining employee organization plan			34 Yes
When your employee organization life insurance plan enrollment is INVOLUNTARILY TERMINATED due to an employment change you may change to the Health Fund Life Insurance Plan or to another employee organization life insurance plan			35 Yes

(Continued on Next Page)

* Event Code Numbers for employing agency use only

USE TYPEWRITER OR PRINT WITH BALL POINT PEN WITH HEAVY PRESSURE

A9.690
Attachment D

INSTRUCTIONS:

1. Read entire form . . . contact your employing agency if you need additional information or assistance.
2. Complete Item Nos. 1, 2, 4, 5, 11 or 12, 13, and 14.
3. Return form to your employing agency.

STATE OF HAWAII — MEDICAL PLAN INSURANCE DEDUCTION AUTHORIZATION

1. Department	2. Subdivision or School
University of Hawaii	

3. Form No.	4. Social Security No.	5. Last Name, First Name, Middle Initial	6. Type	7. Agent	8. Plan	9. I.D. No	10. Dept
PKI			MD	701			F

11. ☐ I hereby AUTHORIZE the STATE OF HAWAII to deduct my monthly MEDICAL PLAN contribution from my compensation each payroll period as follows:

$ _____ the first month and $ _____ each month thereafter . . . . beginning __/__/__ .

My authorization also includes any contribution increase, decrease, adjustment or cancellation as required by the HEALTH FUND under applicable laws, rules or regulations.

12. ☐ I hereby CANCEL, as of __/__/__ , my previous authorization.

HAWAII PUBLIC EMPLOYEES HEALTH FUND

13. Date	14. Employee's Signature	15. Date	16. Authorization Signature

STATE ACCOUNTING FORM D-63
MARCH 1, 1977

STATE COMPTROLLER (CENTRAL PAYROLL)

NOTE: THIS IS A STANDARD DAGS FORM WHICH IS BULK-PURCHASED BY THE UNIVERSITY PROCUREMENT AND PROPERTY MANAGEMENT OFFICE. ADMINISTRATIVE OFFICERS SHOULD SUBMIT THEIR NEEDS TO PPMO.

*Event Code No. 27499

HAWAII PUBLIC EMPLOYEES HEALTH FUND

NOTICE OF BENEFITS CHANGES OR TERMINATIONS DUE TO PERSONNEL ACTION

A9.690
Attachment E

Employee (Last Name, First, Initial)

Soc. Sec. No.

*Date Code No.

*Actual Date

PART A YOUR HEALTH FUND BENEFITS STATUS

Your Health Fund benefits will be changed or terminated on the following dates due to the personnel action marked with an "x" below:

Personnel Action	1. Medical Plan (Last Day of Pay Period from Actual Date)	2. Dental Plan (Last Day of the Month)	3. Life Insurance Plan (Last Day of the Month)	Refer to information on reverse side regarding Health Fund benefits	*Code Numbers
☐ Authorized leave of absence without pay From ____ To ____	Part B below	Part B below	Part B below		82 - 34
☐ Termination of employment	Part D	Part D	Part D		51 - 35
☐ Transfer to (Agency) (Department)	Part E	Part E	Part E		81 - 32
☐ Retirement	Part F	Part F	Part F		81 - 32
☐ Death of employee or retiree	Part G	Part G	Part G		52 - 35
☐ Other:					

*Code Numbers and Actual Date for employing agency use only.

PART B AUTHORIZED LEAVE OF ABSENCE WITHOUT PAY

Your Dental and Life Insurance Plan benefits, if any, are paid in full by your employer. They will be continued as long as you are on an authorized leave of absence without pay.

If you wish to CONTINUE your Medical Plan benefits during your leave, you are required to pay your monthly employee contributions to the Health Fund or to your respective County Director of Finance as follows:

1. $ ____ **on or before** ____ 10, 19 ____ ; **and,**

2. $ ____ ***on or before the 10th of each succeeding month*** **until you return to an active pay status. You may send multiple monthly payments in advance of your payment due dates.**

NOTE: If you fail to make your Medical Plan payment on time, the Administrator will notify you of your premium shortage and suspend your benefits. If full payment (shortage plus current month's premium) is made by the 10th day of the next month following the date of the Administrator's letter, your enrollment will be reinstated. Failure to pay will result in the cancellation of your enrollment. You will not be permitted to enroll until next year's Open Enrollment Period.

