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.

   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.
      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 be made if an employee
 relocates or moves from the geographic/service area of his/her medical insurance carrier or into another area where his/her current plan is not available but other Health Fund plans are 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 on 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:

<table>
<thead>
<tr>
<th>If your last day worked is between:</th>
<th>You must pay the monthly premium for:</th>
<th>State begins full payment on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st thru 15th</td>
<td>first half</td>
<td>16th of the month and thereafter</td>
</tr>
<tr>
<td>16th thru end of month</td>
<td>full month</td>
<td>1st of the following month and thereafter</td>
</tr>
</tbody>
</table>

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

SEND FORMS TO: DEPARTMENT __________________________________________________________________________

ADDRESS ________________________________________________________________________________________

ATTENTION: ____________________________________________________________________________________

Rev. 1/82
3. LIST EMPLOYEES IN ALPHABETICAL ORDER:

NAME  E-1  CHECK  E-5  D-63  D-1  F-1  N-1  HU-1

SAMPLE
### Hawaii Public Employees Health Fund

**Enrollment Application**

**Part A**
- Applicant must complete this part. Please print all letters.

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. Your Soc. Sec. No</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>02. Name</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>03. Address Number &amp; Street</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>04. City and State</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>05. Zip Code</td>
<td>[Redacted]</td>
</tr>
</tbody>
</table>

**Part B**
Complete items in this section for any changes which have occurred since your most recent enrollment application.

<table>
<thead>
<tr>
<th>Names of Family Members</th>
<th>Birthdate</th>
<th>R.C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>Last Name</td>
<td>Initial</td>
</tr>
<tr>
<td>[Redacted]</td>
<td>[Redacted]</td>
<td>[Redacted]</td>
</tr>
<tr>
<td>[Redacted]</td>
<td>[Redacted]</td>
<td>[Redacted]</td>
</tr>
</tbody>
</table>

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

- A. Enroll me in or change my present enrollment to (Plan).
- 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: [Redacted]
  - Secondary beneficiary: [Redacted]

**Part E**
Applicant must sign this part.

---

**For Employing Agency Use Only**

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

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

**Remarks**

**Use applicable block**

**Forms E-1 (Rev. 9/84)**

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.

<table>
<thead>
<tr>
<th>EVENTS</th>
<th>CHANGE PERMITTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>You may file these enrollment changes within 31 days of the following event dates.</td>
<td></td>
</tr>
<tr>
<td>Regular opportunity to enroll (Date of eligible employment, retirement, or re-employment, return from active military leave, return from L/WOP — all costs paid by educational grant or government program, Dental Plan — first child, etc.)</td>
<td>10</td>
</tr>
<tr>
<td>Loss of your Health Fund Benefit Plan coverage (including children) because of termination of your spouse’s enrollment</td>
<td>11</td>
</tr>
<tr>
<td>Loss of your Health Fund Benefit Plan coverage because your spouse changed his enrollment from Family to Self Only or changed from Self Only to Family enrollment</td>
<td>12</td>
</tr>
<tr>
<td>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</td>
<td>13</td>
</tr>
<tr>
<td>Change in marital status (Marriage, divorce, annulment, death of spouse, etc.)</td>
<td>20</td>
</tr>
<tr>
<td>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.)</td>
<td>21</td>
</tr>
<tr>
<td>When your spouse loses his Self Only Health Fund Benefit Plan coverage because of employment or eligibility termination</td>
<td>22</td>
</tr>
<tr>
<td>When your spouse loses his Self Only non-Health Fund Benefit Plan coverage (including children) because of employment termination</td>
<td>23</td>
</tr>
<tr>
<td>Open enrollment period (NOTE: Special filing time limits are set by the Board of Trustees)</td>
<td>29</td>
</tr>
<tr>
<td>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</td>
<td>30</td>
</tr>
</tbody>
</table>

Upon your retirement, you may change from the Health Fund Life Insurance Plan to your employee organization life insurance plan

