



Dear HSBA Member,

Thank you for inquiring about the Hawaii State Bar Association Group Insurance Program. Enclosed you'll find the information you requested for the following plan: 20 Year Level Group Term Life Insurance Plan.

Before you take a look at the information I've enclosed, let me mention some of the important benefits you receive with all our insurance plans.

- These are group plans, negotiated especially for HSBA Members. Rates, although not scheduled, can only be changed on a group basis.
- Each plan is backed by a 30-day Free Look. After you receive your Certificate of Insurance, you have a full 30 days to review your new coverage. If you decide that it's not exactly what you want and need, simply return it. Every dollar you've paid will be refunded, and your coverage will be invalidated, no questions asked – provided no claims have been submitted or paid.

Please read the enclosed brochure for more information, including eligibility, renewability, costs, exclusions, limitations and terms of coverage on this plan.

Once you determine the type and amount of personal insurance coverage you need, simply complete and return the application in the postage-paid envelope provided. If you have questions along the way, just pick up the phone and call us. Our toll-free number is: 1-866-810-9451.

Whatever your personal situation, I hope you'll take a few minutes today to candidly assess your family's insurance needs and apply to bring your coverage up-to-date through this exclusive member program. Please return your application today!

Yours truly,

A handwritten signature in black ink that reads "Stephen Miller". The signature is written in a cursive, flowing style.

Stephen Miller, Senior Vice President  
Association Member Benefits Advisors, LLC  
License #1936106

P.S. Each insurance plan is offered through a well respected insurance company and every plan carries a 30-day Free Look!

(over, please)

The Hawaii State Bar receives a fee for its endorsement of the insurance programs. The fees are used to offset the cost of program oversight and support member benefits and services.  
Group Term Life Insurance underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. Policy form LP08GP.

**Association Member Benefits Advisors, LLC**  
**P.O. Box 14536 • Des Moines, IA 50306**  
**1-866-810-9451•customerservice.service@getamba.com•www.hsbainsurance.com**

66716-1

L1E

## Group Term Life Application for 10-Year or 20-Year Level Term Rate



Please complete the entire Application. The proposed insured should fill out this Application. Please print clearly in dark ink and mail to HSBA **Group Insurance Program, P.O. Box 14536, Des Moines, IA 50306, or call 1-866-810-9451, or email customerservice.service@getamba.com.**

Hawaii State Bar Association	Policy No. 66716-1
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### 1. TELL US ABOUT YOURSELF

**Member/Employee's Information (complete this section only if applying for Member/Employee coverage on this application):**

Name (Last, First, MI)		Name of Member		<input type="checkbox"/> Member	<input type="checkbox"/> Male
				<input type="checkbox"/> Employee of Member	<input type="checkbox"/> Female
Date of Birth (MM/DD/YYYY)	Place of Birth		Social Security Number		
Address		City	State	Zip	
Home/Cell Phone #	Work Phone #	Email Address			

**Spouse's Information (complete this section only if applying for Spouse coverage on this application):**

Name (Last, First, MI)		Name of Member		<input type="checkbox"/> Spouse of Member	<input type="checkbox"/> Male
				<input type="checkbox"/> Spouse of Employee	<input type="checkbox"/> Female
Date of Birth (MM/DD/YYYY)	Place of Birth		Social Security Number		
Address		City	State	Zip	
Home/Cell Phone #	Work Phone #	Email Address			

**Dependent Child(ren)'s Information (complete this section only if applying for Dependent Child(ren) on this application):**

Number of eligible children: _____ Include Name, Date of Birth (DOB), and Social Security Number (SSN) of each child below					
Name	DOB	SSN			
Name	DOB	SSN			
Name	DOB	SSN			
Name	DOB	SSN			
Address		City	State	Zip	Home/Cell Phone #

- |                                                                                                                                                                   | <u>Member/Employee</u>                                   | <u>Spouse</u>                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| a) Do you currently use or have you used tobacco or nicotine products in any form in the last 5 years?<br><b>Date of last use (month/year):</b> _____/_____/_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) Are you currently working less than 30 hours per week at your regular occupation and place of business?                                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force?                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If yes, please explain: \_\_\_\_\_

