



EMPLOYERS' PROTECTIVE INSURANCE COMPANY
P.O. Box 859, Honolulu, HI 96808

APPLICATION FOR:
HAWAII TEMPORARY DISABILITY INSURANCE POLICY

Form with multiple sections: Full Legal Name of Proposed Policyholder, If doing business under a different name, provide "dba" (doing business as) name, Type of Entity, List any subsidiaries to be included, Nature of Business, Address: Street, City, State, Zip, Contact Name and Billing Address, Telephone, Fax, Email Address, Hawaii Unemployment Insurance Number (DOL Number), Federal Identification Number, Effective Policy Date, All employees defined by the Hawaii Temporary Disability Insurance Law are eligible. Are all eligible employees to be covered by this policy?, If no, Classes Excluded, Number of Eligible Employees for which application is made, Total taxable wages per month of covered employees, Employer premium rate quoted per \$100 of covered payroll, Percentage of Premium Paid by Employer.

The Group's Authorized Representative agrees that to the best of his or her knowledge and belief, the information provided in this Application is true and accurate; that any Policy issued will be on the basis of this information and the Application will form a part of the Policy; that any misrepresentation may result in rescission; enrollment information must be submitted before the Insurance Company ("We") can act on the Application and that the Policy will not become effective before We approve the Application. The Policy, Certificate, and other documents related to this Application may be transmitted electronically.

Signature section: Group's Authorized Representative Name (Print), Title, Group's Authorized Representative Signature, Date, Agent / Broker Name (Print), Agent / Broker Code, Agent / Broker Signature, Date.