

Royal State National Insurance Co. Ltd.

819 South Beretania Street • Honolulu, Hawaii 96813 • (808) 539-1600

GROUP LONG TERM DISABILITY INSURANCE REGULAR ENROLLMENT APPLICATION

IMPORTANT: Submitting this form does not automatically entitle you to coverage. Please check with your plan administrator to confirm that you are eligible based on the provisions of the group policy(ies) issued by Royal State National Insurance Company, Limited (referred to as “the Company”). Insurance will not be in force until the Company approves the request and provides written notification. **PLEASE PRINT ALL ANSWERS.**

Applicant Information

Last Name: _____ First Name: _____ Middle Initial: _____

Sex: _____ Home Phone: _____ Cell Phone: _____

Address: _____

_____ E-mail address _____

Date of Birth: _____ State or Country of Birth: _____

Employment Information

State/County _____ Dept: _____ Division: _____ District/School: _____

Date of Hire: _____ Base monthly earnings: \$ _____ per month*

I certify that I am an HGEA member who is an active, full-time employee of the State of Hawaii, or any of its Counties, or the HGEA, working at least 20 hours per week.

Option Requested (See Brochure): 5-Year Plan Retirement Age Plan

*Benefit payments will be based on the base monthly earnings from the employer in effect just prior to the date disability begins, and for which premium has been paid, excluding commissions, bonuses, overtime pay or other extra compensation.

Please answer or check (✓) the following questions:				
1. Height: _____ Weight: _____ Weight change within last year (+/-): _____ Reason: _____				
2. Date last seen by a doctor: _____ Reason for visit: _____ Name and address of primary physician: _____				
3. Have you ever had life or disability coverage denied, rated or postponed?..... <input type="checkbox"/> Yes <input type="checkbox"/> No				
4. Have you ever been diagnosed or treated for any disease or disorder of the heart or blood vessels; high blood pressure; diabetes; cancer; drug or alcohol abuse; any disease disorder of the immune system; mental or nervous disorder, any disease or disorder of the blood, kidneys, liver, lungs, stomach or intestines?..... <input type="checkbox"/> Yes <input type="checkbox"/> No				
5. Within the past 5 years, have you consulted a physician or practitioner for or been diagnosed as having any injury, medical or surgical condition not stated above?..... <input type="checkbox"/> Yes <input type="checkbox"/> No				
6. Do you regularly take prescription drugs or medications for any physical or mental condition? <input type="checkbox"/> Yes <input type="checkbox"/> No				
7. Have you had a member of the medical profession diagnose or prescribe treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or advise that you tested HIV positive?..... <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please provide details to all “Yes” answers for questions 3-7. Use additional page if necessary.				
Question Number	Medical Condition	Date Condition		Name, Address and Phone # of Doctors and Hospitals
		Began	Ended	

Member Name (Last/First/Middle): _____

APPLICANT'S STATEMENT AND AGREEMENT

I have read and understand this completed application. I have read all questions and answers, and hereby declare that to the best of my knowledge and belief, the answers are complete and true, and that the Company may rely on the statements in the issuance of a policy and/or certificate. I declare: a) that no waiver or modification of this application will bind the Company unless in writing and signed by an officer of the Company; **b) that no insurance will be in force unless and until the policy and/or certificate has been delivered, received and accepted;** c) **that no insurance coverage and benefits will be in force until the full first premium is paid during the lifetime and continued insurability of each person on whom insurance is requested as described in this application;** d) that the Company reserves the right to accept or deny this application after taking into account information available to it, including availability of coverage by its reinsurers; and e) that this application, and all supplementary documentation, the medical exam, questionnaires, and supplements to the application, and amendments issued by the Company will be made a part of the policy and/or certificate.

Furthermore, I agree that I have an obligation to report to the Company any change in the information provided on this application that occurred between the time I completed the application and the effective date outlined in the group policy.

AUTHORIZATION TO OBTAIN INFORMATION

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, medical or other medically related facility, insurance company, or reinsurance company, the Veteran's Administration or Medical Information Bureau (MIB), consumer reporting agency or employer or sponsoring organization to release to the Company and its reinsurers any of the following pertaining to me: information relating to physical and mental condition; medical care, diagnosis or treatment; avocation; insurance coverage and benefits; aviation; criminal activity; income, earnings and other financial information; occupation; employment-related information; habits; driving record; and general character. This information will be used by the Company and its reinsurers to determine eligibility for insurance and to evaluate claims. I agree to complete an Authorization for Release of Health-Related Information when requested.

To facilitate rapid transmission of such information, I authorize all such sources, except MIB, Inc., to provide such records of information to any of the Company's legal representatives. I understand that the Company will not release this information to any person or organization except its reinsurer(s); MIB, Inc. (formerly the Medical Information Bureau); other life insurance companies with which I have policies or to whom I may apply, or to whom a claim for benefits may be submitted; other persons or organizations performing business or legal services in connection with my application, including group plan administrators; or as may be otherwise lawfully required, or as I further authorize.

I understand that I or my authorized representative have the right to receive a copy of this authorization and agree that a photographic copy will be as valid as the original. I also understand that this authorization will be valid for two years (24 months) from the date shown below.



REQUIRED SIGNATURES


I wish to enroll in the Long Term Disability Insurance Plan and I also authorize the necessary deductions from my wages through payroll deduction to pay for the cost of my insurance.

This enrollment application and the first premium must be received by the Company before coverage is effective.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and imprisonment.

Signed at (city and state): _____ on (date): _____

 _____  _____
Signature of Witness Signature of Proposed Insured (age 18 or older)

 _____ _____
Print Name Print Name

For a complete description of the Long Term Disability Insurance coverage offered by Royal State National Insurance Co. Ltd., including all exclusions, limitations, reductions, and termination provisions, please refer to the Group Insurance Policy issued to the Hawaii Government Employees Association or to the Group Insurance Certificate you will receive if you become insured or to website www.royalstate.com.