PLEASE COMPLETE AND  
SIGN END OF APPLICATION

## 2. SELECT YOUR COVERAGE

**20-Year Level Term**

**Member/Employee Amount:**

- \$1,000,000
- \$500,000
- \$250,000
- Other \$ \_\_\_\_\_ in \$25,000 increments (Minimum: \$25,000 Maximum: \$1,000,000)

**20-Year Level Term**

**Spouse Amount:**

- \$1,000,000
- \$500,000
- \$250,000
- Other \$ \_\_\_\_\_ in \$25,000 increments (Minimum: \$25,000 Maximum: \$1,000,000)

Please select if you wish to include additional options with your coverage:

- Dependent Child(ren) Coverage\*  
 \$10,000     \$5,000

\*If both Member/Employee and Spouse are applying, only one can apply for Dependent Child(ren) Coverage.

## 3. PROVIDE YOUR HEALTH INFORMATION

Member/Employee: Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs.    Spouse: Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs.

List the name, address and phone number of your regular health care provider and the date you last consulted him or her:

Member/Employee : \_\_\_\_\_ Spouse: \_\_\_\_\_

	<u>Member/Employee</u>	<u>Spouse</u>
1) Have you ever been treated for or been diagnosed by a member of the medical profession as having a positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Have you ever been diagnosed or treated by a member of the medical profession for:		
a. stroke/TIA (Transient Ischemic Attack), sleep apnea, high blood pressure or any disease or disorder of the heart or lungs?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a member of the medical profession to discontinue or reduce the use of such substances?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) Have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Have you in the last three years flown, or do you anticipate flying in an aircraft, other than as a passenger on a scheduled airline?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6) Have you in the last five years had any DUI (driving under the influence) convictions, driver's license suspensions/revocations or moving violations?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Member/Employee's driver's license number and state of issue: _____		
b. Spouse's driver's license number and state of issue: _____		
7) Have you ever applied for insurance that was declined, postponed or modified in any way?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8) Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed or provided by a member of the medical profession for any disorder, condition or disease not shown above?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE COMPLETE AND SIGN END OF APPLICATION

**For every "Yes" answer to questions in the previous section, give details below. Please attach a separate sheet if additional space is needed.**

Q#	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Health Practitioner Name, Full Address and Phone
	<input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse				
	<input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse				

#### **4. DESIGNATE YOUR BENEFICIARY**

Include Name, Address, Date of Birth, and Social Security Number for each beneficiary you list below. List the percent each will receive. The total must equal 100 percent. Beneficiary for dependent child(ren) coverage (if elected) will be the insured under the certificate to which the dependent child(ren) coverage is attached. Attach additional sheets if necessary.

**Beneficiary for Member/Employee Coverage (complete this section only if applying for Member/Employee coverage on this application)**

Name (First, Last, MI)					
Date of Birth (MM/DD/YYYY)	Social Security Number		Relationship		Percent
Address		City	State	Zip	Home/Cell Phone #

Name (First, Last, MI)					
Date of Birth (MM/DD/YYYY)	Social Security Number		Relationship		Percent
Address		City	State	Zip	Home/Cell Phone #

**Beneficiary for Spouse Coverage (complete this section only if applying for Spouse coverage on this application)**

Name (First, Last, MI)					
Date of Birth (MM/DD/YYYY)	Social Security Number		Relationship		Percent
Address		City	State	Zip	Home/Cell Phone #

Name (First, Last, MI)					
Date of Birth (MM/DD/YYYY)	Social Security Number		Relationship		Percent
Address		City	State	Zip	Home/Cell Phone #

PLEASE COMPLETE AND SIGN END OF APPLICATION

**5. COMPLETE THE FOLLOWING PAYMENT OPTION SECTION**

*(Choose only one. Option selected is applicable to all coverages approved through this application):*

**Option 1: AUTOMATIC CHECK WITHDRAWAL REQUEST:**     Monthly     Quarterly

By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

**Checking Account**

Routing #: \_\_\_\_\_ Account #: \_\_\_\_\_

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

**Signature of Premium Payer:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Option 2: DIRECT BILL:**     Quarterly     Semi-Annual     Annual

Billing dates will begin after coverage is approved and initial premium has been received.

