

A Group Life/AD&D Benefits Package

with benefits
up to
\$200,000



KELSEY NATIONAL
CORPORATION

Your State IIA Endorsed Group Life Program Provides These Important Features

- ✓ **Choice of plans** so you can select the one that best meets your needs.
- ✓ Life coverage with benefits up to **\$200,000**.
- ✓ An AD&D benefit **equal** to and **additional** to the life benefits.
- ✓ Competitive **group rates**.
- ✓ **24-Hour Coverage**...anywhere in the world.
- ✓ **Waiver Of Premium** for disability.
- ✓ **Conversion Privilege** to individual coverage upon retirement regardless of health status.
- ✓ **Supplemental Life and Dependent Life** coverage available.
- ✓ Available to State IIA Association firms with **as few as 1** enrolling employee.

For State IIA Association Members

Effective July, 2001

Underwritten by The United States Life Insurance Company, rated A+ (Superior)) by A.M. Best Company for financial stability. Policy# G181851

Select The Term Life Plan That Best Meets Your Needs

<i>Plan Options</i>	<i>Benefit Selection*</i>	<i>Maximum Benefit</i>
Plan I	For Owners, Partners, Officers and Employees earning \$60,000 or more yearly	\$100,000
	For Owners, Partners, Officers and Employees earning less than \$60,000 yearly and more than \$40,000 yearly	\$ 40,000
	All others	\$ 20,000
Plan II	Employer chooses the level amount for all employees from \$20,000 to \$100,000 in \$10,000 increments	\$100,000
Plan III	One times yearly earnings**	\$200,000
Plan IV	Two times yearly earnings**	\$200,000

* Benefits reduce to 65% of original amount at age 65 with a maximum of \$65,000; then, to 50% or original amount at age 70 with a maximum of \$50,000; then, to 30% or original amount at age 75 with a maximum of \$30,000: Then, no further reductions.

** Insurance will be rounded to next \$1,000. Example: Employee earns \$14,200, insured for \$15,000.

OTHER BENEFITS

* **Accidental Death and Dismemberment**

The AD&D Benefit is equal to and additional to the Life Benefit.

Pays for any of the following losses suffered within the 12 month period immediately following the date of accidental bodily injury:

Pays 100% of AD&D amount for loss of life, both hands, both feet, sight of both eyes, or any combination of the above in one accident.

Pays 50% of AD&D amount for loss of one hand, one foot or sight of one eye.

* **Waiver of Premium**

If the employee is disabled before age 60, Life coverage continues without having to pay premiums as long as the disability continues.

* **Accelerated "Living" Benefit**

The employee can receive up to 60% of the Life Benefit when diagnosed terminally ill with a life expectancy of 12 months or less. The money can be used in any way the insured chooses. Benefits not paid while living will be paid as a regular death benefit.

ELIGIBILITY

Available to firms that are Independent Insurance Agents Association members, all active, full-time employees (working 30 hours or more per week), their spouses and unmarried children to age 21 (or to age 23 if full-time students).

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.

New employees may be added without health evidence for amounts less than the Non-Evidence Maximums within the firm's 30, 60 or 90 day waiting period, selected by the employer.

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

Participation

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

Takeovers

Takeovers are available for groups of 2 or more lives. Simply provide proof of prior coverage.

ENROLLMENT

Enrollment simply requires an Employer Application and completed Enrollment Forms for each employee.

No Health Statements are Required for:

Firms of 5-9 enrolling employees:
Coverage \$50,000 or less

Firms of 10+ enrolling employees:
*Coverage \$100,000 or less, or
\$75,000 or less if age 50+*

Health Statements are Required for:

Amounts higher than those listed and for all firms of 1 or 2 enrolling employees.

Simplified Underwriting for:

Firms of 3 or 4 enrolling employees. Just answer questions on the Employer Application.

Choice of Beneficiary

The employee may name or change any beneficiary at any time by notifying Kelsey National Corporation.

OTHER PROVISIONS

Plan Changes

Once during the course of the year, the employer firm may change Life schedules or add options to an existing plan with the approval of The United States Life Insurance Company.

Termination of Coverage

Coverage terminates on the earliest date that premium payments end, full-time employment ends, the employer firm no longer meets participation requirements or the group policy is terminated.

Limitations

The AD&D policy does not cover loss resulting from: suicide or intentionally self-inflicted injury, insurrection, war or act of war; physical or mental sickness, or treatment of that sickness; voluntary or involuntary intake of gas, fumes, poison or drugs, unless taken as prescribed by a physician; committing a crime, or an attempt to do so; being intoxicated or under the influence of drugs, unless taken as prescribed by a physician; flight in any type of aircraft while a crew member or pilot, whether licensed or unlicensed.

