

Voluntary Group Long Term Disability Insurance

COVERAGE

Disability income protection insurance provides a benefit for "long term" disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration. (See Certificate)

ELIGIBILITY (See Certificate)

Each Active, Full-time employee working 30 or more hours per week, and earning an annual salary of at least \$15,000, except any person working on a temporary or seasonal basis. If you become unemployed for more than 60 days, you are no longer eligible for the plan and premium payment should be discontinued.

BENEFIT AMOUNT

You may elect a monthly benefit in increments of \$100, from a minimum of \$500 up to a maximum benefit of \$7,500 per month, not to exceed 60% of your covered earnings (rounded to the next lower increment).

ELIMINATION PERIOD (See Certificate)

180 consecutive days of total disability

MAXIMUM BENEFIT DURATION (See Certificate)

Benefits will not extend beyond the longer of: Social Security Normal Retirement Age or Duration of Benefits (see Certificate).

LIMITATIONS (See Reliance Standard Certificate)

- Mental/Nervous Illness Limitation – 24 Months out-patient, see Certificate
 - Offsets (such as, but not limited to, Social Security, Workers Compensation, State Disability Plans, See certificate)
 - Pre-Existing Condition Limitation, see Certificate
 - Substance Abuse Limitation – 24 Months
- Please note- pre-ex limitations also apply to benefit Increases, see Certificate

EXCLUSIONS (See Certificate)

Benefits will not be payable for any disability caused by: an intentionally self-inflicted injury; an act of war (declared or undeclared); commission of a felony; injury or sickness occurring while confined in any penal or correctional institution. For a comprehensive list of exclusions, limitations, and any applicable benefit offsets, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

This Plan Highlights is a brief description of the key features of the RSL insurance plan. The availability of the benefits and features described may vary by state. It is not a certificate of insurance or evidence of coverage.

Insurance is provided under group policy form LRS-6564,

If your Annual Base SALARY is this amount

Your monthly BENEFIT would be this

And your monthly PREMIUM

<u>Annual Base Salary</u>	<u>Monthly Benefit</u>	<u>Monthly Premium</u>	<u>Annual Base Salary</u>	<u>Monthly Benefit</u>	<u>Monthly Premium</u>
\$10,000	\$500	\$14.40	\$82,000	\$4,100	\$82.08
\$12,000	\$600	\$16.28	\$84,000	\$4,200	\$83.96
\$14,000	\$700	\$18.16	\$86,000	\$4,300	\$85.84
\$16,000	\$800	\$20.04	\$88,000	\$4,400	\$87.72
\$18,000	\$900	\$21.92	\$90,000	\$4,500	\$89.60
\$20,000	\$1,000	\$23.80	\$92,000	\$4,600	\$91.48
\$22,000	\$1,100	\$25.68	\$94,000	\$4,700	\$93.36
\$24,000	\$1,200	\$27.56	\$96,000	\$4,800	\$95.24
\$26,000	\$1,300	\$29.44	\$98,000	\$4,900	\$97.12
\$28,000	\$1,400	\$31.32	\$100,000	\$5,000	\$99.00
\$30,000	\$1,500	\$33.20	\$102,000	\$5,100	\$100.88
\$32,000	\$1,600	\$35.08	\$104,000	\$5,200	\$102.76
\$34,000	\$1,700	\$36.96	\$106,000	\$5,300	\$104.64
\$36,000	\$1,800	\$38.84	\$108,000	\$5,400	\$106.52
\$38,000	\$1,900	\$40.72	\$110,000	\$5,500	\$108.40
\$40,000	\$2,000	\$42.60	\$112,000	\$5,600	\$110.28
\$42,000	\$2,100	\$44.48	\$114,000	\$5,700	\$112.16
\$44,000	\$2,200	\$46.36	\$116,000	\$5,800	\$114.04
\$46,000	\$2,300	\$48.24	\$118,000	\$5,900	\$115.92
\$48,000	\$2,400	\$50.12	\$120,000	\$6,000	\$117.80
\$50,000	\$2,500	\$52.00	\$122,000	\$6,100	\$119.68
\$52,000	\$2,600	\$53.88	\$124,000	\$6,200	\$121.56
\$54,000	\$2,700	\$55.76	\$126,000	\$6,300	\$123.44
\$56,000	\$2,800	\$57.64	\$128,000	\$6,400	\$125.32
\$58,000	\$2,900	\$59.52	\$130,000	\$6,500	\$127.20
\$60,000	\$3,000	\$61.40	\$132,000	\$6,600	\$129.08
\$62,000	\$3,100	\$63.28	\$134,000	\$6,700	\$130.96
\$64,000	\$3,200	\$65.16	\$136,000	\$6,800	\$132.84
\$66,000	\$3,300	\$67.04	\$138,000	\$6,900	\$134.72
\$68,000	\$3,400	\$68.92	\$140,000	\$7,000	\$136.60
\$70,000	\$3,500	\$70.80	\$142,000	\$7,100	\$138.48
\$72,000	\$3,600	\$72.68	\$144,000	\$7,200	\$140.36
\$74,000	\$3,700	\$74.56	\$146,000	\$7,300	\$142.24
\$76,000	\$3,800	\$76.44	\$148,000	\$7,400	\$144.12
\$78,000	\$3,900	\$78.32	\$150,000	\$7,500	\$146.00
\$80,000	\$4,000	\$80.20			

Premium is paid monthly by bank draft only.

