INSURANCE PLANS
POWERED BY CIGNA AND NEW YORK LIFE
exclusively for HGEA Members

Underwritten by Life Insurance Company of North America
Administered by MWG Mestmaker & Associates

HGEA
AFSCME
LOCAL 152 AFL-CIO

MWG MESTMAKER & ASSOC.
A division of Morgan White Group

833-448-6466
1164 Bishop Street, Suite 400,
Honolulu, HI 96813

TERM LIFE BY NEW YORK LIFE

Highlights

- Provides up to $200,000 Guaranteed Issue for members, up to $75,000 for spouse, and up to $10,000 for dependents if you apply within your initial eligibility period
- Up to $500,000 of coverage may be purchased under this program for members (up to $75,000 for spouse)
- **Portability Conversion:** Coverage will continue at the same benefit level as long as you retain your membership in HGEA*

More Details

- Members of HGEA in good standing who work at least 20 hours per week on a regular basis are eligible to participate
- Up to 100k or double your term life benefit coverage amount of common carrier coverage (a fare-paying ticketed passenger on a plane, ship, train, or bus) included for members
- Special living benefits, up to 75% of the insurance, may be paid if the attending physician indicates the insured has a terminal illness with less than twelve months life expectancy. This means that money can be received from this program at a time when funds are needed most.
- If you become totally disabled before age 60, premiums will be waived until you are no longer disabled, or you begin to receive retirement benefits, or you attain age 65
- All amounts of insurance will reduce 35% at age 65, 55% at age 70, and 70% at age 75
- This plan has limitations and exclusions

Term-Life Rate Summary

Member Paid Monthly Age Banded Rates

Attained Age	Member				Spouse		
	$50,000	**$100,000**	**$150,000**	**$200,000**	**$25,000**	**$50,000**	**$75,000**
Under 29	$2.50	$5.00	$7.50	$10.00	$1.25	$2.50	$3.75
30-34	$3.00	$6.00	$9.00	$12.00	$1.50	$3.00	$4.50
35-39	$3.50	$7.00	$10.50	$14.00	$1.75	$3.50	$5.25
40-44	$5.00	$10.00	$15.00	$20.00	$2.50	$5.00	$7.50
45-49	$10.00	$20.00	$30.00	$40.00	$5.00	$10.00	$15.00
50-54	$16.50	$33.00	$49.50	$66.00	$8.25	$16.50	$24.75
55-59	$29.00	$58.00	$87.00	$116.00	$14.50	$29.00	$43.50
60-64	$40.50	$81.00	$121.50	$162.00	$20.25	$40.50	$60.75
	Coverage and Premium reduction from age 65						
65-69 (coverage reduced by 35%)	**$32,500**	**$65,000**	**$97,500**	**$130,000**	**$16,250**	**$32,500**	**$48,750**
	$37.38	$74.75	$112.13	$149.50	$18.69	$37.38	$56.06
70-74 (coverage reduced by 55%)	**$22,500**	**$45,000**	**$67,500**	**$90,000**	**$11,250**	**$22,500**	**$33,750**
	$45.45	$90.90	$136.35	$181.80	$22.73	$45.45	$68.18
75+ (coverage reduced by 70%)	**$15,000**	**$30,000**	**$45,000**	**$60,000**	**$7,500**	**$15,000**	**$22,500**
	$30.30	$60.60	$90.90	$121.20	$15.15	$30.30	$45.45

Child	
$5,000	**$10,000**
$1.00/month	$2.00/month

***If leaving government service you may keep your coverage by becoming an associate member.**

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CRITICAL ILLNESS BY CIGNA

Highlights

- Pays a lump sum benefit upon diagnosis of a covered critical illness (including cancer, heart attack, stroke, Parkinson's disease, heart disease and more)
- Provides up to $20,000 Guaranteed Issue for members, up to $10,000 for spouse, and up to $5,000 for dependents if you apply within your initial eligibility period
- No waiting period and no age restrictions
- Pre-existing conditions do not apply with this plan
- Maximum Lifetime Limit is equal to the lesser of five times the elected benefit amount or $100,000 per covered person (exclusions apply)
- **Portability Conversion:** Coverage will continue at the same benefit level as long as you retain your membership in HGEA*

More Details

- Pays a lump sum benefit direct to the insured, unless otherwise assigned, upon the date of diagnosis made after the coverage effective date, for each of the covered conditions listed below in Summary of Benefits
- Critical Illness Recurrence Benefit will be paid for the diagnosis of a subsequent covered condition that has already received a benefit payout under this policy after a 12-month waiting period from the previous diagnosis, subject to the Maximum Lifetime Limit, listed below in Summary of Benefits.
- This plan has limitations and exclusions listed below in Benefit-Specified Conditions, Exclusions & Limitations.

