

Group Long Term Disability Insurance with Assisted Living Benefit



**For State IIA
Association Members**

With State IIA Endorsed Group Long Term Disability Insurance, You Get These Valuable Benefits

- ✓ \$10,000 maximum monthly disability benefits based on covered earnings.
- ✓ Valuable Assisted Living benefit included... extra protection for the severely disabled.
- ✓ 24-hour global coverage.
- ✓ Waiver of premium while receiving disability benefits.
- ✓ Built in dismemberment benefit at no additional cost.
- ✓ Motivational return to work incentive.
- ✓ Available to IIA State Association firms with as few as 1 enrolling employee.

PLUS...

You get a \$5,000
Life and AD&D Insurance
Benefit to protect loved ones.



Administered by:
Kelsey National Corporation
3030 South Bundy Drive
Los Angeles, CA 90066



Underwritten by:
Standard Insurance Company rated A (Excellent)
by A. M. Best Company for financial stability
Policy# 287265-A

Effective March 2005

AN OVERVIEW OF YOUR PLAN BENEFITS

Maximum Insured Monthly Earnings*	\$16,667		
% Earnings Payable	Plan 1 66 ² / ₃ % of first 4 mos. 60% for remainder	Plan 2 60%	Plan 3 60%
Maximum Monthly Benefit	\$10,000		
Benefit Duration**	To age 65		
Benefit Elimination Period	Plan 1 60 days	Plan 2 90 days	Plan 3 120 days
Premium Waiver	Yes While receiving disability benefits		
Guaranteed Issue	\$5,000 maximum in firms of 3 - 9 \$10,000 maximum in firms of 10 or more		
Assisted Living Benefit	Yes While receiving disability benefits		
Survivors Benefit	Yes 3 months of LTD benefits payable in one lump sum		
	<small>* Exclusive of overtime, bonuses and other extra compensation if you are a salaried employee. ** But not beyond age 65, except modified to comply with Federal Age Discrimination in Employment Act. (Applicable schedule printed in certificate. Advance copies available on request.)</small>		

FEATURES

RETURN TO WORK INCENTIVE

This provision is designed to encourage you to return to work. You are eligible for the Return to Work Incentive on the first day you work after the Benefit Elimination Period if LTD benefits are payable on that date.

During the first 12 months, your LTD benefit will be reduced by that portion of your work earnings, which when added to the amount of your LTD benefit (determined without reduction by deductible income) exceeds 100% of your indexed pre-disability earnings. After those first 12 months, one half of your work earnings will be used to reduce your LTD benefit.

INTEGRATION

Your monthly benefit is integrated with, but not limited to, any amounts payable under Workers' Compensation, State Disability programs, (if applicable), Full Family Social Security or any other disability (or employer sponsored) income benefits through a common group. However, any partial continuation of your salary and benefits from any group insurance coverage will not reduce your benefits unless this combination plus this plan's integrated monthly benefit exceeds 75% of your indexed pre-disability earnings.

DISMEMBERMENT BENEFIT

Loss of any two eyes, hands or feet will be considered as totally disabling for 5 years. The loss of one eye, hand or foot will be considered as totally disabling for 6 months, even if the claimant is not actually disabled. Benefits beyond the 5 years or 6 months may be continued if the insured is actually disabled. This provision does not provide benefits beyond the maximum benefit period.

SURVIVORS BENEFIT

If death occurs during a period for which monthly income is payable, a lump sum payment equal to three monthly payments will be paid to the surviving spouse or children. This benefit is only payable to spouse or children (children means your unmarried children under age 21).

CONVERSION

If your Group LTD insurance ends, you may have a right to buy LTD Conversion Insurance without submitting Evidence of Insurability. The Right to Convert extends to 31 days after the Group LTD Insurance ends.

ASSISTED LIVING BENEFIT (ALB)

The ALB provides **additional income replacement** if, while receiving LTD benefits, you:

- are unable to perform two or more activities of daily living...bathing, continence, dressing, eating, toileting and transferring/moving... without assistance from another person.

or

- suffer from a severe cognitive impairment (such as Alzheimer's disease), and therefore require continual supervision by another person.

