



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

APPLICATION FOR:
HAWAII TEMPORARY DISABILITY INSURANCE POLICY

Full Legal Name of Proposed Policyholder: _____	
If doing business under a different name, provide "dba" (doing business as) name: _____	
Type of Entity: _____ If LLC: <input type="checkbox"/> Corporation <input type="checkbox"/> Single Member <input type="checkbox"/> Multi-Member (Corporation, LLC, Partnership, Sole Proprietor, LLP, Other)	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, Classes Excluded: <input type="checkbox"/> None <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Management <input type="checkbox"/> Other Excluded Class _____	
Number of Eligible Employees for which application is made: _____ Male _____ Female	
Total taxable wages per month of covered employees: \$ _____ (Maximum weekly wage base and maximum weekly benefit amount: \$1,318.48 for 2023)	
Employer premium rate quoted per \$100 of covered payroll: \$ _____	
<i>The insurance company reserves the right to establish new premium rates.</i>	
Percentage of Premium Paid by Employer: _____% (Must be at least 50%)	[Plan: <input checked="" type="checkbox"/> Hawaii Temporary Disability Insurance]

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.

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