If the insured dies by suicide, then for amounts which have been in force for less than 2 years and for which evidence of insurability was required, the insurance company's only liability will be a return of the premiums paid.

Conversion Privilege

If an employee's insurance ends, life insurance may be converted within 31 days to an individual policy in the same amount or less without medical examination.

GROUP RATES

Rates are based on cost per \$1,000 of coverage and graded according to age. Rates increase when the insured enters a new age category.

Employee Age	Monthly Premiums Per \$1,000
0 - 39	\$ 0.19
40 - 44	0.36
45 - 49	0.47
50 - 54	0.77
55 - 59	1.20
60 - 64	1.95
65 - 69	2.96
70+	5.12

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.

INDIVIDUAL OPTIONS

Double Benefit

Individuals may choose to supplement their coverage with a benefit equal to their basic coverage, with health evidence. The rate per \$1,000 is the same as the basic rate. There is a \$200,000 coverage maximum for basic and supplemental combined.

Dependent Life Coverage

Dependent life coverage is available. \$1.75 per month covers all the employee's dependents as follows:

Spouse (Coverage terminates at age 70)	\$5,000
Each Child (Age 6 months to 21 years or to 23 years if full-time student)	\$2,500
Each Child (Birth to 6 months)	\$500

Participation requirements are 100% for firms of 1-3 and 100% of eligible dependents. For firms of 4 or more, option requires 100% until at least 3 dependent units are covered; thereafter it is 75% but with no less than 3 dependent units covered.

This is a summary of benefits only and is subject to the terms, conditions and limitations of the actual Group Policy. The actual policy should be consulted for complete details of policy provisions. Where state regulations vary from benefits, state regulations will apply. Cost and further details of coverage, including exceptions, reductions or limitations and the term 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.

Low Cost 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.
(See separate brochure for details.)

State IIA Association Group Life/AD&D Employer Application

Introducing...an Employer Application that makes it easy to say "Yes!" to
State IIA Association Group Coverage!

YOUR ENROLLMENT STEPS

Yes! Our firm is a successful: Sole Proprietor Partnership Corporation

Yes! Our firm is a member of the IIA: Yes No

Yes! Our firm is enrolled in another group plan administered by Kelsey National Corporation/Trust Administration Services:
 Yes, Account Number: _____ No

Yes! Our firm has chosen the following Life/AD&D plan:

Life Plan I
\$100,000/\$40,000/\$20,000

Life Plan II
Equal amount of \$_____ on all employees
(Choose \$20,000 to \$100,000 in increments of \$10,000)

Life Plan III
1 x annual earnings to \$200,000

Life Plan IV
2 x annual earnings to \$200,000

Yes! Our firm has chosen the following Waiting Period for new hires: 30 days 60 days 90 days

Yes! Our firm has chosen: Dependent Life Option (Available for all plans)

Yes! Our firm certifies that the total number of full-time employees is: _____

Yes! Our firm pays the following portion of the Employee monthly premium: _____ %

If your firm does not already have Fiduciary Liability Coverage and ERISA Bond protection as a participant in another IIA Group Insurance Trust plan, it will automatically be included for your firm now, unless waived by applicant by initialling this form here: _____ (Not available in Kentucky.) Coverage is underwritten by American Surplus Lines Insurance Company.

Yes! We wish to enroll! Please make the effective date: _____ / _____ / 200____. We understand that you will bill us and confirm the effective date. We hereby acknowledge that insurance coverage will not take effect until approved in writing by the insurance company.

Firm Name _____

Phone # (_____) _____ FAX # (_____) _____

Email _____

Street Address _____

City _____ State _____ ZIP _____

Mailing Address (if different than above) _____

City _____ State _____ ZIP _____

Individual to contact for routine information _____

Individual to contact for special information _____

Yes! We have completed this EMPLOYER APPLICATION and understand this form and the Joinder Agreement on the next page constitute application by our firm for participation in the State IIA group plan.

Signature (Owner, Partner, Corporate Officer) **X** _____

Title _____ Date _____

INDEPENDENT INSURANCE AGENTS GROUP INSURANCE TRUST
– Continued on next page–

Enrollment Instructions

To complete your enrollment steps, be sure to confirm:

- Yes!** We have completed this **EMPLOYER APPLICATION**. (This form constitutes application by your firm for participation in the State IIA Association Group Life/AD&D Plan. This form should be signed by an Owner, Partner or Corporate Officer.)
- Yes!** We understand that **EMPLOYEE ENROLLMENT FORMS**, should be distributed to all eligible employees. (The forms should be completed and signed by all eligible employees, including Owners, Partners, Officers, Agents, Brokers, Solicitors, etc. who work 30 hours or more per week at our firm.) Health questions must be completed by the following: (a) Firms of 1-4 eligible employees; (b) All employees enrolling in the Double Life Benefit Option; (c) Employees applying for more than \$50,000 in firms of 5-9; (d) Employees applying for more than \$100,000 in firms of 10 or more; (e) Employees age 50 or older in firms of 10 or more, who are applying for \$75,000 or more; and (f) All late applicants.