The ALB benefit is 20% of your pre-disability earnings and is paid in addition to the LTD benefit amount. For example: If your pre-disability earnings are \$10,000, the monthly LTD benefit is \$6,000 (under the LTD plan with 60% replacement), reduced by deductible income. In this example, a 20% ALB benefit would be an additional non-integrated \$2,000 paid to you by a separate check.

Benefits are paid if your need for assistance or supervision is expected to last 90 days or more and ends when you no longer meet the ALB requirements. The ALB benefit is not payable if your inability to perform 2 or more activities of daily living or severe cognitive impairment is caused or contributed to by a mental disorder or use of alcohol, alcoholism, use of any drug: including hallucinogens or drug addiction. Other exclusions and limitations apply.

PLUS... you get a \$5,000 LIFE and AD&D INSURANCE BENEFIT
 \$5,000 will be paid to the beneficiary of your choice if death occurs while coverage is in force.

GROUP RATES

CA, HI, NJ, RI			
Firms of 9 or Less, Monthly Rates			
Age	Plan 1	Plan 2	Plan 3
Under 40	\$.73	\$.63	\$.59
40 - 49	\$.97	\$.84	\$.77
50 - 59	\$ 1.37	\$ 1.18	\$ 1.08
60 - 64	\$ 1.95	\$ 1.67	\$ 1.54
65 - 69	\$ 2.49	\$ 2.15	\$ 1.98
70 +	\$ 2.97	\$ 2.55	\$ 2.35
Firms of 10 or more, Monthly Rates			
Age	Plan 1	Plan 2	Plan 3
Under 40	\$.62	\$.55	\$.49
40 - 49	\$.82	\$.71	\$.65
50 - 59	\$ 1.16	\$ 1.01	\$.93
60 - 64	\$ 1.66	\$ 1.43	\$ 1.32
65 - 69	\$ 2.11	\$ 1.82	\$ 1.68
70 +	\$ 2.51	\$ 2.17	\$ 2.00

ALL OTHER STATES			
Firms of 9 or Less, Monthly Rates			
Age	Plan 1	Plan 2	Plan 3
Under 40	\$.77	\$.67	\$.62
40 - 49	\$ 1.00	\$.88	\$.79
50 - 59	\$ 1.42	\$ 1.25	\$ 1.13
60 - 64	\$ 2.10	\$ 1.83	\$ 1.69
65 - 69	\$ 2.67	\$ 2.33	\$ 2.14
70 +	\$ 3.17	\$ 2.76	\$ 2.54
Firms of 10 or more, Monthly Rates			
Age	Plan 1	Plan 2	Plan 3
Under 40	\$.65	\$.57	\$.53
40 - 49	\$.85	\$.74	\$.69
50 - 59	\$ 1.22	\$ 1.06	\$.98
60 - 64	\$ 1.79	\$ 1.57	\$ 1.43
65 - 69	\$ 2.27	\$ 1.98	\$ 1.81
70 +	\$ 2.70	\$ 2.36	\$ 2.16

HOW TO CALCULATE RATES

Rates are based on each \$100 of insured monthly earnings and graded according to age. For example:

Under Plan I, 60-day elimination period, the monthly cost for an employee age 35 in CA with firms of 9 or less, with a \$900 monthly income would be \$6.57:

$$\$900 \div \$100 = 9 \quad 9 \times \$.73 = \$6.57 \text{ per month}$$

Because premiums are calculated on the first \$16,667 of monthly earnings, the monthly cost for an employee age 48 under Plan I in all other states, with firms of 10 or more, for the maximum insurable earnings of \$16,667 would be \$127.50.

$$\begin{aligned} \$16,667 \div \$100 &= 166.67 \\ 166.67 \times \$.85 &= \$141.67 \text{ per month} \end{aligned}$$

For employees paid entirely or partly by commission, the benefit is based on average earnings of record. For Partners and Sole Proprietors, the benefit is based on income as reported for tax purposes.