Be sure to indicate your Social Security Number and the applicable month(s) on your checks. Send your payments to:

☐ HAWAII PUBLIC EMPLOYEES HEALTH FUND
P. O. Box 2121
Honolulu, Hawaii 96805

☐ DIRECTOR OF FINANCE
City and County of Honolulu
City Hall—Payroll Section
Honolulu, Hawaii 96813

☐ DIRECTOR OF FINANCE
County of Hawaii—Payroll Section
25 Aupuni Street
Hilo, Hawaii 96720

☐ DIRECTOR OF FINANCE
County of Maui—Payroll Section
200 South High Street
Wailuku, Hawaii 96793

☐ DIRECTOR OF FINANCE
County of Kauai—Payroll Section
P. O. Box 111
Lihue, Hawaii 96766

☐ BOARD OF WATER SUPPLY
Payroll Section
630 S. Beretania Street
Honolulu, Hawaii 96843

PART C DATE OF NOTICE

Agency/Department State/UH, (coll., school, etc) Code 01 022 Tel. No.

Authorized Signature

Date of Notice

Form N-1 (Rev. 5 85)

TO EMPLOYEE

PART D — TERMINATION OF EMPLOYMENT

1. **MEDICAL PLAN**—Your benefits will continue at no additional cost for 31 days or if hospital-confined on the 31st day up to a maximum of 60 days after the date shown in PART A, Item 1 (last day of the pay period from actual date). Contact your carrier within the 31-day period if you are interested in obtaining an individual medical plan contract.

2. **DENTAL PLAN**—Your benefits terminate on the date shown in PART A, Item 2 (last day of the month).

3. **LIFE INSURANCE PLAN**—Your life insurance coverage will be continued for 31 days after the date shown in PART A, Item 3 (last day of the month).

   You are hereby notified of your right within the 31-day period to obtain an individual policy of life insurance from your carrier without evidence of insurability by applying and paying the premium for such policy. Contact your carrier for additional information and premium rates.

4. **RE-EMPLOYMENT**—Under the Health Fund's rules, you are deemed to have "transferred to another agency" if you are re-employed by your former agency or another State or County agency within the same pay period or the next consecutive pay period. Refer to PART E below.

PART E — TRANSFER TO ANOTHER AGENCY

When you transfer from one governmental agency to another, the Health Fund's rules do not provide you with an opportunity to enroll in a Health Fund benefits plan if you are presently unenrolled on your date of transfer.

Show this form to your new personnel officer on your first workday so that he may be able to assist you to continue your current Health Fund benefits as shown in PART A, Item 1, 2, and 3 with your new agency.

PART F — RETIREMENT

1. Contact your retirement system counselor for a detailed explanation of your Health Fund benefits.

2. Upon becoming a retired member, you are permitted to enroll in a Health Fund benefit plan if you are presently unenrolled or to change your Self Only Medical Plan to a Family enrollment or to transfer your employer's contribution from the Health Fund Life Insurance Plan to your employee organization plan.

3. If you are enrolled in the Health Fund's Life Insurance Plan, your life insurance coverage will be reduced according to the contract governing the Plan on the date shown in Part A, Item 3. You are hereby notified of your right within the 31-day period to obtain an individual policy of life insurance from your carrier without evidence of insurability by applying and paying the premium for such policy. Contact your carrier for information and premium rates.

PART G — DEATH OF EMPLOYEE OR RETIREE

1. Contact your spouse's personnel officer or retirement system counselor, if the deceased was a retiree, for a detailed explanation of available Health Fund benefits.

2. The surviving spouse and dependent children of a deceased enrolled:

   (a) EMPLOYEE—will receive Medical Plan benefits for 31 additional days from the date shown in PART A, Item 1; Dental Plan benefits will be terminated on the date shown in PART A, Item 2.

   (b) RETIREE OR EMPLOYEE KILLED IN THE PERFORMANCE OF DUTY—will receive continuous Medical and Dental Plan benefits from date of death as provided by the Health Fund law and rules.

HAWAII PUBLIC EMPLOYEES HEALTH FUND

ELECTION OF PRIMARY MEDICAL PLAN INSURANCE CARRIER
FOR ACTIVE EMPLOYEES AGE 65 - 69 ONLY

NAME _____ EMPLOYER State of Hawaii

SSN _____ DEPARTMENT University of Hawaii

ADDRESS _____ PRESENT HF MEDICAL

_____ PLAN ENROLLMENT _____

I elect to receive my PRIMARY health insurance coverage from my:

_____ 1. Employer's plan. I will enroll in the federal Medicare Plan as our SECONDARY insurer.

_____ 2. Employer's plan only. I will not apply for the federal Medicare Plan.

_____ 3. Federal Medicare Plan only. Please cancel my State Health Fund enrollment as of _____.

_____ 4. Currently covered through private sector. (For example: Federal Government, spouse's plan, Carpenter's Union, etc.)