New groups of 3 or 4 employees must complete the simplified health statement below.

New groups of 3 or 4 employees please answer the following question.

Are there any employees who, in the last 12 months, have been out of work due to injury or sickness for at least 5 consecutive working days? **YES** **NO**

If "YES" give details below. If more space is needed, attach a separate sheet, signed and dated by the Applicant.

Name of Employee	Date Disability Began	Current Amount of Group Life Insurance In Force	Describe Nature of Injury/Sickness

Participation and Eligibility

Firms of 1-3 eligible employees must enroll 100%. Firms of 4 or more must enroll 75%

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.

Important: Send No Money At This Time

You will soon receive an acceptance or declination from the IIA Group Insurance Trust. When 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. The signee hereby acknowledges that he has received information containing the administration fees.

All completed applications should be sent to:
KELSEY NATIONAL CORPORATION
3030 South Bundy Drive
Los Angeles, CA 90066

Underwritten by:
The United States Life Insurance Company
in the City of New York
Member American General Financial Group
Rated A+ (Superior) by A. M. Best & Company

EMPLOYEE ENROLLMENT FORM

IIA Group Insurance Trust Request for Group Life/AD&D Insurance Enrollment Card Part 1

Administrator Section	Plan:	Certificate Effective Date:	Account #:
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Please complete employer and employee sections below.

Employer Section	PLEASE CHECK ONE BOX ONLY <input type="checkbox"/> Initial Request <input type="checkbox"/> Request for a change	Name of Firm:	Account #:
		Firm Phone #: ()	

Employee Section • Please print all information. • Sign and date this form below.	Employee's Name: _____ <small>(last) (first) (initial)</small>				Social Security #:		
	Home Address: _____ <small>(street) (city) (state) (zip)</small>						
	Email: _____						
	Date of Birth: _____ <small>Mo. Day Year</small>		Age: _____	Date Employed: _____ <small>Mo. Day Year</small>		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Monthly Earnings: _____
	Occupation: _____ <small>(Title/Position)</small>		Beneficiary: _____		Relationship: _____		Do you work 30 or more hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No

I hereby declare that I am an active full-time 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 IIA 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 Supplement to Request for Group Insurance (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.

Employee's signature **X** _____ Date _____

Family Information: <input type="checkbox"/> Married <input type="checkbox"/> Not Married Eligible Children <input type="checkbox"/> Yes <input type="checkbox"/> No	I want to insure (check one): <input type="checkbox"/> Myself only <input type="checkbox"/> Myself and my dependents Select the option(s) you want: <input type="checkbox"/> Double Life Benefits <input type="checkbox"/> Dependent Life	If applying for spouse and/or dependent coverage, list names and birthdates below. <table style="width: 100%;"> <tr> <th style="text-align: left;">Name:</th> <th style="text-align: left;">Birthdate:</th> </tr> <tr> <td>1. Spouse _____</td> <td>_____/_____/____</td> </tr> <tr> <td>2. Child _____</td> <td>_____/_____/____</td> </tr> <tr> <td>3. Child _____</td> <td>_____/_____/____</td> </tr> <tr> <td>4. Child _____</td> <td>_____/_____/____</td> </tr> <tr> <td>5. Child _____</td> <td>_____/_____/____</td> </tr> </table>	Name:	Birthdate:	1. Spouse _____	_____/_____/____	2. Child _____	_____/_____/____	3. Child _____	_____/_____/____	4. Child _____	_____/_____/____	5. Child _____	_____/_____/____
Name:	Birthdate:													
1. Spouse _____	_____/_____/____													
2. Child _____	_____/_____/____													
3. Child _____	_____/_____/____													
4. Child _____	_____/_____/____													
5. Child _____	_____/_____/____													

Enrollment Form Part 2

Refusal or Discontinuance of Coverage

Complete this section in addition to Part 1 if you are refusing or discontinuing coverage for yourself or a dependent for Life/AD&D. Then sign, date and return to your employer.

Reason for refusal:

- | | |
|--|---|
| <input type="checkbox"/> Covered under spouse's Employer Group Insurance
Spouse's Employer: _____
Name of Insurance Company: _____ | <input type="checkbox"/> Covered under a Military Insurance Plan: _____
<input type="checkbox"/> Religious Beliefs
<input type="checkbox"/> Cannot afford |
|--|---|

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 _____

Name of Employer Firm _____