ADMINISTRATIVE FEES

An installation fee of \$12.65 is charged for each employee and each new employee added to the plan; \$37.95 maximum in any one month. Monthly firm fee is \$14.85 for firms of 1-3 insureds or \$19.85 for firms of 4 or more insureds per premium statement, regardless of how many plans are included.

The installation fee is waived if the employer has another IIA Group Insurance Trust plan administered by Kelsey National Corporation.

This is not a contract but is intended to provide a general description of the coverage. The actual policy should be consulted for complete details of policy provisions. Cost and further details of coverage, including exceptions, reductions or limitations and the terms under which the policies may be continued in force will be furnished by Kelsey National Corporation. Final acceptance of the group will be subject to approval by the carrier.

FIDUCIARY LIABILITY AND ERISA BOND OPTION

(Underwritten by American International Surplus Lines Insurance Co.)

Covers employer liability for errors and omissions in handling employee benefit plans to \$1 million per loss with \$1,000 deductible. Provides a \$100,000 ERISA bond. Automatically issued unless waived on Employer Application.

STATE IIA ASSOCIATION GROUP LTD INSURANCE EMPLOYER APPLICATION

FIRM INFORMATION

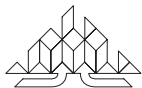
Firm Name: _____
Street address: _____
City _____ State _____ ZIP _____
Phone (_____) _____ FAX (_____) _____
Individual to contact for routine information: _____
Email _____
Individual to contact for special information: _____
Email _____

FIRM QUESTIONNAIRE

1. Our firm is a Sole Owner Partnership Corporation
2. Our firm has chosen the . . . Plan 1 (60-day waiting period) Plan 2 (90-day waiting period) Plan 3 (120-day waiting period)
3. We certify that the total number of full-time, eligible employees, (including owners, partners, etc.) is _____ of which the total number of enrolled employees is _____.
4. Our firm pays the following portion of Employee premiums: _____%
5. We would like the insurance to become effective on _____, 20_____. We understand that you will confirm an effective date and bill us later.
Note: Your requested effective date may not be your actual effective date.
6. Our probationary period for new employees is 1st of the month following:
 Date of hire 30 days 60 days 90 days 180 days
7. Our firm is enrolled in another group plan administered by Kelsey National Corporation. Yes No
(If "Yes") Our account number is: _____

TO COMPLETE YOUR ENROLLMENT STEPS, BE SURE TO COMPLETE THE CHECKLIST BELOW:

- We have completed this **EMPLOYER APPLICATION**.
This form constitutes application by your firm for participation in the IIA Group LTD Insurance plan, underwritten by Standard Insurance Company, Home Office Portland, Oregon. This form should be signed by the Owner, a Partner, Sole Proprietor or a Corporate Officer.
- We understand that **EMPLOYEE ENROLLMENT FORMS** should be completed and signed by all eligible employees, including Owner-Employees, Partners, Sole Proprietors, Officers, Agents, Brokers, Solicitors, etc. who work 30 hours or more per week at our firm, whether or not they wish to enroll.
- We understand that **firms enrolling 1-2 employees must complete health statements** for each of the enrolling employees. Health statements must also be completed for firms with 3-9 employees applying for coverage in excess of \$5,000 maximum monthly benefits. Health statements will be provided, if applicable, upon receipt of your application.
- If your firm has been enrolled in a prior plan, please enclose a copy of your prior plan's last monthly statement and a plan brochure or certificate.
- Completed Applications should be mailed to:



IIA Group Insurance Trust
Kelsey National Corporation
3030 S. Bundy Dr., Los Angeles, CA 90066

Fiduciary Liability and ERISA Bond Option: Fiduciary liability and ERISA bond coverage is automatically included unless already in force or waived by applicant initialing here _____ (not available in Kentucky).

IMPORTANT: Send no money at this time. You will receive written acceptance or declination from the IIA Group Insurance Trust. If accepted you will also receive an itemized premium statement showing individual monthly premiums and an administration fee, which covers all group plans included on the premium statement.

