



| Question # | Condition | Date Began | Date Ended | Treatment or Care of Problem, Injury or Illness | Physician Consulted Name & Address |
|------------|-----------|------------|------------|---|------------------------------------|
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Use this space to give details to any "YES" answers to questions #13 (b, c, d, e)

ROYAL STATE INSURANCE OFFICES

Oahu Office
 819 S. Beretania Street
 Honolulu, HI 96813
 Phone: (808) 539-1600
 1-800-890-9022 (Toll-free from the Neighbor Islands)

Hawaii Office (Hilo)
 120 Pauahi Street, Suite 201
 Hilo, HI 96720
 Phone: (808) 935-2766

Kauai Office
 4370 Kukui Grove Street, Suite 105
 Lihue, HI 96766
 Phone: (808) 245-4571

Maui Office
 2145 Kaohu Street, Suite 205
 Wailuku, HI 96793
 Phone: (808) 244-7245
 1-800-774-7668 (Toll-free from Molokai and Lanai)



www.royalstate.com

Specialty Group Term Life Insurance

\$50,000 Fixed Death Benefit Term Life Insurance Plan.



HGEA Specialty Group Term Life

This is a pure group term life insurance plan with a fixed death benefit of \$50,000. Rates are based on age and sex (see below). Rates increase as the insured gets older. This plan is underwritten by Royal State National Insurance Company, Ltd. (RSN)

HGEA members in good standing & actively at work for at least 20 hours per week may enroll within 60 days of employment. Otherwise, you will need to provide evidence of insurability.

Eligibility

You are eligible for this plan if you:

- are a HGEA member in good standing and a Hawaii State or County active employee;
- have provided evidence of insurability, except if you enroll within the first 60 days of employment.

How to Apply

Complete the attached application. Sign and date where indicated. Tear off application and return in enclosed reply envelope.

If you are accepted, you will receive a group term life insurance certificate and your monthly premiums will be conveniently deducted through payroll deductions.

No insured shall be issued more than one certificate of coverage under this group plan and another group plan of same benefits.

In the interest of simplicity, the Plan is described only in general terms in this brochure. The extent of each person's insurance is at all times governed by the terms of the Master Group Policy issued by Royal State National Insurance Company, Limited.

| | | |
|--------|----------|----------------------------------|
| Oahu | 539-1600 | Molokai and Lanai |
| Hawaii | 935-2766 | Call toll-free at 1-800-774-7668 |
| Kauai | 245-4571 | |
| Maui | 244-7245 | |

| Monthly Premium Rates | | |
|-----------------------|---------|----------|
| Age | Female | Male |
| 18-30 | \$4.16 | \$4.16 |
| 31-35 | \$4.16 | \$4.16 |
| 36-40 | \$4.16 | \$4.16 |
| 41-45 | \$5.31 | \$6.31 |
| 46-50 | \$10.21 | \$13.96 |
| 51-55 | \$15.66 | \$23.61 |
| 56-60 | \$23.66 | \$37.11 |
| 61-65 | \$37.66 | \$64.91 |
| 66-70 | \$56.66 | \$105.26 |
| 71-75 | \$90.66 | \$167.61 |

For monthly premium rates beyond 75, please contact Royal State.

ROYAL STATE NATIONAL INSURANCE CO., LTD., Specialty Group Term Life Application Form

Print legibly with ballpoint pen or type. Detach application and return in reply envelope.

Asking for your Social Security number protects you from fraud and from other people potentially taking out a life insurance policy in your name.

| | | | | |
|---|--|---|--|--|
| 1. Social Security Number - - - - - | 2. Applicant's (Member's) Name (Last, First, Middle Initial) | 3. Date of Birth Mo / Day / Yr | 4. Sex <input type="checkbox"/> M <input type="checkbox"/> F | 5. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single |
| 6. Phone Number Res.: _____ Bus.: _____ | 7. Mailing Address (Street) | (City) | (State) | (Zip) |
| 8. Member's Employer (Check One) <input type="checkbox"/> State of Hawaii <input type="checkbox"/> C&C of Honolulu <input type="checkbox"/> Hawaii County <input type="checkbox"/> Kauai County <input type="checkbox"/> Maui County | 9. Department/School or Division | 10. Date of Employment Mo / Day / Yr | 11. Bargaining Unit | |

12. BENEFICIARY INFORMATION

Beneficiary's name: _____

Relationship: _____

Residence of Beneficiary _____

**Application for:
\$50,000**

13. Answer the following questions (a through e) If "Yes", please provide details: Nature of sickness, date, duration, treatment, result, complete name & address of attending physician. **Use the back side of this form.**

a) What is your Height? _____' _____" What is your Weight? _____ lbs.

b) Have you ever had arthritis, or rheumatism; asthma; tuberculosis or any lung disease; any heart disease; chest pain; gall stones; goiter; syphilis; kidney stones; any kidney disease; high blood pressure; diabetes; sugar, albumin, pus or blood in urine; nervous or mental disease; epilepsy, eye or ear disease, apoplexy; paralysis; liver disease; any deformity; surgical operations; indigestion; peptic ulcer; any disease of stomach or colon; tumor or cancer or ulcer; disease of the rectum or bladder; Acquired Immune Deficiency Syndrome ("AIDS"), AIDS Related Complex ("ARC") or HIV related conditions? Yes No

c) Do you know of any impairment in your physical condition or health? Or do you know of any chronic ailment, disease, or other condition now existing, which is likely to lead to hospitalization or surgical procedure? Yes No

d) Have any symptoms manifested themselves that lead you to think that you may be suffering from any disease or injury? Yes No

e) Have you been absent from work because of any sickness or ailment listed in question "b" during the past 12 months? Yes No

14. I hereby declare that to the best of my knowledge and belief, all the statements and answers to above are true, and that they are the basis on which insurance may be extended to me under the Group Policy. I agree that the insurance is not effective until Royal State National Insurance Co., Ltd. approves this application and a Certificate of Insurance has been issued and I have paid the required premium.

I hereby authorize any physician, medical or health practitioner, hospital, clinic, or other medical or medical related facility, insurance company, the Medical Information Bureau, Inc., Consumer Reporting Agency, any other organization, institution or person that has information, records or knowledge of me or my physical or mental health, to give Royal State National Insurance Co., Ltd., its reinsurers or its representatives any such information. I agree that such information shall be used to determine if I qualify for this insurance. I agree that this authorization shall be valid for 30 months from the application date, or until I revoke it in writing. I agree that a photocopy of this authorization shall be valid as the original.

I hereby request enrollment, or change in enrollment, and agree to abide by the terms and condition of the Group Contract issued to HGEA/AFSCME. I hereby authorize my employer to make the necessary post-tax payroll deduction to my wages necessary for the contributions required of me for the HGEA/AFSCME Specialty Group Term Life Insurance Plan. My authorization also includes any contribution increase, decrease, adjustments or cancellation as required under the Group Policy.

Member Applicant's Signature: **x** _____ Date: _____

OFFICE USE: HGEA Member in good standing verified and certified by _____ (RSG Client Service) Date: _____

Effective Date if application approved: _____ Keyed Date: _____

Comments: _____