

# Group Long Term Disability Income Protection

with monthly  
benefits to  
**\$10,000**



KELSEY NATIONAL  
CORPORATION



## With Your State IIA Endorsed Group Long Term Disability Income Protection You Get These Important Features

- ✓ Pays up to **\$10,000** monthly income benefit.
- ✓ **Choice of Plans** so you can select the one that best meets your needs.
- ✓ Protection **24 hours a day...** at home, while traveling, on the job or at play.
- ✓ Provides valuable benefits during **rehabilitation.**
- ✓ Available to State IIA Association firms with **as few as 1** enrolling employee.
- ✓ **Competitive group rates.**
- ✓ **Waiver of Premium** included.
- ✓ **Non-Integrated** with individual policies.

## 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# G182528

## Select The LTD Plan That Best Meets Your Needs

PLAN BENEFITS	PLAN I	PLAN II	PLAN III
Maximum Insured Monthly Earnings	\$15,000	\$16,667	\$16,667
% Earnings Payable	66 ⅔ %	60%	60 %
Maximum Monthly Benefit	\$10,000	\$10,000	\$10,000
Benefit Duration * Sickness Accident	<u>5 years</u> to age 65	<u>to age 65</u> to age 65	<u>to age 65</u> to age 65
Elimination Period	60, 90 or 180 days	60, 90 or 180 days	60, 90 or 180 days
Survivor Income	6 months	6 months	None
Cost of Living Increase	Yes	Yes	None
Guaranteed Issue **	Up to \$5,000 monthly benefit in firms of 5 or more	Up to \$5,000 monthly benefit in firms of 5 or more	Up to \$5,000 monthly benefit in firms of 5 or more

\* Complies with Federal Age Discrimination laws. Benefits to age 65 for eligible employees disabled prior to age 62. Benefits for persons disabled at age 62 or older are listed in the Maximum Duration of Benefit schedule.

\*\* Medical evidence of good health is needed in firms of 4 or less enrolling employees, and on amounts over \$5,000 monthly benefit in firms of 5 or more.

— All benefits are subject to integration —

# Here's How Income Protection Works For You

## \* Pre-existing Condition Coverage

**YOU GET FULL COVERAGE IMMEDIATELY**, except for conditions for which you incurred charges, received medical treatment, consulted a physician or took prescribed drugs 3 months prior to effective date on Plans I and II; 12 months prior to effective date on Plan III. All pre-existing conditions are covered when employee has been insured and actively at work for 12 consecutive months.

## \* Partial Disability

The partial disability benefit provides continuing support for a claimant attempting a gradual or partial return to work within 31 days of a period of total disability during which disability benefits are payable from United States Life.

This benefit is payable until the claimant is able to earn 80% of pre-disability income. The claimant must have been totally disabled throughout the elimination period. The partial Disability Benefit equals the total disability benefit less 50% of the claimant's partial earnings. An employee may receive up to 100% of pre-disability income.

## \* Cost of Living Increase (Plans I and II only)

After one complete calendar year of total disability, the net monthly benefit is increased 3%. Should disability continue, benefit increases will take effect on each subsequent anniversary, subject to any policy maximum.

## \* Premium Waiver

Premium payments are waived while the employee collects benefits for total disability under this plan.

## \* Vocational Rehabilitation

Whenever possible, getting the claimant back to work is the goal of everyone affected by disability.

With United States Life, trained counselors assess each claimant's situation to determine the best possible route to recovery. When appropriate, our counselors work with the claimant and the employer to determine an individualized vocational rehabilitation strategy. Toward this goal, workplace modification, retraining and academic upgrading may be suggested.

## \* Survivor Income (Plans I and II)

Pays benefits to dependents for 6 months if an employee dies after being disabled for 180 consecutive days and while receiving benefits.

## \* Accumulation of the Waiting Period

An employee may attempt a return to work for one period of less than two weeks during the elimination period. Days accumulated prior to this attempt will be used toward satisfying the elimination period should disability continue.

## \* Elimination Period

The elimination period is the number of days of continuous total disability before benefits begin under this plan. The benefit period begins at the end of the 60, 90, or 180 day Elimination Period.