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

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

(Continued on Next Page)

* Event Code Numbers for employing agency use only
**STATE OF HAWAII MEDICAL PLAN INSURANCE DEDUCTION AUTHORIZATION**

<table>
<thead>
<tr>
<th>Form No</th>
<th>Social Security No</th>
<th>Last Name, First Name, Middle Initial</th>
<th>Type</th>
<th>Agent</th>
<th>Plan</th>
<th>DO No</th>
<th>Dept</th>
</tr>
</thead>
<tbody>
<tr>
<td>PK1</td>
<td></td>
<td>University of Hawaii</td>
<td>MD</td>
<td>701</td>
<td></td>
<td></td>
<td>F</td>
</tr>
</tbody>
</table>

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

   $_____ per 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**

<table>
<thead>
<tr>
<th>Date</th>
<th>Employee's Signature</th>
<th>Date</th>
<th>Authorization Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STATE COMPTROLLER (CENTRAL PAYROLL)**

NOTE: THIS IS A STANDARD DADS FORM WHICH IS HULK-PURCHASED BY THE UNIVERSITY PROCUREMENT AND PROPERTY MANAGEMENT OFFICE. ADMINISTRATIVE OFFICERS SHOULD SUBMIT THEIR NEEDS TO PPMO.
**Employee (Last Name, First, Initial)**

**Social Security No.**

---

**Date**

**Actual Code No.**

**Date**

---

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

<table>
<thead>
<tr>
<th>Personnel Action</th>
<th>Code Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorized leave of absence without pay</td>
<td>Part B below</td>
</tr>
<tr>
<td>Termination of employment</td>
<td>Part D</td>
</tr>
<tr>
<td>Transfer to (Agency) (Department)</td>
<td>Part E</td>
</tr>
<tr>
<td>Retirement</td>
<td>Part F</td>
</tr>
<tr>
<td>Death of employee or retiree</td>
<td>Part G</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

---

**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

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.

---

**Your Social Security Number and the applicable month(s) on your checks. Send your payments to:**

- **HAWAII PUBLIC EMPLOYEES HEALTH FUND**
  - P.O. Box 2122
  - Honolulu, Hawaii 96805

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

- **DIRECTOR OF FINANCE**
  - State of Hawaii—Payroll Section
  - 25 Aupuni Street
  - Hilo, Hawaii 96720

- **DIRECTOR OF FINANCE**
  - County of Kauai—Payroll Section
  - P.O. Box 111
  - Lihue, Hawaii 96760

- **BOARD OF WATER SUPPLY**
  - Payroll Section
  - 630 S. Beretania Street
  - Honolulu, Hawaii 96813

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**Authorized Signature**

**Date of Notice**

---

**State/UH (coll., school, etc.) Code 01 023**

---

**Date of Notice**

---

**Form No. Rev. 1/91**

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**To Estimate**

---

**Attachment E**
PART D — TERMINATION OF EMPLOYMENT

1. MEDICAL PLAN—Your benefits will continue for the additional period for 31 days or hospitalization on the 31st day to a maximum of 60 days after the date shown in PART A, Item 1 (last day of the pay period). 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 transfer 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 HP 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:

<table>
<thead>
<tr>
<th>INSURANCE CARRIER</th>
<th>ENROLLMENT TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Kaiser Plan</td>
<td>___ Self Only</td>
</tr>
<tr>
<td>___ HMSA Plan</td>
<td>___ Family</td>
</tr>
<tr>
<td>___ CHP Plan</td>
<td>___ Self Only</td>
</tr>
<tr>
<td>___ Island Care Plan</td>
<td>___ Family</td>
</tr>
</tbody>
</table>

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 ______

Form EF-1 (8/83)
(UH 11/83)
HAWAII PUBLIC EMPLOYEES HEALTH FUND
ENROLLMENT APPLICATION — MEDICARE SUPPLEMENTAL PLAN

PART A

<table>
<thead>
<tr>
<th>Name</th>
<th>First</th>
<th>Middle Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Age No.</th>
<th>Social Security No.</th>
<th>Date of Birth</th>
<th>Hospital insurance off date</th>
<th>Medical insurance off date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim No.</th>
<th>Hospital insurance off date</th>
<th>Medical insurance off date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Information in this application is given to obtain insurance and is made in reliance 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.