Summary of Benefits

Benefit Waiting Period	None
Pre-Existing Condition Limitations	Does not apply.
Member Benefit Amount(s)	***Voluntary Benefit Amounts (options for member selection):*** $10,000 or $20,000 Guaranteed Issue
Spouse/Domestic Partner Benefit Amount(s) *(Spouse to age 99 is eligible for coverage if member is enrolled)*	***Voluntary Benefit Amounts (options for spouse selection):*** 50% of issued member benefit amount (Guaranteed Issue)
Dependent Child Benefit Amount(s) *(Child only eligible if member is enrolled; Birth to 26; 26+ if disabled)*	***Voluntary Benefit Amounts (options for child selection):*** 25% of issued member benefit amount
Age Based Reductions	None
Initial Critical Illness Benefit	Pays a lump sum benefit direct to the insured, unless otherwise assigned, upon the date of diagnosis made after the coverage effective date, for each of the covered conditions listed on the next page. The amount payable per covered condition is the Initial Benefit Amount multiplied by the applicable percentage for the diagnosis of the covered condition shown on the next page. Each covered condition will be payable one time per covered person, subject to the Maximum Lifetime Limit below. A 180-day separation period between the dates of diagnosis is required.
Recurrence Critical Illness Benefit	Benefits will be paid for the diagnosis of a subsequent covered condition that has already received a benefit payout under this policy after a 12-month separation period from the previous diagnosis, subject to the Maximum Lifetime Limit below.
Skin Cancer Benefit	Pays a flat dollar benefit. See next page for benefit amount.
Maximum Lifetime Limit	The lesser of 5 times the elected Benefit Amount or $100,000 per covered person. Does not apply to skin cancer.

List of Covered Conditions

Coverage and Benefit Amounts • Series 2.1

Cancer Conditions	***Option 1, % of Initial Benefit Amount***	***Recurrence, % of Initial Benefit Amount***
Invasive Cancer	100%	100%
Carcinoma in Situ	25%	25%
	Benefit Amount	
Skin Cancer	$250; 1x per lifetime	Not Available
Vascular Conditions	***Option 1, % of Initial Benefit Amount***	***Recurrence, % of Initial Benefit Amount***
Heart Attack	100%	100%
Stroke	100%	100%
Coronary Artery Disease	25%	25%
Nervous System Conditions	***Option 1, % of Initial Benefit Amount***	***Recurrence, % of Initial Benefit Amount***
Advanced Alzheimer's Disease	25%	Not Available
Amyotrophic Lateral Sclerosis (ALS)	25%	Not Available
Parkinson's Disease	25%	Not Available
Multiple Sclerosis	25%	Not Available
Other Specified Conditions	***Option 1, % of Initial Benefit Amount***	***Recurrence, % of Initial Benefit Amount***
Benign Brain Tumor	100%	100%
Blindness	100%	Not Available
Coma	25%	25%
End-Stage Renal (Kidney) Disease	100%	100%
Major Organ Failure	100%	100%
Paralysis	100%	100%

Benefit-Specified Conditions, Exclusions & Limitations

In addition to the Common Exclusions, the following additional conditions, exclusions and limitations apply:

- The date of diagnosis occurs while the covered person's coverage under this policy is active.
- The definition for the covered condition is satisfied.
- Only one Initial Benefit paid for each covered condition per covered person. Only one Initial Benefit paid for each covered condition per covered person. Additional benefits available under the Recurrence Benefit.
- Maximum Lifetime Limit and separation periods apply.
- **Invasive Cancer:** Excludes pre-malignant conditions or conditions with malignant potential, carcinoma in situ, basal cell carcinoma, squamous cell carcinoma of the skin (unless metastatic disease develops), melanoma that is diagnosed as Clark's Level I or II or Breslow less than 0.75mm, or melanoma in situ, or prostate tumor that is classified as T-1a, b, or c, N-0, and M-0 on a TNM classification scale. Also excludes the recurrence or metastasis of an original cancer that was diagnosed prior to the coverage effective date if the Insured has undergone treatment for such cancer within one year of being diagnosed while under this coverage.
- **Carcinoma in Situ:** Excludes premalignant conditions or conditions with malignant potential, skin cancers (basal/squamous cell carcinoma or melanoma/melanoma in situ)
- **Stroke:** Must have neurological deficits or confirmatory finding 96 hours after the event occurs. Excludes transient ischemic attack (TIAs), brain injury related to trauma or infection, brain injury associated with hypoxia or anoxia, vascular disease affecting eye or optic nerve or ischemic disorders of the vestibular system.
- **Coronary Artery Disease:** Excludes angioplasty (percutaneous coronary intervention) and stent implantation.
- **Coma:** Does not mean any state of unconsciousness intentionally or medically induced from which the covered person is able to be aroused.
- **Major Organ Failure:** If the covered person has a combination transplant (i.e. heart and lung), a single benefit amount will be payable. Recurrence Benefit not payable for same organ for which a benefit was previously paid.
- **Paralysis:** Excludes loss due to stroke and multiple sclerosis.

Critical Illness Rate Summary

Member Paid Monthly Age Banded Rates							*Member Paid Guaranteed Issue Level: $10,000*	
Attained Age	**Member**		**Member & Spouse**		**Member & Child(ren)**		**Member & Family**	
	Non-Tobacco	***Tobacco***	***Non-Tobacco***	***Tobacco***	***Non-Tobacco***	***Tobacco***	***Non-Tobacco***	***Tobacco***
0-24	$1.99	$2.55	$3.12	$4.01	$2.69	$3.25	$3.82	$4.71
25-29	$2.41	$3.40	$3.71	$5.26	$3.11	$4.11	$4.41	$5.96
30-34	$3.59	$5.50	$5.39	$8.31	$4.29	$6.21	$6.10	$9.02
35-39	$5.49	$9.60	$8.12	$14.31	$6.19	$10.30	$8.82	$15.02
40-44	$7.30	$13.41	$10.86	$20.05	$8.00	$14.11	$11.56	$20.76
45-49	$10.57	$20.58	$16.04	$31.44	$11.27	$21.28	$16.74	$32.15
50-54	$14.68	$28.67	$23.17	$44.97	$15.39	$29.37	$23.87	$45.67
55-59	$20.15	$38.42	$32.60	$61.70	$20.85	$39.13	$33.30	$62.40
60-64	$25.62	$46.98	$41.79	$75.97	$26.33	$47.68	$42.49	$76.67
65-69	$31.84	$55.74	$51.72	$88.57	$32.54	$56.45	$52.42	$89.27
70-74	$45.45	$74.91	$73.10	$118.58	$46.15	$75.61	$73.80	$119.28
75-79	$60.93	$90.55	$98.29	$144.18	$61.63	$91.25	$98.99	$144.88
80-84	$79.50	$113.16	$123.05	$177.57	$80.20	$113.87	$123.76	$178.28
85+	$113.25	$137.09	$175.41	$213.34	$113.95	$137.79	$176.11	$214.05

Member Paid Monthly Age Banded Rates							*Member Paid Guaranteed Issue Level: $20,000*	
Attained Age	**Member**		**Member & Spouse**		**Member & Child(ren)**		**Member & Family**	
	Non-Tobacco	***Tobacco***	***Non-Tobacco***	***Tobacco***	***Non-Tobacco***	***Tobacco***	***Non-Tobacco***	***Tobacco***
0-24	$3.98	$5.10	$6.24	$8.02	$5.38	$6.50	$7.64	$9.42
25-29	$4.82	$6.80	$7.42	$10.52	$6.22	$8.22	$8.82	$11.92
30-34	$7.18	$11.00	$10.78	$16.62	$8.58	$12.42	$12.20	$18.04
35-39	$10.98	$19.20	$16.24	$28.62	$12.38	$20.60	$17.64	$30.04
40-44	$14.60	$26.82	$21.72	$40.10	$16.00	$28.22	$23.12	$41.52
45-49	$21.14	$41.16	$32.08	$62.88	$22.54	$42.56	$33.48	$64.30
50-54	$29.36	$57.34	$46.34	$89.94	$30.78	$58.74	$47.74	$91.34
55-59	$40.30	$76.84	$65.20	$123.40	$41.70	$78.26	$66.60	$124.80
60-64	$51.24	$93.96	$83.58	$151.94	$52.66	$95.36	$84.98	$153.34
65-69	$63.68	$111.48	$103.44	$177.14	$65.08	$112.90	$104.84	$178.54
70-74	$90.90	$149.82	$146.20	$237.16	$92.30	$151.22	$147.60	$238.56
75-79	$121.86	$181.10	$196.58	$288.36	$123.26	$182.50	$197.98	$289.76
80-84	$159.00	$226.32	$246.10	$355.14	$160.40	$227.74	$247.52	$356.56
85+	$226.50	$274.18	$350.82	$426.68	$227.90	$275.58	$352.22	$428.10

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Frequently Asked Questions

1. When will my coverage begin?

Your coverage effective date is based on the payment method elected (ACH or Payroll Deduction).

