

SECTION 743: INSTRUCTIONS FOR COMPLETING  
HEALTH BENEFITS PLAN DEDUCTION AUTHORIZATION, STATE ACCOUNTING FORM D-66

1. Purpose.

- (a) The HEALTH BENEFITS PLAN DEDUCTION AUTHORIZATION, SAFORM D-66 is used by an employee to authorize the deduction of monthly health benefits plan contributions as required by the Hawaii Public Employees Health Fund (Health Fund); it is also used to change or cancel any previous authorizations.
- (b) The form is also used by the Health Fund to initiate certain deduction transactions as required by the Health Fund under applicable laws, rules, or regulations, when such use has been approved by the Comptroller; for such use, the forms are prepared by the Health Fund and do not require an employee's signature.

2. Prepared By. The employee with the assistance of the appropriate office within the employing department or with the assistance of the Health Fund.3. Frequency. Prepared whenever an employee enrolls, changes enrollment or cancels a previous enrollment.4. Distribution. Forms for new authorizations and cancellations must be submitted directly to the Health Fund for audit and eligibility review. Upon approval, the Health Fund must submit forms for new authorizations to Central Payroll, DAGS, by 4:00 p.m. on the first work day of the month, if they are to be reflected in the payroll for that month. Forms for cancellations must be submitted to Central Payroll by 4:00 p.m. of the first work day of either pay period in a month, if they are to be reflected in that payroll period. (Health Fund, by controlling the submission of SAFORM D-66 to Central Payroll, may in effect control the pay period in which a new authorization or a cancellation will be effective.)

## (a) If completed at employing department.

- (1) Copy #1 - To Health Fund for authorization signature; to Central Payroll; to data processing center; and to Central Payroll for verification and control filing.
- (2) Copy #2 - To Health Fund for reference filing.
- (3) Copy #3 - Retained by department for payroll verification and filing into employee's personnel jacket.
- (4) Copy #4 - Retained by department, and routed to the employee for employee's personal record.

## (b) If completed at Health Fund's office.

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- (1) Copy #1 - To Central Payroll; to data processing center; and to Central Payroll for verification and control filing.
- (2) Copy #2 - Retained by the Health Fund for reference filing.
- (3) Copy #3 - To employing department for payroll verification and filing into employee's personnel jacket.
- (4) Copy #4 - To employing department and routed to the employee for employee's personal record.

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ITEM NO.	DATA AND DATA INSTRUCTIONS
①	DEPARTMENT - Enter the title of the department in which the employee is employed.
②	SUBDIVISION OR SCHOOL - Enter the title of the subdivision or school in which the employee is employed.
③	FORM NO. - Form number PK1 is pre-printed.
④	SOCIAL SECURITY NO. - Enter the employee's social security number.
⑤	LAST NAME, FIRST NAME, MIDDLE INITIAL - Enter the employee's name in the following sequence: last name, first name, middle initial. The name must be identical with the name reflected on the EMPLOYEE'S EARNINGS, DEDUCTIONS AND LEAVE STATEMENT. A comma must be placed between the last name and the first name; do not use a comma elsewhere in the name.
⑥	AGENT - Agent code 701 is pre-printed.
⑦	DEPT. - Enter the one character code of the department in which the employee is employed.
⑧	EFFECTIVE DATE - Enter the date when the form is to take effect.
⑨	<input type="checkbox"/> AUTHORIZE - Enter an "X" in this box if the employee is authorizing a deduction.
⑩	<input type="checkbox"/> CANCEL - Enter an "X" in this box to cancel any previous authorization.
⑪	BENEFIT PLAN - Enter an "X" in the box for the Benefit plan(s) desired: Medical, Drug, Vision, and/or Adult Dental.
⑫	TYPE CODE - The applicable type codes for item #11 are pre-printed.
⑬	PLAN CODE - Enter the three-digit number plan code in which the employee is enrolled. Refer to Table I: HEALTH FUND PLAN CODES FOR PAYROLL DEDUCTIONS.
⑭	FIRST MONTH CONTRIBUTION - Enter the dollar amount that is to be deducted for the first month.

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ITEM NO.	DATA AND DATA INSTRUCTIONS
①5	NEXT MONTH IF DIFFERENT - Enter the dollar amount that is to be deducted for subsequent months if different from the first month.
①6	The date and signature of the employee.
①7	The date and the authorized signature of Health Fund.

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TABLE I: HEALTH FUND PLAN CODES FOR PAYROLL DEDUCTIONS

<u>PLAN CODE</u>	<u>TYPE OF PLAN</u>
<u>MEDICAL</u>	
111	KAISER - Self Only
112	KAISER - Self and Family
211	HMSA - Self Only
212	HMSA - Self and Family
411	CHP - Self Only
412	CHP - Self and Family
511	ISLANDCARE - Self Only
512	ISLANDCARE - Self and Family
<u>PRESCRIPTION DRUG</u>	
311	HDS MEDICAL - Self Only
312	HDS MEDICAL - Self and Family
<u>VISION CARE</u>	
011	VSP - Self Only
012	VSP - Self and Family
<u>ADULT DENTAL</u>	
631	HDS - Self Only
632	HDS - Self and Spouse

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EXHIBIT A: SAMPLE FORM KEYED TO INSTRUCTIONS FOR SAFORM D-66

**USE TYPEWRITER OR PRINT WITH BALL POINT PEN WITH HEAVY PRESSURE**

**INSTRUCTIONS:**

1. Read entire form . . . contact your employing agency if you need additional information or assistance.
2. Complete Item Nos. 1, 2, 4, 5, 9 or 10, 11, 16 and 17.
3. Return form to your employing agency.

