

# A Group Short Term Disability Income Protection Benefit

that pays up to \$500 a week



KELSEY NATIONAL CORPORATION

## With State IIA Endorsed Group Short Term Disability Income Protection, You Get These Important Features

- ✓ Pays up to **\$500** weekly income benefit.
- ✓ **Choice of Plans** so you can select the one that best meets your needs.
- ✓ Confinement is **not** required.
- ✓ Available to IIA firms with **as few as 1** enrolling employee.
- ✓ **Affordable** group rates. You get the **maximum value** for your insurance dollar.
- ✓ **Guaranteed Issue** - you cannot be turned down.
- ✓ **Prompt, individualized service** from IIA Group Insurance Trust administrator Kelsey National Corporation.



## 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 STD Plan That Best Meets Your Needs

## PLAN FEATURES

- \* **Benefit Level**  
Pays 70% of weekly earnings.
- \* **Benefit Duration**  
Duration of benefits is the number of weeks for which an insured can receive short term disability benefits. Choose from:  
**Plan A .....13 weeks**  
**Plan B .....26 weeks**
- \* **Elimination Period**  
The elimination period is a period of consecutive days of total disability for which no benefit is payable. The elimination period begins on the first day of disability.  
  
Benefits begin on the 1st day for accident and on the 8th day for sickness.
- \* **Full Maternity Coverage**  
Loss of work due to disabilities related to pregnancy will be covered on the same basis as sickness.
- \* **Mental and Nervous Provisions**  
Benefits are paid for disabilities resulting from mental and/or nervous conditions for the maximum benefit period for sickness.
- \* **Integration**  
Payment is coordinated with other insurance in the states of California, Hawaii, New Jersey, New York and Rhode Island, wherein benefits will be reduced if State Disability Insurance is paid. In no case shall benefits exceed 70% of regular base pay.  
  
Payment is integrated with any amount the employee receives or is entitled to receive under the mandatory portion of any "no fault" motor vehicle plan.  
  
Payment is integrated with any amount the employee receives or is entitled to receive under any state compulsory benefit act or law and any amount of disability income benefits the employee receives or is entitled to receive under any other group insurance plan.

## PLAN BENEFITS

**PLAN A**

**PLAN B**

<b>Maximum Weekly Benefit</b>	<b>\$500</b>	
<b>% Earnings Payable</b>	<b>70 % of weekly earnings</b>	
<b>Benefit Duration Accident or Sickness</b>	<b>13 weeks</b>	<b>26 weeks</b>
<b>Benefits Begin (Elimination Period)</b>	<b>1st day of accident 8th day of sickness</b>	
<b>Maternity Coverage</b>	<b>Yes (paid as sickness)</b>	
<b>Guaranteed Issue</b>	<b>Yes</b>	

### \* **Continuity of Coverage Upon Transfer of Insurance Carriers**

This feature provides that an employee insured by the prior carrier of your group STD plan will neither lose nor gain coverage solely because of the change in carriers. This protects employees who would otherwise not get full coverage upon changing carriers because of failure to be actively at work on the effective date (due to injury or sickness) or because of a pre-existing condition.

*If an employee is not actively at work:*

An employee insured with the prior carrier who is not actively at work due to injury or sickness on the day the employer switches carriers will be covered on the same basis as he would have been under the prior carrier's plan. The plan will pay the benefits that would have been paid by the prior carrier had coverage remained in force, less any benefits for which the prior carrier is liable.

# GENERAL PLAN INFORMATION

## Eligibility and Enrollment

Available to all firms that are Independent Insurance Agents Association members; all active full-time employees (working 30 hours or more per week).

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

Commission-only employees and independent contractors are also eligible and are included with all other eligible employees for participation requirements providing actual commission combined with any draw against commissions must equal at least 150 hours per month times the minimum wage and the employer verifies full-time status (30 or more hours per week) with the participating firm to Kelsey National Corporation.

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 you return to work.

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

## Participation

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

## Total Disability

Total Disability shall mean the inability of the insured to perform the duties of his occupation, and that the insured is not otherwise gainfully employed for wage or for profit. Total disability requires that the insured be under the regular care and attendance of a legally licensed physician or surgeon. If the insured requires a license in order to perform part or all of the occupational duties, loss of license does not in itself constitute total disability.

## Recurrent Disability

While the policy is in force as to the insured, any recurrent total disability for the same cause – for which the insured received benefits under the plan – will be considered as the same disability and will not require a new elimination period, unless the two periods of disability are separated by more than two weeks of continuous active employment.