## \* Benefits for Mental, Nervous, Emotional Disorders

These conditions are covered for the first 24 months as any sickness. Benefits may be payable beyond 24 months if you are hospitalized beyond the last day of the 24 month period

## \* Maximum Duration Of Benefit

The benefit period begins at the end of the Elimination Period. For eligible employees who become disabled prior to age 60, benefits are payable according to each plan's Benefit Duration shown on chart above. For eligible employees who become disabled on or after the 60th birthday, benefits are payable according to the following schedule:

Age* at Beginning of Total Disability	Maximum Duration of Benefit
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

\*Age at insured's last birthday

### Benefits will continue until:

- Maximum benefit period ends
- Total or partial disability ends
- You fail to give the required proof of continuing disability
- You die

# IMPORTANT PROVISIONS

## Eligibility and Enrollment

Available to firms that are Independent Insurance Agents State Association members and active full-time 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 monthly at least 150 hours per month times the minimum wage. New employees may be added without health evidence for amounts up to \$5,000 after working 3 months if enrolled during the eligibility period. Real estate, banking, mortgage loan or escrow firms affiliated with the insurance agency through common ownership (whole or in part) are also eligible. You must be actively at work on the day that the insurance is to take effect. If you are not, the insurance will take effect on the day that you return to work.

## Participation

Firms of 1-3 enrolling employees = 100%

Firms of 4 or more enrolling employees = 75%

## Total Disability

Total disability means during the waiting period and next 24 months, the complete inability to perform the material duties of your regular occupation. (Regular occupation is that which you were performing on the day before total disability began.)

## Any Occupation Definition of Disability

After 24 months, total disability is your complete inability to perform the material duties of any job for which you are reasonably fit by training, education or experience.

The total disability must be the result of an injury or sickness.

## Confinement Not Required

Benefits are payable after the elimination period while an employee remains continuously totally disabled and under doctor's care. Confinement to hospital, indoors or bedrest, is not required.

## Integration

1. Your monthly income benefit is reduced by any benefits for which you are eligible from any government plans. (i.e. Social Security benefits, Workers' Compensation, etc.)
2. Then, if any benefits are available from other group Disability and Retirement plans, or any other income from employment, the benefit is reduced so that the total benefit amount does not exceed 66 2/3% of your pre-disability earnings. This means your monthly income benefit can be as high as 66 2/3% of your total pre-disability earnings.

Benefit Integration does not apply to individual policies.

## Termination of Coverage

Coverage terminates on whichever of the following dates is earliest: 1) the end of the period for which premium payments have been paid; 2) full-time employment ends; 3) the employer firm no longer meets participation requirements, or cancels; or 4) the group policy is terminated.

## Exclusions

Disability resulting from the following conditions are not covered: Intentionally self-inflicted injuries; war, or act of war; committing a crime or an attempt to do so.

## Plan Changes

On January 1 of each year, a firm may change LTD plans or upgrade benefits in an existing plan with the approval of The United States Life Insurance Company.

# OPTIONAL BENEFITS

## Continued Family Income Option

For employees under age 55, family will receive 66 2/3% of insured earnings for 1 year (or 33 1/3% for 2 years at the survivor's request) if the insured dies. Benefit is payable whether or not the insured is disabled at time of death and in addition to Survivor Income if applicable. For employees age 55 or over, pays 66 2/3% of insured earnings for 8 months.

## 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.)

# Choose an Elimination Period & Find Your Rate

## Rates per \$100 of monthly earnings

	Age	60 Day Elimination	90 day Elimination	180 Day Elimination
<b>PLAN I</b>	<i>Accident to age 65, Sickness to 5 years</i>			
	0-39	\$ .69	\$ .62	\$ .52
	40-49	.85	.77	.63
	50-54	1.22	1.09	.89
	55-59	1.39	1.22	1.03
	60-64	1.77	1.56	1.31
	65+	2.25	1.98	1.80
<b>PLAN II</b>	<i>Accident to age 65, Sickness to age 65</i>			
	0-39	\$ .76	\$ .69	\$ .58
	40-49	.98	.88	.73
	50-54	1.27	1.13	.95
	55-59	1.44	1.26	1.07
	60-64	1.59	1.40	1.18
	65+	2.03	1.78	1.62
<b>PLAN III</b>	<i>Accident to age 65, Sickness to age 65</i>			
	0-39	\$ .39	\$ .36	\$ .29
	40-49	.57	.53	.45
	50-54	1.11	1.03	.89
	55-59	1.45	1.35	1.15
	60+	1.57	1.46	1.26