We have completed the EMPLOYER APPLICATION and understand this form and the Joinder Agreement on the back page constitute application by our firm for participation in the State IIA Group Plan.

Signature X: _____
(Owner, Partner or Corporate Officer)

Title: _____ Date: _____

Administrator Section	Certificate Effective Date:	Account #
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Employees you wish to add to the plan must complete the employer and employee section below and sign and date the enrollment form. Employees refusing or discontinuing coverage under this plan must complete the employer, employee and refusal or discontinuance of coverage section.

EMPLOYER SECTION

Please check one box only: <input type="checkbox"/> Initial Request <input type="checkbox"/> Request for a Change	Firm Name:	Account #:
	Firm Phone:	

EMPLOYEE SECTION *(Please print all information, sign and date)*

Employee's Name:	(last)	(first)	(initial)	SS#:
Home Address:	(street)	(city)	(state)	(zip)
Date of Birth:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Job Title:	Monthly Earnings:			
Date Hired:	Do you work 30 or more hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email:				
Beneficiary:			Relationship:	

PLEASE SIGN AND DATE HERE

I hereby declare that I am an active full-time employee, partner, sole proprietor or owner-employee of the employer indicated above and that I regularly work at least 30 hours per week at or from the employment location indicated. I hereby request the group insurance for which I am or may become eligible under the policies issued to the Trustee of the Independent Insurance Agents Group Insurance Trust by the Insurance Company. I authorize the deductions from my earnings of any contributions I may have to make toward the cost. I understand that my request shall include this form and any part or parts of the health statement which may be required. All information given by me on this form is true and complete and is offered as an inducement to grant insurance.

Dated this _____ day of _____ 20 _____

Signature of Applicant **X** _____

Witness **X** _____

REFUSAL OR DISCONTINUANCE OF COVERAGE

Complete this section only if you are REFUSING or DISCONTINUING COVERAGE UNDER THIS PLAN. Then sign, date and return to your employer.

REFUSAL:

I understand the plan of Group Insurance offered to me, but I decline to participate.

REASON FOR REFUSAL:

Covered under a Military Insurance Plan.

Covered under spouse's Employer Group Insurance Plan with: _____
(Name of Insurer and/or Employer)

Other (Specify): _____

I understand that if I later wish to enroll or re-enroll in the Group Plans, I must provide satisfactory evidence of insurability to the Insurance Company or be subject to limited benefits for a specified period of time. I also understand that I may not be eligible for all plans made available through the Independent Insurance Agent Group Insurance Trust.

Employee's Signature **X** _____ Date _____



All completed Enrollment Forms should be sent by the employer to:
KELSEY NATIONAL CORPORATION
 3030 South Bundy Drive
 Los Angeles, CA 90066



Insured by:
Standard Insurance Company
 Policy# 287265-A

IMPORTANT PROVISIONS

ELIGIBILITY

Available to firms that are State Independent Insurance Agents Association members, including all active, full-time employees, partners, sole proprietors and owner-employees (working 30 hours or more per week).

Employees paid entirely or partly by commission are eligible if they work 30 hours or more per week and earn at least 150 hours per month times the minimum wage.

Real estate banking mortgage loan or escrow firms affiliated with the insurance agency through common ownership (whole or in part) are also eligible.

New employees in firms of 3 or more lives may be added without health evidence for amounts less than the Non-Evidence Maximums, if application is submitted within 31 days of the firm's selected waiting period.

PARTICIPATION

Firms of 1-3 eligible employees	=	100%
Firms of 4 or more eligible employees	=	75%

ENROLLMENT

Firms of 1-2 lives insured: All eligible enrolling employees applying for benefits need to submit a health statement.

Firms of 3-9 lives insured: All eligible enrolling employees have Guaranteed Issue up to \$5,000. Amounts greater than this need to submit a health statement.

Firms with 10 or more lives insured: All eligible enrolling employees have Guaranteed Issue up to the \$10,000 maximum.

