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 #: _____ Cellular Phone #: _____

## 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 (only applicable if there is no primary beneficiary living at the time of participant's death)

| 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 Member 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 Member Supplemental Life

☐ Yes, for $1 per month per family

☐ No

Amount of Child Coverage:

Child at least 14 days and under 6 months $ 1,000

Child 6 months to 18 years (or age 23 if a full-time student, or any age if handicapped) $ 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 an Evidence of Insurability form.

_____ _____
Signature of Participant (Insured) – REQUIRED Date – REQUIRED

HOME OFFICE USE ONLY: Received and recorded by Pacific Guardian Life Insurance Co.
Date_____ By_____

PACIFIC GUARDIAN LIFE
1440 Kapiolani Boulevard Suite 1700 • Honolulu, Hawaii 96814
(808) 942-1306 • Toll Free: 1-800-367-5354 • www.pacificguardian.com