## Confinement

Insured need not be confined to a hospital or indoors, or be bedridden in order to receive benefits. Benefits are payable while insured is totally disabled and under the care of a legally licensed physician or surgeon.

## Effective and Termination Date

Coverage will take effect on the first the month following the date that coverage is approved by the Carrier.

Coverage for any individual not at work on the effective date of coverage will take effect on the earlier of the first day of the month following the individual's return to active full-time work.

For new hires, employers may select, at time of application, a 1, 2 or 3 month waiting period before eligibility begins. New employees become eligible on the first day following the waiting period selected by the employer and must apply within 31 days of that date or submit health evidence.

Coverage for an insured employee terminates on the earliest of the following: termination of the Master Group Policy; non-payment of premium; termination of employment or eligibility; on the sixteenth day after the insured enters the Armed Forces of any country or international authority.

## Pre-existing Conditions

Any disability caused by, contributed to or resulting from a pre-existing condition will not be covered unless the individual remains treatment-free for 12 consecutive months. A pre-existing condition is a sickness or injury for which the individual received medical treatment, consultation, care or services including diagnostic measures or took prescribed drugs or medicines within 24 months prior to the effective date of insurance.

Earning increases accumulating 10% or greater in any tax year are also subject to the above pre-existing condition provisions.

## Exclusions

Disabilities not covered include those caused by or resulting from war and any act of war, occupational injury or sickness, (but this exclusion will not apply to a partner or sole proprietor who cannot be covered by law under Workers' or Workmen's Compensation or any similar law), or intentionally self-inflicted injuries, or while in the service of the Armed Forces of any country or international authority or active participation in a riot, or committing or attempting to commit an assault or felony. Pre-existing conditions (see Pre-existing Condition).

## Plan Rates

<i>Monthly rate per \$10 of Weekly Benefits</i>		
Ages	13 Weeks PLAN A 0 - 7 - 13	26 Weeks PLAN B 0 - 7 - 26
0 - 24	\$0.30	\$0.39
25 - 29	0.32	0.41
30 - 34	0.37	0.48
35 - 39	0.46	0.61
40 - 44	0.56	0.74
45 - 49	0.65	0.85
50 - 54	0.84	1.10
55 - 59	1.04	1.37
60 - 64	1.30	1.71
65 - 69	1.58	2.08
70+	1.88	2.47

### How to Calculate Rates

Rates are based on each **\$10** of weekly benefits and are graded according to age.

For example under **PLAN A**, the monthly cost for an employee age 35 with a **\$300 weekly income** would be \$9.66:

$\$300 \times 70\% = \text{\$210 weekly benefit}$

$\text{\$210} \div \$10 = 21$

$21 \times \$ .46 = \text{\$9.66 monthly rate}$

### 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 a brief summary and is subject to the terms, conditions and limitations of the 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.*

### Fiduciary Liability and ERISA Bond

(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 \$100,000 ERISA bond. Automatically issued unless waived on Employer Application.  
(See separate brochure for details.)

# IIA Group Insurance Trust 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 Short Term Disability (STD) plan:

STD Plan A (13 week benefit duration)  STD Plan B (26 week benefit duration)

**YES!** Our firm has chosen the following Waiting Period for new hires:  30 days  60 days  90 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.)  
Fiduciary Liability Coverage and ERISA Bond Option Coverage is underwritten by American International Surplus Lines Insurance Company, an AIG Company.

## Group Short Term Disability Income Protection Plan

Underwritten by The United States Life 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 Association Group Short Term Disability Plan. This form is signed by an Owner, Partner or Corporate Officer.

Signature (Owner, Partner or Corporate Officer) **X** \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_

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# 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 your IIA State Association Group STD 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 have returned 1 employee enrollment form for each eligible full-time employee regardless of whether employee is participating or not.
- YES!** We understand that in **firms of one, a health statement is required**. It will be provided 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.

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 STD Income Protection Insurance Enrollment Form**

Underwritten by The United States Life Insurance Company

<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 card below.	Employee's Name: (last) (first) (initial)		Social Security #:		
	Home Address: (street) (city) (state) (zip)				
	Email:				
	Date of Birth: (Mo. Day Year)	Age:	Date Employed Full Time: (Mo. Day Year)	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.

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

Dated this \_\_\_\_\_

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

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