_____ 5. I am not enrolled in the State Health fund plan now and do not wish to enroll at this time.

Please enroll me in the following employer's plan provided by the Hawaii Public Employees Health Fund:

INSURANCE CARRIER	ENROLLMENT TYPE	
____ Kaiser Plan	____ Self Only	____ Family
____ HMSA Plan	____ Self Only	____ Family
____ CHP Plan	____ Self Only	____ Family
____ Island Care Plan	____ Self Only	____ Family

I understand my monthly premiums will remain the same because the Health Fund's Medicare Supplemental Plan rate is no longer available to employees ages 65 through 69 who are currently employed. I agree to pay the REGULAR PLAN premium which applies to younger employees as I am currently employed.

If I am dissatisfied with my choice of PRIMARY insurance carrier, I may change to another Health fund medical plan carrier or elect to have the federal Medical Plan as my PRIMARY insurance carrier. I agree to send my written appeal to the Health Fund Administrator within 60 days of the effective date of insurance coverage as stated above.

_____ I have attached a xerox copy of my Medicare card and my spouse's Medicare card as proof of my current enrollment in the federal Medicare Plan.

_____ I will submit a xerox copy of my spouse's Medicare card upon receipt from Social Security Administration.

Information in this election form is given to comply with the federal Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). I authorize my employer or finance officer to complete the required Health Fund enrollment forms and to deduct my monthly employee contribution for my Health Fund medical plan from my salary, wages, or other compensation including any contribution increase, decrease, adjustment or cancellation as required by the Health Fund under applicable laws, rules or regulations.

Applicant's Signature _____ Business Tel. No. _____ Date _____

E-5 17866

HAWAII PUBLIC EMPLOYEES HEALTH FUND
ENROLLMENT APPLICATION — MEDICARE SUPPLEMENTAL PLAN

PART A Please provide the following information from your Medicare Card:

01. Your Soc Sec No. | 02. Name Last: | First | Middle Initial

50. Your Claim No. | 51. Hospital insurance eff date / / | 52. Medical insurance eff date / /

53. Your spouse's Claim No. | 54. Hospital insurance eff date / / | 55. Medical insurance eff date / /

PART B Applicant and or spouse must sign this part.

Information in this application is given to obtain insurance and is true and complete to the best of my knowledge and belief. I (we) understand that the effective dates of coverage shall be set by the Health Fund in accordance with its rules and regulations.

I (we) hereby authorize the Social Security Administration to release all information in its possession relating to my eligibility for benefits under Title XVIII of the Social Security Act to the Hawaii Public Employee Health Fund. A photocopy of this authorization shall be valid as the original.

X _____ Applicant's Signature

X _____ Spouse's Signature

_____ Date

FOR EMPLOYING AGENCY USE ONLY

AGENCY-DEPARTMENT NAME: State - UH, (coll., school, etc.)

Agency 26.	Dept. 27.	Div. 28.	B.U. 29.
01	022	—	

I certify that the applicant is an eligible employee-beneficiary as defined in Chaper 87, HRS.

_____ Authorized Signature _____ Date

REMARKS:

Retirement Date / /

MEDICARE REIMBURSEMENT INFORMATION FOR RETIREES ONLY

	MONTHLY PAYMENT	INITIAL PAYMENT	ELIGIBLE DATE
Applicant 56.	$	$	/ /
Spouse 57.	$	$	/ /
TOTAL 58.		$	

Rev. 7 [illegible]

TO HEALTH FUND

NOTICE TO HEALTH FUND

CHANGES TO EMPLOYEE'S DATA ON FILE

A9.690
Attachment H

70696

INSTRUCTIONS
1. Please type or print.
2. Enter your Social Security Number.
3. For your specific type of change, complete all informational items.