PLEASE COMPLETE AND  
SIGN END OF APPLICATION

**6. READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW**

- To the best of my knowledge and belief, the information I have provided is complete and correct.
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life Insurance Company and the first premium is paid in my lifetime.
- I understand my coverage begins on the “effective date” assigned by ReliaStar Life Insurance Company.

**Authorization and Acknowledgment** – Please read and sign below. For underwriting and claim purposes, I give my permission to: Any physician, or any other member of the medical profession, hospital, clinic, other medical or medically related facility, pharmacy, pharmacy benefit manager, insurance or reinsurance company, MIB, LLC. (MIB), Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery, pharmacy prescriptions or prescription records or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life, or its reinsurers, to make a brief report of personal health information to MIB about these same persons. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about these same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it. I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the date shown below. I acknowledge that I have been given ReliaStar Life’s Consumer Privacy Notice.

**Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.**

Member/Employee's Signature (always required)	Date	Spouse's Signature (if applying)	Date
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**Owner of Member/Employee Certificate** (if other than yourself). The owner controls all rights to the Certificate.

Name (First, Last, MI)		Date of Birth (MM/DD/YYYY)		Social Security Number	
Address	City	State	Zip	Home/Cell Phone #	
Owner's Signature				Date	

**Owner of Spouse Certificate** (if other than yourself). The owner controls all rights to the Certificate.

Name (First, Last, MI)		Date of Birth (MM/DD/YYYY)		Social Security Number	
Address	City	State	Zip	Home/Cell Phone #	
Owner's Signature				Date	

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## **ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York Consumer Privacy Notice and Insurance Information Practices Notice**

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

### **Our Underwriting Procedures**

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

### **Privacy and Information Practices**

#### **Collecting Information**

Your application or claim form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, LLC., formerly known as the Medical Information Bureau. See “Notice Regarding MIB, LLC.” below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

#### **Notice Regarding Consumer Reports**

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

#### **Information Use**

We will use the information only for business purposes arising from the relationship you have with us.

#### **Information Maintenance and Disclosure**

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, LLC, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

#### **Access to Information**

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

#### **Notice Regarding MIB, LLC.**

We or our reinsurers may make brief reports to MIB, LLC (hereafter “MIB”). The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB’s file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB’s phone number is 866-692-6901. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

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# Group 20-Year Level Term Life Insurance Plan



FOR HSBA MEMBERS, EMPLOYEES OF MEMBERS, AND THEIR FAMILIES

- *Premiums designed to remain level for 20 Years\**

## Group 20-Year Level Term Life Insurance is Coverage Your Family Needs

You certainly understand the importance of having sufficient life insurance. Your loved ones will appreciate the peace of mind this Plan provides, with benefits up to \$1,000,000 that will let them go on with their lives with fewer financial concerns.

## About This Plan

You may apply for \$200,000 to \$1,000,000 in 20-Year Life insurance coverage (in \$25,000 increments). Coverage continues as long as you remain an active member of the Hawaii State Bar Association, pay your premium when due, and the Group Policy remains in force. Your amount of insurance will not decrease due to age during a level term rate period.

For members/employees or spouses who are age 50 or less at the end of a level term period, coverage will not reduce until age 70. For members/employees or spouses who are over age 50 at the end of a level term period, coverage will reduce to 50% on the premium due date on or after attainment of age 70.

## Eligibility

All HSBA members age 50 or less, and their active employees, may apply for coverage for themselves, their spouses age 50 or less, and their unmarried dependent children ages 14 days to 21 years (25 if a full time student).

Spouse coverage amount cannot exceed member/employee coverage amount.

If both member and their spouse are insured, either member or spouse, but not both can apply for dependent children insurance.