## Continued Family Income Option

AGE	RATES	RATE
0 - 39		\$ .17
40 - 49		.41
50 - 54		.77
55 - 59		.80
60 - 64		1.20
65+		1.81

## 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.**

## 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 with a **\$900** monthly income would be \$6.21:

$$\$900 \div \$100 = 9 \quad 9 \times \$ .69 = \$6.21 \text{ per month}$$

Because premiums are calculated on the first **\$15,000** of monthly earnings, the monthly cost for an employee age 48 under PLAN I for the maximum insurable earnings of **\$15,000** would be \$127.50.

$$\begin{aligned} \$15,000 \div \$100 &= 150 \\ 150 \times \$ .85 &= \$127.50 \text{ per month} \end{aligned}$$

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.

## Discounts

Size discounts are available on PLANS I and II and on Family Income Option.

<u>ENROLLING EMPLOYEES</u>	<u>DISCOUNT</u>
10-19	8%
20-34	15%
35 or more	20%

*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 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.*

# State IIA Association Group LTD Income Protection Benefit Employer Application

Introducing...

an employer application that makes it easy to say "YES!" to State IIA Association endorsed 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  
Services:  Yes Account Number: \_\_\_\_\_  No

**YES!** Our firm has chosen the following Long Term Disability (LTD) plan:

LTD Plan I  LTD Plan II  LTD Plan III

**YES!** Our firm has chosen:  Continued Family Income Option

**YES!** Our firm has chosen the following Elimination Period:  60 days  90 days  180 days

**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: \_\_\_\_\_ %

Fiduciary Liability Coverage and ERISA Bond Option is automatically included unless already in force as a participant in another IIA Group Insurance Trust plan or waived by applicant initialing here: \_\_\_\_\_ (Not available in Kentucky.)  
This coverage is underwritten by American International Surplus Lines Insurance Company.

**YES!** We wish to enroll! Please make the effective date: \_\_\_\_/\_\_\_\_/200\_\_ 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 enclosed the following number of Enrollment Forms with this application: \_\_\_\_\_

**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. This form is signed by an Owner, Partner or Corporate Officer.

Signature (Owner, Partner or 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 LTD Income Protection Benefit Plan, underwritten by The United States Life Insurance Company. The form should be signed by the owner, a partner or a corporate officer.
- ❑ **YES!** We understand that **EMPLOYEE ENROLLMENT 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, whether or not they are enrolling.
- ❑ **YES!** We understand that **firms enrolling 4 or less employees must complete health statements** for each of the enrolling employees. Health statements must also be completed for employees applying for coverage in excess of \$5,000 maximum monthly benefits. Health Statements will be provided, if applicable, upon receipt of your application.

## Participation

Firms of 1 to 3 eligible persons 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 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 LTD Income Protection Enrollment Form**

<b>Administrator Section</b>	Plan	Certificate Effective Date	Account #
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Please complete employer and employee sections below.

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

<b>Employee Section</b>  • Please print all information.  • Sign and date this form below.	Employee's Name: _____ (last) _____ (first) _____ (initial)		Social Security #: _____		
	Home Address: _____ (street) _____ (city) _____ (state) _____ (zip)				
	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: _____
	Job Title: _____		Beneficiary: _____	Relationship: _____	Do you work 30 or more hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No

### 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 \_\_\_\_\_

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 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 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.

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 200 \_\_\_\_\_

Witness **X** \_\_\_\_\_ Signature of Applicant **X** \_\_\_\_\_

All completed Enrollment Forms should be sent by the employer 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