



P.O. Box 1650  
Little Rock, AR 72203

## Acknowledgement of Group Life and Accidental Death and Dismemberment Coverage under HMSA Student Plan 19

The participant understands that:

1. The Plan includes Group Term Life Insurance with an Accelerated Death Benefit and an Accidental Death, Dismemberment and Loss of Sight (AD&D) benefit. This group Insurance is provided through a master group policy issued by US Able Life to the Hawaii Medical Service Association.
2. All benefits are subject to the provisions, limitations and conditions of the master group policy.
3. By participating in the Plan, you are automatically accepted for coverage under the master group policy.
4. The Plan of Insurance, including amount of coverage and eligibility, is summarized below.

| <b>PLAN OF INSURANCE</b>  |   |                       |           |                           |           |                                  |          |
|---|---|-----------------------|-----------|---------------------------|-----------|----------------------------------|----------|
| <b>Eligibility:</b> Individuals who:  |   |                       |           |                           |           |                                  |          |
| <ol style="list-style-type: none"> <li>1. are active Plan participants of Hawaii Medical Service Association's Student Plan programs; and</li> <li>2. have been approved for health coverage under the Student Plan by the Hawaii Medical Service Association.</li> </ol> |   |                       |           |                           |           |                                  |          |
| Amount of Group Insurance:  | <table style="width: 100%; border: none;"> <tr> <td style="padding-left: 20px;"><i>Life Insurance</i></td> <td style="text-align: right;">\$ 15,000</td> </tr> <tr> <td style="padding-left: 20px;"><i>AD&amp;D Insurance</i></td> <td style="text-align: right;">\$ 15,000</td> </tr> <tr> <td style="padding-left: 20px;"><i>Accelerated Death Benefit</i></td> <td style="text-align: right;">\$ 7,500</td> </tr> </table> | <i>Life Insurance</i> | \$ 15,000 | <i>AD&amp;D Insurance</i> | \$ 15,000 | <i>Accelerated Death Benefit</i> | \$ 7,500 |
| <i>Life Insurance</i>   | \$ 15,000   |                       |           |                           |           |                                  |          |
| <i>AD&amp;D Insurance</i>   | \$ 15,000   |                       |           |                           |           |                                  |          |
| <i>Accelerated Death Benefit</i>  | \$ 7,500  |                       |           |                           |           |                                  |          |
| Benefits terminate upon termination of health coverage under the HMSA Student Plan 19.  |   |                       |           |                           |           |                                  |          |

Each person insured for group life and accidental death insurance has the right to designate a beneficiary for insurance proceeds. Indicate your beneficiary below. Unless otherwise noted, if two or more beneficiaries are named, the proceeds will be paid in equal shares to the named beneficiaries surviving the insured.

I hereby designate the following beneficiary(ies) under this certificate and revoke the appointment of any existing beneficiary.

| Name (Last, First, MI) | Date of Birth<br>Mo./Day/Yr. | Relationship | Benefit | Primary or<br>Secondary |
|------------------------|------------------------------|--------------|---------|-------------------------|
|                        |                              |              | %       |                         |
|                        |                              |              | %       |                         |
|                        |                              |              | %       |                         |

Please sign and date this Acknowledgement of Coverage and send it along with your completed application to:

HMSA  
Community Sales & Service  
P.O. Box 860  
Honolulu, HI 96808-0860

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

Date Received Home Office

\_\_\_\_\_  
HMSA ID #