If both employee of member and their spouse are insured, either member or spouse, but not both can apply for dependent children insurance.

Coverage of \$5,000 or \$10,000 is available for your children at a monthly rate of 1.00 or 2.00, respectively. One premium covers all eligible children.

This coverage is available only to residents of the United States. Product availability may vary by state.

## PLAN FEATURES

### Pay Less if You're a Qualified Non-Tobacco User

Non-Tobacco users meeting the highest underwriting standards may qualify for the Plan's lowest rates.

### Satisfaction Guaranteed

You may return your Certificate of Insurance within 30 days if you are not completely satisfied with the coverage this Plan provides, provided no claims have been submitted or paid. Any premiums paid will be fully refunded.

### Convenient Payment Options

Four modes of payment are available to suit your budget: Direct Bill Quarterly, Semiannual, and Annual, or Monthly by EFT.

If you would like to change your payment method, please contact the program administrator at 1-866-810-9451.

### Beneficiary Selection

You may name anyone you wish as the beneficiary of your coverage, and you may change the beneficiary by contacting the Insurance Administrator in writing and advising them of the change.

You may also choose to name a beneficiary that you cannot change without his or her consent. This is an irrevocable beneficiary.

### Continuing Insurance After the 20-Year Term Ends

Premiums are designed to remain level for the first 20 years of coverage.\* At the end of the 20-year period, if you still meet the requirements of eligibility, you may apply for a new 20-year level term period. A written application and proof of good health satisfactory to ReliaStar Life is required.

Or, coverage can be automatically transferred to group annual renewable term life coverage with attained age rates, without proof of good health, and subject to all terms and eligibility requirements of the group policy. The initial premium rate will be based on the insured's age at the time of transfer.

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\*The initial premium will not change for the first 20 years unless the insurance company exercises its right to change premium rates for all insureds covered under the group policy with 60 days advance written notice.

**Effective Date**

The Member's/Employee's/Spouse's insurance will become effective on the first day of the month on or after the later of the following dates:

- ReliaStar Life approves your proof of good health;
- Your premium is received;
- You become eligible for insurance; or
- You apply for insurance, if proof of good health is not required.

**When Coverage Ends**

Your insurance stops the earliest of the following dates:

- The last day of the month during which you are no longer eligible for insurance under the Group Policy.
- For members and spouses, the premium due date after the date you attain age 75.
- For employees, the last day of the month during which you were last actively at work for a member of the Policyholder.
- The date the Group Policy stops.
- The end of the period for which you paid premiums, if you do not make the next required premium contribution when due.

**Exclusions**

You're covered 365 days a year, wherever you are. The only exclusion is suicide within the first two years of the date your insurance or increase in insurance starts. The Accelerated Life Benefit is subject to additional exclusions.

**OTHER IMPORTANT INFORMATION****Accelerated Life Benefit**

The Accelerated Life Benefit option is available to help terminally ill insureds during a difficult, and often financially challenging, time. Under this benefit, you may request one advance payment up to 50% of your in force life insurance, or \$100,000, whichever is less, to be paid while the terminally ill person is still alive. The amount of insurance payable after death will be reduced by this payment. (Premium contributions will not be reduced.)

This money can be used to help cover high prescription drug costs ... medical bills ... outstanding debts ... to help pay for experimental treatments ... the cost of modifications to your home ... or for a family vacation - the choice is yours.

To qualify, a terminally ill insured must provide ReliaStar Life with a doctor's statement which gives the diagnosis of the medical condition and states that the insured has a life expectancy of no more than 6 months. The insured must also have at least \$10,000 of life insurance coverage in force to qualify for this benefit. For additional details and limitations, please see the Certificate of Insurance.

Receipt of the accelerated benefit may be taxable, or may adversely affect your eligibility for Medicaid or other government benefits. You should consult your personal tax advisor to assess the impact of this benefit.

**Waiver of Life Insurance Premium Disability Benefit**

The Member/Employee or Spouse pays no premiums if he/she becomes totally disabled as defined in the Certificate. Your life insurance coverage will continue at no cost to you if you become continuously totally disabled for at least 6 months and if your disability occurs before age 60.