Applicant's Signature  

Spouse's Signature  

Date  

PART B

Applicant and all spouse must sign this part.

FOR EMPLOYING AGENCY USE ONLY

AGENCY DEPARTMENT NAME  

STATE - UH, UH M/C, etc.  

01/02/22  

MEDICARE REIMBURSEMENT INFORMATION FOR RETIREES ONLY

<table>
<thead>
<tr>
<th>MONTHLY PAYMENT</th>
<th>INITIAL PAYMENT</th>
<th>ELIGIBLE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant 56.</td>
<td>$</td>
<td>/</td>
</tr>
<tr>
<td>Spouse 57.</td>
<td>$</td>
<td>/</td>
</tr>
<tr>
<td>TOTAL 58.</td>
<td>$</td>
<td>/</td>
</tr>
</tbody>
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REMARKS:

Retirement Date / 

TO HEALTH FUND
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: __________________________

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 or Employee __________________________ Social Security No. __________________________

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

Signature __________________________ Date __________________________

FORM D-1 (REV. 7/81)
HAWAII PUBLIC EMPLOYEES HEALTH FUND
FOSTER-CHILD STATEMENT

NATURAL PARENTS

1. I, ________________________________, hereby certify that at the present time, I am unable to provide my child, birthdate ________________, with parental care and financial support.

2. I have authorized ________________________________ (relationship to child: __________________) to act as foster parent(s) with full responsibility 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 ____________________________ DEPARTMENT ____________________________ (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

______________________________
County of ________________________

On this ________________ day of ________________, 19 ________________ 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)
HAWAII PUBLIC EMPLOYEES HEALTH FUND

REFUND CLAIM APPLICATION

Employee's Name
Mailing Address
City, State Zip Code

Soc. Sec. No.
Bus. Tel. No.
Res. Tel No.

TO HEALTH FUND OFFICE or COUNTY DIRECTOR OF FINANCE:
Hereby claim a refund of my employee Medical Plan contributions:

REASONS — ENDING DATES
OF PAY PERIODS

PART A
CLAIMANT MUST
COMPLETE THIS
PART
PLEASE PRINT
OR TYPE
YOU MAY ATTACH
A SEPARATE
EXPLANATION.

PART B
FOR EMPLOYING
AGENCY USE
ONLY

PART C
AUDIT
FINDINGS
AND
REFUND
DECISIONS.

| Health Fund
| County Director of Finance

Authorized Signature Date Signed
Refund issued via SWV No. Initials
Denial Notice No. sent to claimant on

Total Refund Claimed $

Claimant's Signature Date signed
Payroll registers examined
Enrollment records examined

| Approved | Adjusted to $ | Denied |

| Initials |

Initials

State-LH (coll. school, etc) 01-022
Agency Department Code

SAMPLE

Authorized Signature Date Signed

Initials

Initials

Initials
HAWAII PUBLIC EMPLOYEES HEALTH FUND
EMPLOYEE APPEAL STATEMENT

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) (Notified) ________________ 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.

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

Payroll registers ________________ Initials
Enrollment records ________________ Initials
Comments:

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<tr>
<th>PREMIUM ADJUSTMENT</th>
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<tbody>
<tr>
<td>MONTH</td>
</tr>
<tr>
<td>$</td>
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☐ Approved ☐ Denied ☐ Refund due $ ________________

_________________________________________ _____________________________
Authorized Signature Date signed

Refund issued via SWV No. ________________ dated ________________ Initials
Denial Notice No. ________________ sent to employee on ________________ Initials