LIMITATIONS

You must be under the on-going care of a physician during the Benefit Waiting Period and while receiving benefits. Payment of LTD benefits is limited to 24 months for each period of disability caused or contributed to by a mental Disorder. However, if you are confined in a hospital at the end of the 24 months, this limitation will not apply while you are continuously confined. No LTD benefits are payable when you are not under the on-going care of a physician.

EXCLUSIONS

To keep the costs low, this plan does not cover disabilities caused or contributed to by intentionally self-inflicted injuries: war or act of war.

PRE-EXISTING CONDITIONS

A mental or physical condition treated within 3 months before your insurance is effective will not be covered unless on the date you become disabled you have been continuously insured under the group policy for 12 months and have completed one full day of active work after those 12 months. All other conditions have full coverage immediately.

TERMINATION OF COVERAGE

A member's insurance automatically ceases on the earliest of the following dates: the date of termination of status as a member; the date when member becomes a full-time member of the military forces (land, sea or air) of any country; the date of expiration of the last period for which member has made a required contribution; or, the date of discontinuance of the group policy.

DEFINITIONS

EARNINGS

For all active employees, benefits are based on current salary to a maximum of \$16,667 per month (\$200,000 annually) exclusive of overtime, bonuses and any other extra compensation. For those personnel compensated in whole or in part by commission, the benefit will be based on average earnings over the past 12 months immediately preceding disability.

DISABILITY

Disability means the inability to perform the duties of your own occupation during the first 2 years of disability; thereafter, it means inability to perform the duties of any gainful occupation for which you are reasonably qualified by training, experience or education.

OWN OCCUPATION

During the first 24 months that LTD benefits are paid, you are disabled from your own occupation if, as a result of physical disease, injury, pregnancy or mental disorder you are unable to perform with reasonable continuity the material duties of your own occupation.

ANY OCCUPATION

From the end of the Own Occupation period to the end of the Maximum Benefit period, you are disabled from all occupations if, as a result of physical disease, injury, pregnancy or mental disorder you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience.

PARTIAL DISABILITY

You will be considered partially disabled and be eligible for benefits if, during the benefit waiting period and Own Occupation period, you are able to work in your own occupation, but due to physical disease, injury, pregnancy or mental disorder you are unable to earn more than your Own Occupation level of 80% in relation to your indexed pre-disability earnings. This also applies during the Any Occupation period, if you are able to work in any occupation, but due to physical disease, injury, pregnancy, or mental disorder you are unable to earn more than your Any Occupation level of 60% in relation to your indexed pre-disability earnings.

JOINDER AGREEMENT

TO THE TRUSTEE OF THE INDEPENDENT INSURANCE AGENTS GROUP INSURANCE TRUST FUND:

The signee, a member of an Independent Insurance Agents Association, hereby requests the Trustee of the Independent Insurance Agents Group Insurance Trust Fund to enroll our firm as a participating employer for a plan of group insurance covering eligible employees of the firm applying.

The signee hereby subscribes to the Trust Agreement dated the 22nd day of September, 1988, as amended, and agrees to be bound by the terms and conditions thereof. A copy of said Trust Agreement will be made available to the subscribers upon written request. Kelsey National Corporation receives commission of 2 1/2% for acting as agent and a fee from the Trust for services rendered managing it.

The signee hereby acknowledges that the Trustee of the Independent Insurance Agents Group Insurance Trust Fund in seeking to obtain and keep in force such group insurance, does so as a matter of accommodation only. The participating employer agrees to be bound by the terms of the master policy and in return for benefits provided thereunder guarantees prompt payment of premiums due. The Trustee is merely a holder of the master policy, whose responsibility is to issue certificates to participating employees and to collect premiums, but the insurance agreement and all claims arising thereunder are purely a matter between the signee and the insurance carrier.



All completed Enrollment Forms should be sent by the employer to:
KELSEY NATIONAL CORPORATION
3030 South Bundy Drive
Los Angeles, CA 90066



Insured by:
Standard Insurance Company
Policy# 287265-A