**Hawaii State Bar Association, Group Policy 66716-1-04**  
**20-YEAR GROUP LEVEL TERM MONTHLY RATES PER \$1,000**  
**Rates as of January 1, 2024**

**Member/Spouse/Employee of Member**  
**Volume Band: \$200,000 - \$475,000**

Issue Age	Male			Female		
	Tobacco	Non-Tobacco	Non-Tobacco Preferred	Tobacco	Non-Tobacco	Non-Tobacco Preferred
18-26	0.16	0.09	0.07	0.11	0.06	0.05
27	0.17	0.09	0.07	0.12	0.07	0.05
28	0.18	0.09	0.07	0.13	0.07	0.05
29	0.19	0.10	0.07	0.14	0.07	0.06
30	0.20	0.10	0.08	0.16	0.08	0.06
31	0.22	0.11	0.08	0.17	0.08	0.06
32	0.23	0.11	0.08	0.18	0.09	0.06
33	0.25	0.12	0.09	0.20	0.09	0.07
34	0.28	0.12	0.09	0.22	0.10	0.07
35	0.30	0.13	0.09	0.23	0.10	0.07
36	0.33	0.14	0.10	0.25	0.11	0.08
37	0.36	0.15	0.11	0.27	0.12	0.08
38	0.39	0.16	0.12	0.29	0.13	0.09
39	0.43	0.17	0.12	0.32	0.14	0.10
40	0.46	0.19	0.13	0.34	0.15	0.10
41	0.51	0.20	0.14	0.37	0.16	0.11
42	0.55	0.22	0.15	0.39	0.17	0.12
43	0.60	0.24	0.17	0.42	0.18	0.12
44	0.65	0.26	0.18	0.45	0.19	0.13
45	0.72	0.29	0.20	0.49	0.20	0.14
46	0.78	0.32	0.22	0.53	0.22	0.15
47	0.84	0.35	0.24	0.56	0.24	0.16
48	0.91	0.38	0.26	0.60	0.25	0.17
49	0.98	0.42	0.29	0.64	0.27	0.19
50	1.07	0.46	0.31	0.68	0.30	0.20

The initial premium will not change for the first 20 years unless the insurance company exercises its right to change premium rates for all insureds covered under the group policy with 60 days advance written notice. Coverage does not reduce during a level term period. Premiums will only be increased if premiums are increased for all insureds in the same age and rate class. The level term rate period begins on the effective date assigned by ReliaStar Life. To obtain a rate quote for other ages, benefit amounts, or for information on the 20-year Level Term Life Plan, call toll-free 1-866-810-9451. The classes of rates are "Preferred" and "Tobacco." Only non-tobacco users may qualify for the "Preferred" rates. (Note: Tobacco users may only qualify for the "Tobacco" rates.) Upon approval of your application by the insurer, you will be notified of the rate classification for each approved person. Approval of coverage is subject to medical evidence of insurability as determined by ReliaStar Life. Depending on your age, amount of coverage you request and your answers on the application, a medical examination, medical test(s) or other evidence of good health may be required. Any exams/tests requested by ReliaStar Life will be conducted at your convenience at no expense to you. For more information including eligibility, rates, benefit provisions, exclusions, limitations and termination provisions, please contact the HSBA Insurance Administrator at 1-866-810-9451. Coverage terminates at age 75.

Policy form LP08GP

If applicable, an additional \$2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