Long Term Disability

Income Protection

When you suffer a serious injury or illness, your life changes in an instant.

You might feel overwhelmed, and unsure how you will provide for yourself or family, and for how long?

How will you make it to retirement?

IBEW Local Unions developed this affordable LTD plan for IBEW members only. The premium is about 1% of your salary. Locate your annual salary in the center of this brochure to find your premium .

The plan provides members income replacement for a covered injury, accident or illness, on or off the job, that pays you up to 60% of your base salary, tax free, up to age 65 or normal retirement.

Complete the application on reverse side and return to Union office .

Brought to you by:



**Reliance Standard Life Insurance Company
Enrollment and Statement of Health**

COMPLETE ONLY AREAS HIGHLIGHTED

IBEW #			
Policy # and Class #			
VP_L302251 / 1			

Application Type: Initial Eligibility/New Hire

Employee/Member Information – Always Complete

Name		Social Security Number		N/A
Gender		Date of Birth	Age	State of Birth
				N/A
Address	N/A	City	N/A	State
				N/A
Phone Number	N/A	Occupation	Annual Compensation	Hours Worked Per Week
Email Address	N/A			

Are you actively performing all the duties of your occupation or profession? Yes No

If "No," explain: _____

Coverage Elected and Amounts

Coverage	Enroll or Decline	Current Amount	Increase or Decrease	Total Amount Applied For	Premium
Voluntary LTD: Employee	<input checked="" type="checkbox"/> Enroll <input type="checkbox"/> Decline			\$ _____ per Month	See Premium Table

Read, Sign and Date Below

- I understand and agree that:
 - The information provided on this Enrollment and Statement of Health form is true and correct to the best of my knowledge.
 - The insurance requested will become effective in accordance with the individual effective date information in the Policy; any amount subject to evidence of insurability will not become effective until approved by Reliance Standard and Reliance Standard has the right to refuse my request. Coverage is subject to a minimum participation requirement at the employer level and if the minimum is not met, coverage may not be issued even though an enrollment form has been completed. An effective date is subject to eligibility requirements, satisfaction of service waiting period (if applicable) and payment of first premium when due. An effective date may be deferred for an employee not actively at work and enrolled dependents confined to a hospital or at home.
 - Benefits are subject to terms and conditions of the Policy.
 - For age-banded rate plans, premiums increase as an employee moves from one age band to the next.
 - If payroll deduction of premiums begins prior to Reliance Standard's processing of the enrollment form, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned.

I further understand and agree that if I am applying after the expiration of my initial eligibility period, all medical tests and costs for attending physician reports may be without expense to Reliance Standard Life Insurance Company and I may be responsible for paying the expenses, if any.

I acknowledge receipt of "Important Information Regarding Applications for Insurance".

Please Note: During an approved enrollment, guaranteed issue amounts of insurance will not require a Statement of Health form provided the Enrollment form is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to insurance for yourself; or b) during your present service with your employer or an affiliate, you have not with respect to insurance with Reliance Standard had an application withdrawn, been previously declined, had coverage postponed, or voluntarily terminated within the past 5 years; or c) the enrollment period is not one with specific guaranteed issue/health acceptability rules.

<input checked="" type="checkbox"/>	Employee's Signature	Date
	(required at all times)	

ACH Recurring Payment Authorization Form Schedule your payment to be automatically deducted from your checking or savings account. Just complete and sign this form to get started!

Please complete the information below:

I, _____ (full name) authorize Sagebrush Insurance Services, Inc. to charge my bank account indicated below on the 1st of each month for payment of my insurance premium.

Billing Address _____ Phone# _____
 City, State, Zip _____ Email _____

Account Type: Checking Savings


Name on Acct _____

Bank Name _____

Bank Routing # _____

Account Number _____

Bank City/State _____



SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Sagebrush Insurance Services, Inc., in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted periodic payment dates fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF), I understand that Sagebrush Insurance Services, Inc. may at its discretion attempt to process the charge again within 30 days and agree to an additional \$10.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I agree not to dispute this recurring billing with my bank so long as the transactions correspond to the terms indicated in this authorization form.

MUST RETURN THIS FORM TO UNION HALL

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