

Mercer Voluntary Benefits

**HAWAIIAN TELCOM Ref #80825**

**GROUP UNIVERSAL LIFE ENROLLMENT FORM**

106642010101

**EMPLOYEE NAME:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Last First M.I.

**ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
 No. Street

**SEX:**  M  F **BIRTH DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **TITLE PREFERENCE:**  MR.  MRS.  MS. **ANNUAL EARNINGS:** \_\_\_\_\_  
 (MM/DD/YYYY)

**DAYTIME PHONE:** \_\_\_\_\_ **PAYROLL CENTER:** \_\_\_\_\_ **EMPLOYEE ID:** \_\_\_\_\_ **HIRE DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**REASON FOR ENROLLMENT**

- New Enrollment  
 Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**EMPLOYEE COVERAGE**

Note: A reduction in coverage may result in an irreversible Modified Endowment Contract (MEC) status and unfavorable tax treatment of withdrawals and loans, depending on circumstances. If you are planning to reduce your GUL coverage and do not want your certificate to become a MEC, please call 1-800-293-2818 to find out whether this will result in unfavorable tax consequences.

- A.** Select coverage in \$1,000 increments between \$10,000 and \$1,500,000, not to exceed 5 times the employee's annual earnings.<sup>1</sup> I elect the following total amount of coverage. \$ \_\_\_\_\_
- B.** Have you smoked cigarettes, pipes or cigars or used tobacco in any form in the past 1 year?.....  Yes  No
- C.** In addition to the coverage, I elect to contribute a monthly dollar amount to my Cash Fund: \$ \_\_\_\_\_
- D.** I am electing the Accidental Death Benefit .....  Yes  No

**SPOUSE COVERAGE**

- A.** Select coverage in \$1,000 increments between \$10,000 and \$150,000, not to exceed 2 times the employee's annual earnings. I elect the following total amount of coverage:<sup>1,3</sup> \$ \_\_\_\_\_
- B.** Has your Spouse<sup>2</sup> smoked cigarettes, pipes or cigars or used tobacco in any form in the past 1 year?.....  Yes  No
- C.** In addition to the coverage, I elect to contribute a monthly dollar amount for my Spouse's<sup>2</sup> Cash Fund. \$ \_\_\_\_\_
- D.** I am electing the Accidental Death Benefit for my Spouse<sup>2</sup>.....  Yes  No

**NAME:** \_\_\_\_\_ **BIRTH DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **SS#:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Last First M.I. (MM/DD/YYYY)

**SEX:**  M  F **TITLE PREFERENCE:**  MR.  MRS.  MS.

**CHILD(REN) COVERAGE**

- A.** Check box of desired coverage:<sup>3</sup>  \$10,000
- NAME:** \_\_\_\_\_ **BIRTH DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **SS#:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **SEX:**  M  F  
 Last First M.I. (MM/DD/YYYY)
- NAME:** \_\_\_\_\_ **BIRTH DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **SS#:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **SEX:**  M  F  
 Last First M.I. (MM/DD/YYYY)

If you have more than two children, include their information on a separate sheet.

<sup>1</sup>Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

<sup>2</sup>Spouse includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available.

<sup>3</sup>Amounts will be subject to state limits, if applicable.

**GEF02-1 ADM**  
 (The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;

**GEF02-1 ADM** applies to residents of Connecticut, North Dakota and Utah)

**HEALTH INFORMATION**

If you are enrolling during the initial enrollment period and you are enrolling for up to \$300,000 or 2 times your annual earnings (whichever is less) in coverage, or up to \$20,000 for your Spouse or child coverage, you must complete the Hospitalization question.  
 If you are enrolling during the initial enrollment period and if you are electing more than \$300,000 or 2 times your annual earnings in coverage or if you are electing coverage for your Spouse that exceeds \$20,000, you must answer all questions below and complete the enclosed Authorization Form.  
 If you are enrolling after your initial eligibility period; if you answered "Yes" to any of the questions below for you, your Spouse, or dependent children; if you are electing more than \$500,000 or 3 times your annual earnings in new coverage; or if you are electing new coverage for your Spouse that exceeds \$50,000, you must also complete a Statement of Health form for that individual. Mercer Voluntary Benefits will mail a Statement of Health form to the address listed on this enrollment form for your completion.

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refer to the person for whom insurance is being requested.

Your height \_\_\_\_\_ feet \_\_\_\_\_ inches Spouse height \_\_\_\_\_ feet \_\_\_\_\_ inches  
 Your weight \_\_\_\_\_ pounds Spouse weight \_\_\_\_\_ pounds

	Employee	Spouse	Child
<b>1.</b> Have you had any application for life, accidental death and dismemberment or disability insurance, declined, postponed, withdrawn, rated, modified, or issued other than as applied for?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2.</b> Are you now receiving or applying for any disability benefits, including workers' compensation?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>3.</b> Have you been <b>Hospitalized</b> as defined below (not including well-baby delivery) in the past 90 days?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Hospitalized</b> means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.			
<b>4. For residents of all states except CT, please answer the following question:</b> Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>For CT residents, please answer the following question:</b> To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>5.</b> Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:			
a. cardiac or cardiovascular disorder?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. stroke or circulatory disorder?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. high blood pressure? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. cancer, Hodgkin's disease, lymphoma or tumors?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. diabetes? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
f. asthma, COPD, emphysema or other lung disease?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**GEF09-1 HEA**  
 (The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;

**GEF09-1 HEA** applies to residents of Connecticut, North Dakota and Utah)

PLEASE CONTINUE ON THE REVERSE SIDE OF THIS FORM.