STATE OF HAWAII			HEALTH BENEFITS PLAN DEDUCTION AUTHORIZATION					
1. DEPARTMENT <b>(1)</b>			2. SUBDIVISION OR SCHOOL <b>(2)</b>					
3. FORM NO. <b>(3) PKI</b>	4. SOCIAL SECURITY NO. <b>(4)</b>	5. LAST NAME, FIRST NAME, MIDDLE INITIAL <b>(5)</b>			6. AGENT <b>(6) 701</b>	7. DEPT. <b>(7) 7</b>	8. EFFECTIVE DATE <b>(8) L _ L _</b>	
9. <input type="checkbox"/> I HEREBY AUTHORIZE THE STATE OF HAWAII TO DEDUCT ONE-HALF OF MY MONTHLY HEALTH BENEFITS PLAN CONTRIBUTIONS FROM MY COMPENSATION EACH PAYROLL PERIOD AS CHECKED IN COLUMN 11. <b>(9)</b> MY AUTHORIZATION ALSO INCLUDES ANY CONTRIBUTION INCREASE, DECREASE, ADJUSTMENT OR CANCELLATION AS REQUIRED BY THE HEALTH FUND UNDER APPLICABLE LAWS, RULES OR REGULATIONS.  I DO NOT ELECT TO PARTICIPATE IN THE PREMIUM CONVERSION PLAN (PCP) AT THIS TIME. I UNDERSTAND THAT I MAY NOT ENROLL IN THE PCP UNTIL THE NEXT OPEN ENROLLMENT PERIOD, UNLESS PERMITTED UNDER THE PCP ADMINISTRATIVE RULES.  10. <input type="checkbox"/> I HEREBY CANCEL MY PREVIOUS AUTHORIZATION(S) AS CHECKED IN COLUMN 11. <b>(10)</b>				11. BENEFIT PLAN <input type="checkbox"/> MEDICAL <b>(11)</b>	12. TYPE CODE MD <b>(12)</b>	13. PLAN CODE <b>(13)</b>	14. FIRST MONTH CONTRIBUTION \$ <b>(14)</b>	15. NEXT MONTH IF DIFFERENT \$ <b>(15)</b>
				<input type="checkbox"/> DRUG	PD		\$	\$
				<input type="checkbox"/> VISION	VC		\$	\$
				<input type="checkbox"/> ADULT DENTAL	DD		\$	\$
				<b>HAWAII PUBLIC EMPLOYEES HEALTH FUND</b>				
16. DATE <b>(16)</b>				17. EMPLOYEE'S SIGNATURE <b>(17)</b>				
18. DATE				19. AUTHORIZED SIGNATURE				

STATE COMPTROLLER (CENTRAL PAYROLL)

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APRIL 1, 1990

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EXHIBIT B: FILLED-OUT SAMPLE OF SAFORM D-66

**USE TYPEWRITER OR PRINT WITH BALL POINT PEN WITH HEAVY PRESSURE**

**INSTRUCTIONS:**

1. Read entire form . . . contact your employing agency if you need additional information or assistance.
2. Complete Item Nos. 1, 2, 4, 5, 9 or 10, 11, 16 and 17.
3. Return form to your employing agency.

**STATE OF HAWAII HEALTH BENEFITS PLAN DEDUCTION AUTHORIZATION**

1. DEPARTMENT Accounting and General Services				2. SUBDIVISION OR SCHOOL Accounting				
3. FORM NO. PKI	4. SOCIAL SECURITY NO. 576   92   0495	5. LAST NAME, FIRST NAME, MIDDLE INITIAL Watanabe, Rachel L.		6. AGENT 701	7. DEPT. M	8. EFFECTIVE DATE 07/01/90		
9. <input checked="" type="checkbox"/> I HEREBY AUTHORIZE THE STATE OF HAWAII TO DEDUCT ONE-HALF OF MY MONTHLY HEALTH BENEFITS PLAN CONTRIBUTIONS FROM MY COMPENSATION EACH PAYROLL PERIOD AS CHECKED IN COLUMN 11.  MY AUTHORIZATION ALSO INCLUDES ANY CONTRIBUTION INCREASE, DECREASE, ADJUSTMENT OR CANCELLATION AS REQUIRED BY THE HEALTH FUND UNDER APPLICABLE LAWS, RULES OR REGULATIONS.  I DO NOT ELECT TO PARTICIPATE IN THE PREMIUM CONVERSION PLAN (PCP) AT THIS TIME. I UNDERSTAND THAT I MAY NOT ENROLL IN THE PCP UNTIL THE NEXT OPEN ENROLLMENT PERIOD, UNLESS PERMITTED UNDER THE PCP ADMINISTRATIVE RULES.				11. BENEFIT PLAN <input checked="" type="checkbox"/> MEDICAL	12. TYPE CODE MD	13. PLAN CODE 212	14. FIRST MONTH CONTRIBUTION \$ 50.00	15. NEXT MONTH IF DIFFERENT \$ 40.00
				<input checked="" type="checkbox"/> DRUG	PD	312	\$ 30.00	\$ 20.00
				<input checked="" type="checkbox"/> VISION	VC	012	\$ 30.00	\$ 20.00
				<input checked="" type="checkbox"/> ADULT DENTAL	DD	632	\$ 20.00	\$ 10.00
				10. <input type="checkbox"/> I HEREBY CANCEL MY PREVIOUS AUTHORIZATION(S) AS CHECKED IN COLUMN 11.				
16. DATE 06/15/90				17. EMPLOYEE'S SIGNATURE <i>Rachel L. Watanabe</i>				
				18. DATE 06/22/90				
				19. AUTHORIZED SIGNATURE <i>John H. Smith</i>				

STATE COMPTROLLER (CENTRAL PAYROLL)

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