Hawaii Life & Disability Insurance Guaranty Association
1003 Bishop Street
Suite 2030
Honolulu, HI 96813

tel. (808)744-4919
www.hilifega.org

ASSIGNMENT OF BENEFITS

Policyholder Name _____ Policy #_____

I, _____ *(print Policyholder's name)*, authorize and request Hawaii Life & Disability Insurance Guaranty Association (individually and collectively referred to HILIFEGA) to pay directly to the service provider named below (the "Provider"), any amount(s) due me under the above-referenced insurance policy(ies) (the "Policy(ies)") as a result of care or services rendered or provided to or for me by the Provider (the "Assignment"). I understand that benefits due, if any, will be paid in accordance with and subject to all terms and conditions of said Policy(ies).

Service Provider Information

This section MUST be fully completed – Please get this information from your service provider.

Service Provider's Name	Service Provider's Address & Telephone Number	Service Provider's Tax Identification Number

Effective date for new Assignment of Benefits ____ / ____ / ____

I understand that this Assignment shall be effective as of the date I sign this form but it will apply only to those amount(s) due me under the Policy(ies) that have not yet been paid by HILIFEGA as of the date HILIFEGA receives and processes this Assignment, regardless of the dates of service involved. I further understand that any payment made by HILIFEGA to the Provider in accordance with this Assignment does not relieve me of my payment obligation(s) to the Provider, nor does this Assignment create any contractual relationship between HILIFEGA and the Provider. I understand that I am solely responsible for the payment of the Provider's charges and that I may receive amount(s) due to me under the Policy(ies) even after execution of this Assignment. I agree to indemnify and hold HILIFEGA harmless for any amounts paid directly to me under the Policy(ies) following HILIFEGA's receipt of this Assignment. I further understand that the Provider's charges may exceed the amount(s) due me under the Policy(ies) and that I am solely responsible to the Provider for such excess charges.

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Policyholder: _____
Policy number: _____

This Assignment may be revoked by me or my legal representative by sending written notice to HILIFEGA 1003 Bishop Street Suite 2030, Honolulu, HI 96813 or penntreatyaloha@hilifega.org. Such revocation shall be effective only after its receipt has been recorded by HILIFEGA, and shall apply only to payments issued after the revocation effective date, regardless of the date(s) on which covered care or services were rendered or provided, or the charges thereof were incurred.

_____ _____
Signature of Policyholder Date
or Policyholder's personal/legal representative*

NOTE: Please remind your service provider to complete Form W-9 and return it to HILifeA.

The service provider must sign below:

I accept the direct assignment of benefits and understand that I may receive a Form 1099 from HILIFEGA.

_____ _____
Service Provider's Signature Date

***If this Assignment is signed by Policyholder's personal/legal representative, please complete the following and attach copy of legal document if not already on file.**

Personal/legal representative name _____

Relationship to policyholder Other _____

Basis for representation (check one):
❑ Power of Attorney ❑ Guardian ❑ Other: _____

Please submit your completed form using one of the options below. For further assistance please contact us at

Email: penntreatyaloha@hilifega.org
Mail: 1003 Bishop Street
Suite 2030
Honolulu, HI 96813