RESET FORM

TRANSMITTAL REPORT
HAWAII PUBLIC EMPLOYEES HEALTH FUND

1. Name of employing agency

Agency State of Hawaii Code No. 01

Dept. UH - Nursing & Dental Hygiene Code No. 022

2. This report covers the period ____________________

______________________________ ____________
Signature of Agency Official Date

3. LIST EMPLOYEES IN ALPHABETICAL ORDER:

NAME	E-1	CHECK	D-66	D-67	PCP-2	E-5	DC-1	N-1	N-2	RC-1	BD-1	OTHER
NAME	E-1	CHECK	D-66	D-67	PCP-2	E-5	DC-1	N-1	N-2	RC-1	BD-1	OTHER

Total:

REFER TO THE HEALTH FUND PROGRAM MANUAL FOR INSTRUCTIONS