ACH: Coverage effective date is the 1st of the month following date of enrollment.

Payroll Deduction: If the enrollment is received on or before the 23rd of the month, the effective date will be the first of the month following 60 days. IF after the 23rd of the month, the coverage will begin on the first of the month following 90 days.

2. Am I eligible to enroll if I am an Associate Member?

Yes. You must elect ACH payment. Payroll deduction will not be available.

3. Am I eligible to enroll if I am a Retired Member?

No. Retirees are not eligible to enroll in either new benefit plan.

4. When will my first payroll deduction begin?

On your next payroll deduction if the enrollment is received on or prior to the 23rd of the month.

5. When will my first ACH payment be taken?

Your initial payment will be taken within 3 business days of completing your enrollment. After initial payment, your scheduled draft date will be the 1st of each month.

6. What should I except to see on my Bank Statement for my premium payments?

"8888593795 Insurance" will appear on your statement as a description of the charge for your premiums.

7. I am a member of HGEA, and my spouse is also a member. Can we both elect coverage for each other under the new Voluntary Life and Critical Illness plans?

No. A person may be insured only once under the Policy as an Employee, Spouse or Dependent Child, even though he or she may be eligible under more than one class.

8. If I do not elect coverage for myself, can I elect coverage for my spouse and/or dependent child(ren)?

No. A member must elect coverage for him/herself in order to be eligible to elect spouse or dependent coverage.

9. I do not smoke, however my spouse does. Which Critical Illness rate structure will apply to me if I choose family coverage?

If you OR your spouse use tobacco in any form, the tobacco rates will apply.

10. If I applied for additional coverage above Guaranteed Issue, when will I know if I am approved?

You will receive notification directly from Cigna with approval (or denial) of additional coverage. If approved, we will generate an updated benefit confirmation statement and your new premium amount will begin with the next applicable billing cycle.

11. The voluntary life plan shows Common Carrier coverage. What is this?

We will pay a Common Carrier Benefit if you suffer a loss as the result of an accident which occurs while you are riding as a passenger in, or struck by, a common carrier. Common carrier means:

a. a public conveyance (including aircraft) which is licensed for hire to carry fare-paying passengers; or

b. a transport aircraft operated by the U.S. Military Airlift Command or a similar air transport service of another country.

12. How much is the Common Carrier Benefit?

The common carrier benefit matches the death benefit to a max of $100k

13. Will my rate increase?

Yes. Rates for both the Voluntary Life and Critical Illness benefit are based on age. Aging will take place each year on March 1st. If you fall into a new age bracket, your premium will change.

If you have current coverage with AmFirst:

1. Can I keep my current AmFirst plan(s)?

Yes. You may keep your current AmFirst plan(s) if you continue to meet the eligibility requirements.

2. How do I terminate my AmFirst coverage?

Contact MWG Administrators, Honolulu at 1-844-448-3783 or via email at mwahi@morganwhite.com.

3. Who do I call for billing questions?

Contact MWG Administrators, Honolulu at 1-844-448-3783 or via email at mwahi@morganwhite.com.

CLEAR FORM

MESTMAKER & ASSOC.
A division of Morgan White Group

Application for
Employee Term Life Insurance

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Life Insurance Company of North America (LINA), New York Life Group Insurance Company of NY (herein called the Insurance Company)

Enrollment	*Change*	*Member ID*
◯ Initial enrollment ◯ Late applicant	◯ Increase coverage ◯ Add dependent ◯ Address change ◯ Terminate coverage ◯ Reduce coverage ◯ Name change	

Policy name	Policy number	Employer name
North American Insurance Trust (NAIT)	FLX968862	HGEA

Employee Information

Prefix *(choose one)*	Employee		
◯ Mr. ◯ Mrs. ◯ Ms.			
Social Security Number (SSN)	Age	Date of birth	Occupation

