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 ❑ M ❑ F
5. Marital Status ❑ Married ❑ Single
6. Phone Number Res.: Bus.:
7. Mailing Address *(Street)* *(City)* *(State)* *(Zip)*
8. Member's Employer (Check One) ❑ State of Hawaii ❑ C&C of Honolulu ❑ Hawaii County ❑ Kauai County ❑ 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.

Question	Answer
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 Contrac 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: ______

70-137 5/2010

Use this space to give details to any "YES" answers to questions #13 (b, c, d, e)

Question #	Condition	Date Began	Date Ended	Treatment or Care of Problem, Injury or Illness	Physician Consulted Name & Address