Social Security Number	For HF Use	Last Name	First	Initial
___-__-____	____			

NEW ADDRESS

FC 00 B.U. __

03 Number and Street

04 City and State

05 Zip Code

OTHER DATA CHANGES

FC 00 29 B.U. __

06 Birthdate (Use Numbers) __/__/__

07 Sex 1 ☐ Male 2 ☐ Female

08 Are you now married? 1 ☐ Yes 2 ☐ No

DEPENDENT DATA CHANGES

INCORRECT DATA ON FILE				CORRECT DATA		
First Name	Initial	Last Name (if different)	FC	First Name	Initial	Last Name (if different)
Birthdate (Use Numbers) __/__/__			09			
			10	Birthdate (Use Numbers) __/__/__		
			11	Relationship (check one): 1 ☐ Spouse 2 ☐ Son 3 ☐ Daughter 6 ☐ Twins, triplets, etc. 9 ☐ Disabled child		

DEPENDENT DATA CHANGES

INCORRECT DATA ON FILE				CORRECT DATA		
First Name	Initial	Last Name (if different)	FC	First Name	Initial	Last Name (if different)
Birthdate (Use Numbers) __/__/__			09			
			10	Birthdate (Use Numbers) __/__/__		
			11	Relationship (check one): 1 ☐ Spouse 2 ☐ Son 3 ☐ Daughter 6 ☐ Twins, triplets, etc. 9 ☐ Disabled child		

EMPLOYEE NAME CHANGE

FORMER NAME				NEW NAME		
Last Name	First Name	Initial	FN	00		
			02	Last Name	First Name	Initial
			08	Are You Now Married? 1 ☐ Yes 2 ☐ No		

SSN CHANGE

INCORRECT SOCIAL SECURITY NUMBER		CORRECT SOCIAL SECURITY NUMBER	
	FS	00	
___-__-____	01	___-__-____	

Agency/Department Name State / UH (coll., school, etc) Code 01 - 022 Tel. No.

Authorized Signature Date

Form DC-1 (5 85)

HAWAII PUBLIC EMPLOYEES HEALTH FUND

DISABILITY CERTIFICATION FOR DEPENDENT CHILDREN

PHYSICIAN'S STATEMENT

I certify that I have examined _____, birthdate _____ and find (him) (her) to be incapable of self-support because of the following disability which began before attainment of age 19:

1. Nature of disability .....

.....

.....

2. The disability has been continuous from ..... (approximate date)

3. The above person is physically and/or mentally disabled to such a degree that:

☐ (He) (She) will be incapable of self-support for the duration of his life; or

☐ *(He) (She) may become self-supporting if he responds to treatment for* (his) (her) disability.

Approximate date of recovery: .....

SAMPLE

Name of Physician ..... Tel. No. .....

Address ..... (Street) (City) (State) (Zip Code)

Signature ..... Date .....

PARENT'S STATEMENT

I certify that the above-named person is my child, is disabled and is dependent upon me for support and is not married. I hereby request that (he) (she) be continued as a family member under my Health Fund medical plan. I agree to submit additional proof of disability as often as required by the Health Fund or its insurance carriers. I will notify the Health Fund of all changes affecting my child's disability status.

Name of Employee ..... Social Security No. .....

Agency State Department U H- (Coll., School, etc)

Signature ..... Date .....

A9.690
Attachment J

(submit in duplicate)

HAWAII PUBLIC EMPLOYEES HEALTH FUND

FOSTER-CHILD STATEMENT

NATURAL PARENTS

1. I, _____ hereby certify that _____ is my child, birthdate _____. At the present time, I am unable to provide my child with parental care and financial support.
2. I have authorized _____ (relationship to child: _____) to act as foster parents with full responsiblity for all decisions regarding any medical or dental services or surgical procedures pertaining to my child.
3. My child will reside with their foster parents at the following address: _____ from _____ to _____.
4. Attached is a statement from the State Department of Social Services and Housing certifying that I have applied to them for assistance and indicates that agency's denial decision to provide medical and dental care for my child.

FOSTER PARENTS

1. I hereby certify that the above named child is now living with me and is dependent upon me for parental care and financial support. I am an ( ) employee ( ) retiree of: AGENCY State DEPARTMENT UH, (Coll., School, etc)
2. I agree to assume full responsibility for making any decision regarding medical or dental services or surgical procedures pertaining to my foster child and to pay for all unreimbursed medical, dental or surgical bills.
3. I will immediately notify the Hawaii Public Employees Health Fund to remove my foster child from my enrollment in the event my foster child is no longer living with me.
4. I understand and agree that any misrepresentation of my foster child will cause me to lose my Health Fund benefits and enrollment.

NATURAL AND FOSTER PARENTS

We agree to abide by the Health Fund Law and rules governing the eligibility of foster children and to inform the Health Fund of any changes in their living arrangements.