Address	City	State	Zip

Work phone	Home phone

Voluntary Life Insurance

☐ **Employee** *Amount of Coverage Applied for (multiples of $10,000 to a maximum of $500,000)*

Current voluntary life amount		Additional amount requested		Total amount requested
$	+	$	=	$

☐ **Spouse/Domestic Partner** *Amount of Coverage Applied for (multiples of $5,000 to a maximum of $100,000, not to exceed 50% of employee's amount)*

Current dependents voluntary life amount		Additional amount requested		Total amount requested
$	+	$	=	$

Spouse name	Marriage date
Date of birth	Social Security Number (SSN)

☐ **Dependent Children Voluntary Life** *(please select one)* ◯ $2,500 ◯ $5,000 ◯ $10,000

Beneficiary Name	*Birthdate*	*Social Security Number (SSN)*	*Relationship*	*% of Benefit*

Acceptance/Declination

I accept the insurance coverages elected above. If premium is to be paid by payroll, I authorize my employer to deduct the necessary amounts from my earnings. If I have not elected coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability/ good health at my own expense and that coverage is subject to the insurance company's approval.

Signature _____ Date _____
Month / Day / Year

(Important: You must also sign and date the Agreements and Authorizations section)

Employer Use (Mandatory Data Needed): In order to process this application, the employer must complete all requested information.

Date of hire	Annual salary	Group insurance eligibility date	Verified by

Important: you must complete the medical questions in this application if, (1) as a newly enrolled member you apply for life insurance exceeding the guaranteed coverage amount, or life insurance more than 31 days after you are eligible to elect benefits; or (2) you are currently insured under the prior life insurance plan and elect to increase your current insurance amount(s); or (3) you were eligible but did not enroll for insurance under the prior life insurance plan.

Employee		*Spouse/Domestic Partner (if applicable)*	
Height _____ *feet* _____ *inches*	Weight _____ *pounds*	Height _____ *feet* _____ *inches*	Weight _____ *pounds*

Questions

	Please indicate your answer for each question in this section by checking the yes or no box.	*Employee* Yes	*Employee* No	*Spouse/Domestic Partner* Yes	*Spouse/Domestic Partner* No
1.	**Within the last 5 years, has the proposed insured been (a) diagnosed with any of the conditions in items A through F, or (b) told by a medical professional that he/she has or may have any of the conditions in items A through F, or (c) been treated by a medical professional for any of the conditions shown in items A through F below?**				
A	A heart attack or stroke?	◯	◯	◯	◯
B	Cancer (other than nonmelanoma skin cancer), Hodgkin's disease, or leukemia?	◯	◯	◯	◯
C	Emphysema or chronic obstructive pulmonary disease (COPD)?	◯	◯	◯	◯
D	HIV infection or AIDS?	◯	◯	◯	◯
E	Insulin Dependent Diabetes, hepatitis C or cirrhosis of the liver?	◯	◯	◯	◯
F	Alcohol or drug abuse or dependency?	◯	◯	◯	◯
2.	**Within the last 5 years, has the proposed insured had a Driving While Intoxicated (DWI) or a Driving Under the Influence (DUI) conviction?**	◯	◯	◯	◯

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act.

Agreements and Authorizations

To the best of my knowledge and belief, all written, telephonic, and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the insurance company is one of those conditions. I understand and agree that:

1. This request will be a part of the policy that provided the insurance.
2. I may need to provide more medical info.
3. I may need to take medical tests and report the results to the Insurance Company.
4. I must report any change in my health that happens before the insurance is effective.
5. Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date the insurance is to be effective.

I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, The Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record of me to disclose to the insurance company or its authorized agent, any such information, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this authorization is as valid as the original. I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request. I understand that the info will be used to assess my request for insurance. I may revoke this authorization at any time in writing. Any such revocation will not: 1) change any action taken in reliance on the authorization; and 2) change the insurance company's right to use the authorization for context of a claim or policy in accordance with applicable law.I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portabil-ity and Accountability Act (HIPAA). (The insurance companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

Employee signature _____ Date _____
Month / Day / Year

Spouse/Domestic Partner signature _____ Date _____
(*if applying for insurance)*
Month / Day / Year

Email, mail, or fax completed, signed form to:

MWG Mestmaker & Assoc. • P.O. Box 2303 • Bakersfield, CA 93303 • Phone: 661-325-5999 • Fax: 661-325-6090

INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

Cigna Health and Life Insurance Company

Employer: Hawaii Government Employee Association

ALL ABOUT YOU – THE EMPLOYEE

Your Name_____ Social Security #_____ Birthdate _____

Address_____ City_____ State_____ Zip _____ Email_____

Phone_____ Employee ID #_____ Gender _____

Have you smoked or used any form of tobacco in the last 12 months? **Employee:** ☐ Yes ☐ No **Spouse*:** ☐ Yes ☐ No

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE*

☐ I am currently married and my date of marriage is: ____

Name_____ Social Security #_____ Birthdate_____ Gender ___

YOUR COVERAGE ELECTIONS

Employee-Paid (Voluntary) Critical Illness Insurance – Policy # CI110527

Choose an amount and who you would like to include in your coverage. See the Summary of Benefits for Monthly costs.

	Coverage Amount	Acceptance
☐ Employee Only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Children ☐ Employee + Family # of covered children	☐ $10,000 ☐ $20,000**	☐ Accept Coverage ☐ Decline Coverage

*If elected, Spouse and Child(ren) receive a percentage of employee elected coverage amount. **This is the Guarantee coverage amount. You may elect up to this amount during this enrollment. If you elect an amount greater than the Guarantee Coverage Amount you will be required to complete an Evidence of Insurability form.*

*For purposes of this brochure, wherever the term Spouse appears, it shall also include Domestic Partner and Domestic Partners registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Additional information is available from your Benefit Service Representative.

For California Residents: By signing below, I certify that I and my dependents for whom I am applying for coverage are currently covered for comprehensive health benefits from an insurance policy, an HMO policy, or an employer health benefit plan. Anyone who is not currently covered for comprehensive health benefits is NOT eligible for Critical Illness and/or Hospital Care coverage.

Maryland residents: Caution: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly or willfully presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

Oregon residents: Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto; commits a fraudulent insurance act may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk.

Vermont residents: Caution: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

SIGN HERE TO ENROLL IN THE PLAN

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. Or premium can be paid via ACH, upon request. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to Cigna's approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

Employee Name_____ Social Security #_____

Please Sign Here ☚ Signature_____ Date _____

Electronic Payments
Authorization Agreement

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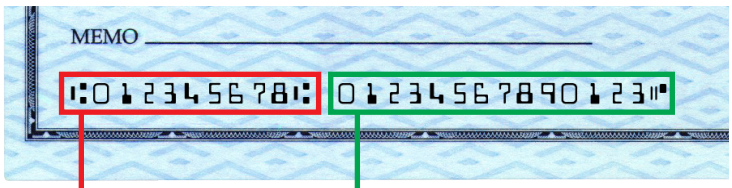
1164 Bishop Street, Suite 400
Honolulu, HI 96813
Toll Free: (833) 448-6466
Email: insureHI@morganwhite.com

Electronic Payment Information

Insured's name			Last four digits of insured's SSN or Alternate ID number
Mailing address	City	State	Zip code
Phone number	Email address		
Account holder name			
Financial institution			
Mailing address	City	State	Zip code



Routing number	
Account number	

I hereby authorize the Financial Institution named above to pay my annual obligation by charging each payment to my account and to make that deduction payable to the order of MWG Administrators. I agree that each payment shall be the same as if it were an instrument personally signed by me. This authorization will remain in effect until revoked by me in writing. In addition, I have the right to stop payment of a charge by timely notification to my Financial Institution prior to charging my account. I understand, however, both the Financial Institution and MWG Administrators reserve the right to terminate this payment plan (or my participation therein).

By signing below I agree to the following terms for all relevant plans:

1. I understand that payments will be debited from my account based on my payment mode.
2. MWG Administrators will post insurance rates increases to my account without requiring additional authorization.
3. MWG Administrators will send notice of payment not honored.
4. Payments not honored will not be submitted a second time.
5. If a payment is not honored my insurance terminates 10 days after notice has been sent.
6. If I wish to continue my insurance after a payment is not honored, MWG Administrators must receive full payment prior to the end of that month.
7. If I wish to continue my insurance after a payment is not honored, MWG Administrators will charge a$30.00 fee in addition to any bank charges.
8. Reinstatement is only possible within 60 days of the not honored payment after which no reinstatement is possible.
9. After two payments are not honored, reinstatement is not possible.

Authorized signature _____ Date _____ / _____ / _____
(Sign as you do for checks) Day Month Year