UNIVERSITY OF HAWAII PROFESSIONAL ASSEMBLY
GROUP TERM LIFE INSURANCE APPLICATION

PARTICIPANT INFORMATION (Please print or type.)

Name (Last/First/Middle): _____

Date of Birth: ____ □ _____ ❑ Male □ ❑ Female Social Security #: _____

Mailing Address: _____

_____ E-mail Address: _____

Home Phone Number: _____ Cellular Phone Number: _____

BENEFICIARY INFORMATION (Please print or type.)

Attach additional sheet with all beneficiary information, if necessary. If more than one beneficiary is named, proceeds will be paid in equal shares, unless otherwise indicated. If no Primary Beneficiary is living, proceeds shall be paid to the Contingent Beneficiary.

PRIMARY BENEFICIARY

Print Full Name	Soc. Sec. #	Address/Phone	% of Benefit	Relationship
1.				
2.				

CONTINGENT BENEFICIARY

Print Full Name	Soc. Sec. #	Address/Phone	% of Benefit	Relationship
1.				
2.				

OPTIONAL COVERAGE (See "Table of Monthly Premium for Supplemental and Dependent Spouse Life" for cost)

Member Supplemental Life

Pick One:

❑ $10,000	❑ $110,000
❑ $20,000	❑ $120,000
❑ $30,000	❑ $130,000
❑ $40,000	❑ $140,000
❑ $50,000	❑ $150,000
❑ $60,000	❑ $160,000
❑ $70,000	❑ $170,000
❑ $80,000	❑ $180,000
❑ $90,000	❑ $190,000
❑ $100,000	❑ $200,000

Dependent Spouse Life*

Available only with Supplemental Life

Not to exceed 50% of Member Supplemental Life Coverage

Pick One:

❑ $10,000	❑ $60,000
❑ $20,000	❑ $70,000
❑ $30,000	❑ $80,000
❑ $40,000	❑ $90,000
❑ $50,000	❑ $100,000

Spouse's Name: _____

Date of Birth: _____/_____/_____ ❑ Male ❑ Female

Social Security #: _____

* Includes reciprocal beneficiary and civil union partners

Dependent Child(ren) Life

Available only with Supplemental Life

❑ Yes, for $1 per month per family

❑ No

Amount of Child Coverage:

Child 15 days to 6 months $ 1,000

Child over 6 months to 18 years (or age 23 if a full-time student) $ 10,000

Selected coverage reduced by 50% at age 65; 67% at age 70; 80% at age 75; 90% at age 80.
Optional coverages may require submission and approval of a Statement of Health form.

_____ _____

Signature of Participant (Insured) - REQUIRED **Date - REQUIRED**

HOME OFFICE USE ONLY: Received and recorded by Royal State National Insurance Co.

Date_____ By_____

Royal State National Insurance Company, Limited

819 South Beretania Street • Honolulu, Hawaii 96813 • (808) 539-1600 • Toll Free: 1-(800) 890-9022 • www.royalstate.com