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GOVERNOR

GLENN M. OKIMOTO
COMPTROLLER

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STATE OF HAWAII
DEPARTMENT OF ACCOUNTING
AND GENERAL SERVICES
P.O. BOX 119
HONOLULU, HAWAII 96810-0119

JUL 12 2002

COMPTROLLER'S MEMORANDUM NO. 2002-28

TO: Heads of Departments

ATTN: Administrative and Fiscal Officers

SUBJECT: Revised Employee's Designation of Beneficiary, SAFORM D-90

This is to inform departments that a revised Employee's Designation of Beneficiary, SAFORM D-90 will be implemented on July 1, 2002. The new form will be available from Correctional Industries beginning the third week in July.

Remaining quantities of the old form may not be used. Personnel offices should remind employees to submit a new SAFORM D-90 when an employee gets married or divorced, or if there is a death of a designated beneficiary.

Attached for your information is a sample copy of the revised form with the significant changes described below.

EMPLOYEE'S DESIGNATION OF BENEFICIARY, SAFORM D-90

The following changes were made to the front page:

1. Changed the section in the title from "79-7" to "78-23(c)."

2. In the top paragraph, changed the section number from "79-7" to "78-23(c)."

3. In the middle part of the form, changed the year from "19" to "20".

4. Changed the revision date to "July 1, 2002".

The following changes were made to the back page:

5. Changed the section in the title from "79-7" to "78-23(c)".

6. In paragraph 2, deleted the wording "be paid to the employee's surviving spouse, if there is no surviving spouse, the unpaid compensation would".

Should there be any questions regarding this memorandum, please call Dona Kang of our Systems Accounting Branch at 586-0610.

GLENN M. OKIMOTO
State Comptroller

Attachment

STATE OF HAWAII

EMPLOYEE'S DESIGNATION OF BENEFICIARY

(PURSUANT TO SECTION 78-23(c) OF THE HAWAII REVISED STATUTES)

1

TO THE COMPTROLLER, STATE OF HAWAII:

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Pursuant to the provisions of Section 78-23(c) of the Hawaii Revised Statutes, the undersigned employee of the State of Hawaii hereby designates the person (or persons who, if living at the employee's death, shall share equally unless specifically indicated otherwise in writing hereon) noted below as his (or her) beneficiary (or beneficiaries) to whom shall be paid all accumulated vacation pay and all earned and unpaid wages due at the time of his (or her) death.

NAME AND SOCIAL SECURITY NUMBER (type only)		ADDRESS (type only)		
NAME:	_____	STREET:	_____	
SSN:	_____	CITY/STATE:	_____	ZIP: _____
NAME:	_____	STREET:	_____	
SSN:	_____	CITY/STATE:	_____	ZIP: _____
NAME:	_____	STREET:	_____	
SSN:	_____	CITY/STATE:	_____	ZIP: _____
NAME:	_____	STREET:	_____	
SSN:	_____	CITY/STATE:	_____	ZIP: _____

The Comptroller of the State is authorized to make such payments to the person or persons designated.

_____
Signature of Employee

Subscribed and sworn to before me, this

_____ day of _____ 20 3 ____

_____
Notary Public, _____ Judicial Circuit
State of Hawaii

My Commission Expires: _____

(In box below, *type* only.)

Place of employment at above date:	EMPLOYEE'S:
Department _____	Last Name _____
Division _____	First Name _____ Middle Initial _____
Branch _____	Social Security Number: _____
	(The above name and social security number must agree with payroll records.)

SEE REVERSE SIDE FOR INSTRUCTIONS.

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STATE ACCOUNTING FORM D-90
JULY 1, 2002 (REVISED)

STATE OF HAWAII

EMPLOYEE'S DESIGNATION OF BENEFICIARY

(PURSUANT TO SECTION 78-23(c) OF THE HAWAII REVISED STATUTES)

5

Explanation and Instructions to Employee

1. Each employee of the State of Hawaii is urged to execute this designation form and have it forwarded through his or her department or agency to the State Comptroller. In the event of the employee's death, this designation form authorizes immediate and direct payment of unpaid compensation (including vacation) to the beneficiary (or beneficiaries) named by the employee.

2. If an employee does not execute this designation form, his unpaid compensation would, in the event of the employee's death, be paid to the employee's estate.

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3. If two or more beneficiaries are named on this designation form, they will share equally in any authorized payment unless the employee specifically indicates a 1st choice, 2nd choice, 3rd choice, etc., in listing the beneficiaries on the designation form.

4. This designation form must be verified by a notary public. Other witnesses' signatures are not required.

5. **Please type all information**, except for employee's signature.

6. The employee's social security number must be accurately entered on this designation form in the space provided.

7. This designation form will be secured in a confidential file with the State Comptroller; a copy is not retained by the employing department or agency.

8. The designation made on this form may be changed by the employee at any time by submitting a new designation form. It is recommended that the employee promptly submit a new form if for any reason the previously submitted designation is no longer desired, because the State Comptroller must make payment according to the most recent designation form on file.

9. To assure continuing confidentiality (paragraph 7 above) and to avoid confusion when designation forms are changed (paragraph 8 above), it is suggested that no copy be made of this designation form; only the original form should be executed and forwarded through the employee's department or agency to the State Comptroller.