

Royal State National Insurance Co. Ltd.
(referred to as "the Company")

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

**INCOME PROTECTOR LONG TERM DISABILITY INSURANCE
GROUP INSURANCE OPEN ENROLLMENT APPLICATION**

PLEASE PRINT ALL ANSWERS.

Applicant Information

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

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Sex: Male Female E-mail address: _____

Address: _____

Employment Information

State/County: _____ Dept: _____ Division: _____

District/School: _____ Date of Hire: _____ Base monthly earnings: \$ _____ per month*
(after furlough and any salary reductions)

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.

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.

COVERAGE DECISION

If enrolling in coverage: **YES**, I wish to enroll in the Income Protector 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.

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.

If declining or cancelling coverage: NO, I do not wish to enroll in the Income Protector long term disability insurance plan available to me. I understand that if I decide to enroll later, I may be required to provide the Company with satisfactory medical evidence of insurability and that the Company will have the right to refuse my request for insurance. Please terminate any existing long term disability coverage I may have with the Company.

Member Signature: _____ **Date:** _____

For a complete description of the Income Protector long term disability insurance coverage insured by Royal State National Insurance Co. Ltd., including all exclusions, limitations, reductions, and termination provisions, please refer to the Group Insurance Policy that will be issued to the Policyholder; or to the group insurance certificate you will receive when you become insured; or go to website www.royalstate.com.

THIS FORM MUST BE RECEIVED BY THE COMPANY BY JANUARY 31, 2012 TO BE VALID.

HOME OFFICE USE ONLY: