

STATE OF HAWAII
EMPLOYEE'S DESIGNATION OF BENEFICIARY
(PURSUANT TO SECTION 78-23(c) OF THE HAWAII REVISED STATUTES)

TO THE COMPTROLLER, STATE OF HAWAII:

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____

Notary Public _____ Judicial Circuit
State of Hawaii

My Commission Expires: _____

(In box below, type only.)

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

PLEASE HAVE A NOTARY IN YOUR STATE NOTARIZE THIS DESIGNATION OF BENEFICIARY FORM

Please indicate first name, middle initial(s), last name and Social Security Number for each beneficiary. Initials are not acceptable for first name. (Example: Mr. John M. Smith; Mrs. Susan B. Smith).

PLEASE NOTE THAT ALL INFORMATION MUST BE TYPED, except for employee's signature.

Please initial all corrections (i.e. white-outs, line-outs, etc.)

FOR REHIRES ONLY: If no change in beneficiary since last date of hire, please indicate " NO CHANGE" on form.