We state upon our oaths that the information given above is true and correct to the best of our knowledge.

NATURAL PARENTS

_____

_____

FOSTER PARENTS

_____

_____

State of Hawaii)
) SS.
_____ County of _____)

On this _____ day of _____, 19 _____, personally appeared before me the said named _____ to me known and known to me to be the persons described in and who executed the foregoing instrument and they acknowledged that they executed the same as their free and voluntary act and deed.

Affix your official seal.

Notary Public, _____

My commission expires _____

FORM F-1 (REV 7/81)

A9.690
Attachment K

HAWAII PUBLIC EMPLOYEES HEALTH FUND

REFUND CLAIM APPLICATION

Employee's Name _____ Soc. Sec. No. _____

Mailing Address _____ Bus. Tel. No. _____

City, State Zip Code _____ Res. Tel. No. _____

TO HEALTH FUND OFFICE or COUNTY DIRECTOR OF FINANCE:

I hereby claim a refund of my employee Medical Plan contributions:

PART A

CLAIMANT MUST COMPLETE THIS PART

PLEASE PRINT OR TYPE

YOU MAY ATTACH A SEPARATE EXPLANATION.

REASONS — ENDING DATES OF PAY PERIODS	AMOUNT DEDUCTED	CORRECT AMOUNT	REFUND CLAIMED

Total Refund Claimed $

Claimant's Signature Date signed

PART B

FOR EMPLOYING AGENCY USE ONLY.

We have verified the claimant's reasons for a refund by examining our agency's enrollment and payroll records. In our opinion, his claim appears proper and reasonable.

Authorized Signature Date

State-UH (Coll., school, etc) 01-022

Agency — Department Code

PART C

AUDIT FINDINGS AND REFUND DECISIONS.

Payroll registers examined Initials

Enrollment records examined Initials

Comments:

[ ] Health Fund

[ ] County Director of Finance

[ ] Approved [ ] Adjusted to $ [ ] Denied

Authorized Signature Date signed

Refund issued via SWV No. dated Initials

Denial Notice No. sent to claimant on Initials

SAMPLE

Form RC-1 5/76

HAWAII PUBLIC EMPLOYEES HEALTH FUND

A9.690
Attachment L

EMPLOYEE APPEAL STATEMENT

PART A

EMPLOYEE MUST COMPLETE THIS PART.

PLEASE PRINT OR TYPE.

YOU MAY ATTACH A SEPARATE EXPLANATION.

Employee's Name _____ Soc. Sec. No. _____

Mailing Address _____ Bus. Tel. No. _____

City, State Zip Code _____ Res. Tel. No. _____

TO HEALTH FUND ADMINISTRATOR:

I hereby appeal your initial decision to (suspend) (cancel) my Medical Plan enrollment per your letter dated _____. I do not owe any contributions because of the reasons stated below. I agree to continue to pay my Medical Plan insurance premiums until such time that the Administrator completes his review of my appeal and issues a final decision.

☐ Medical Plan premiums are being properly deducted from my pay check. Attached are copies of my pay statements for the periods: _____ to _____, cancelled checks, or Health Fund receipts.

☐ I was on a leave of absence without pay from _____ to _____. I did not receive any official notification from the Administrator about my premium shortage and enrollment suspension or cancellation. Upon returning to work, my payroll deductions continued and I believe that I was properly enrolled.

☐ (Voluntary Cancellation)
(Terminated) (Retired) _____
Date

☐ Other . . . see attached statement.

_____ _____
Employee's Signature Date signed

PART B

FOR EMPLOYING AGENCY USE ONLY.

We have verified the employee's statement of appeal by examining our agency's enrollment and payroll records. In our opinion, the appeal appears proper and reasonable.

_____ _____ State - UH, (Coll., school, etc) _____
Authorized Signature Date Agency — Department Tel. No.

PART C

AUDIT FINDINGS AND FINAL DECISION BY ADMINISTRATOR.

Payroll registers _____ Initials _____

Enrollment records _____ Initials _____

Comments:

☐ Approved ☐ Denied ☐ Refund due $ _____

_____ _____
Authorized Signature Date signed

PREMIUM ADJUSTMENT

MONTH	TOTAL	EE	ER
	$	$	$
Total	$	$	$

Refund issued via SWV No. _____ dated _____ Initials _____

Denial Notice No. _____ sent to employee on _____ Initials _____

Form EA-1 8/82