**Hawaii State Bar Association, Group Policy 66716-1-04  
20-YEAR GROUP LEVEL TERM MONTHLY RATES PER \$1,000**

Rates as of January 1, 2024

Member/Spouse/Employee of Member

Volume Band: \$500,000 - \$1,000,000

Issue Age	Male			Female		
	Tobacco	Non-Tobacco	Non-Tobacco Preferred	Tobacco	Non-Tobacco	Non-Tobacco Preferred
18-26	0.15	0.08	0.06	0.11	0.06	0.04
27	0.16	0.08	0.06	0.12	0.06	0.04
28	0.17	0.09	0.06	0.13	0.06	0.04
29	0.18	0.09	0.06	0.14	0.07	0.05
30	0.20	0.09	0.07	0.15	0.07	0.05
31	0.21	0.10	0.07	0.16	0.07	0.05
32	0.23	0.10	0.07	0.18	0.08	0.05
33	0.25	0.11	0.07	0.19	0.08	0.06
34	0.28	0.11	0.08	0.21	0.09	0.06
35	0.30	0.12	0.08	0.23	0.10	0.06
36	0.33	0.13	0.09	0.25	0.10	0.07
37	0.36	0.14	0.09	0.27	0.11	0.08
38	0.39	0.15	0.10	0.29	0.12	0.08
39	0.43	0.16	0.11	0.32	0.13	0.09
40	0.47	0.17	0.11	0.34	0.14	0.10
41	0.51	0.18	0.12	0.37	0.15	0.10
42	0.56	0.20	0.14	0.40	0.16	0.11
43	0.61	0.22	0.15	0.43	0.17	0.11
44	0.67	0.25	0.16	0.46	0.18	0.12
45	0.73	0.28	0.18	0.49	0.20	0.13
46	0.79	0.30	0.20	0.53	0.21	0.14
47	0.85	0.32	0.22	0.56	0.23	0.15
48	0.92	0.36	0.24	0.60	0.25	0.16
49	1.00	0.39	0.26	0.64	0.27	0.18
50	1.09	0.43	0.29	0.69	0.29	0.19

The initial premium will not change for the first 20 years unless the insurance company exercises its right to change premium rates for all insureds covered under the group policy with 60 days advance written notice. Coverage does not reduce during a level term period. Premiums will only be increased if premiums are increased for all insureds in the same age and rate class. The level term rate period begins on the effective date assigned by ReliaStar Life. To obtain a rate quote for other ages, benefit amounts, or for information on the 20-year Level Term Life Plan, call toll-free 1-866-810-9451. The classes of rates are "Preferred" and "Tobacco." Only non-tobacco users may qualify for the "Preferred" rates. (Note: Tobacco users may only qualify for the "Tobacco" rates.) Upon approval of your application by the insurer, you will be notified of the rate classification for each approved person. Approval of coverage is subject to medical evidence of insurability as determined by ReliaStar Life. Depending on your age, amount of coverage you request and your answers on the application, a medical examination, medical test(s) or other evidence of good health may be required. Any exams/tests requested by ReliaStar Life will be conducted at your convenience at no expense to you. For more information including eligibility, rates, benefit provisions, exclusions, limitations and termination provisions, please contact the HSBA Insurance Administrator at 1-866-810-9451. Coverage terminates at age 75.

Policy form LP08GP

If applicable, an additional \$2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

## About This Information

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of coverage. All coverage is subject to the terms of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. The complete terms and conditions of coverage are contained in Group Policy 66716-1, which is issued to the Hawaii State Bar Association. The group policy is situated in the state of Hawaii and is governed by its laws.

This is a Paid Endorsement. HSBA receives a fee from the insurance broker and/or the insurer for its endorsement of this plan.

## How to Apply

1. Complete, sign and date the Application included in the package. Be sure to indicate the coverage amount of your choice.
2. Do not send any money until ReliaStar Life Insurance Company has approved your Application and you're notified of the premium contribution due, based on the information you have provided.
3. Mail your completed Application to:  
Administrator, HSBA Group Insurance Program  
P.O. Box 14536  
Des Moines, IA 50306 or  
Email your completed Application to:  
customerservice.service@getamba.com

### Administered by:



Association Member Benefits Advisors, LLC  
P.O. Box 14536  
Des Moines, IA 50306

### QUESTIONS?

1-866-810-9451  
www.hsbainsurance.com

AR Insurance License #100114462  
CA Insurance License #0196562  
In CA d/b/a Association Member Benefits &  
Insurance Agency

### Group AD&D Insurance Underwritten by:

ReliaStar Life Insurance Company  
Minneapolis, MN

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