

SERFF Tracking Number: SLIA-127086932 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number: 48318
Company Tracking Number:
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
Product Name: Premier Choice - STD
Project Name/Number: /

Filing at a Glance

Company: Security Life Insurance Company of America

Product Name: Premier Choice - STD SERFF Tr Num: SLIA-127086932 State: Arkansas
TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved- State Tr Num: 48318
Closed

Sub-TOI: H11G.002 Short Term Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor
Author: Stacy Patacsil Disposition Date: 03/24/2011
Date Submitted: 03/23/2011 Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Group Market Type: Employer Overall Rate Impact:
Filing Status Changed: 03/24/2011
State Status Changed: 03/24/2011 Deemer Date:
Created By: Stacy Patacsil Submitted By: Stacy Patacsil
Corresponding Filing Tracking Number:

Filing Description:

The following forms are being submitted for your review and approval. These are new forms.

ELHERAPPSTD2-9.2010 – Short Term Disability Insurance 2 to 9 Product Addendum
ELHERAPPSTD.2010 – Short Term Disability Insurance 10+ Product Addendum
ELHERAPPVOLSTD.2010 – Voluntary Short Term Disability Insurance Product Addendum
ELHERAPPSTDCORE/BUYUP.2010 – Short Term Disability Insurance Core/Buy-Up Product Addendum

GP2010SSB - STD Schedule of Benefits

GP2010SBP - STD Benefit Provisions

SERFF Tracking Number: SLIA-127086932 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number: 48318
Company Tracking Number:
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
Product Name: Premier Choice - STD
Project Name/Number: /

GP2010VSSB - Voluntary STD Schedule of Benefits
GP2010VSBP - Voluntary STD Benefit Provisions

The Application consists of:

- Group Application (ERAPP.2010 – approved - SLIA-127053875)
- Applicable Addenda
- Enrollment forms for all eligible employees enrolling for coverage (GB207.2010 – approved - SLIA-127053875)
- Evidence of Insurability Form, when applicable (GB215.2010 – approved - SLIA-127053875)

The Policy issued to the employer will include:

- Application
- Employer Acceptance Application (GP2010APP-AR - approved - SLIA-127053875)
- Master Policy (GP2010MP – approved - SLIA-127053875)
- Master Certificate (GP2010MC – approved - SLIA-127053875)
- Summary of Benefits and Benefit Provisions for each applicable coverage

Certificates issued to employees are comprised:

- Master Certificate
- Summary of Benefits and Benefit Provisions for each applicable coverage

The enclosed group forms provide employer-employee group insurance coverage through policies issued to employers in your state. Policies are sold by licensed agents and brokers to groups.

The coverage provided includes Short Term Disability benefits on a voluntary and non-voluntary basis.

Please note that the Schedule of Benefits and any bracketed text is intended to be variable and is customized for each group policyholder.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Company and Contact

Filing Contact Information

Stacy Patacsil, spatacsil@securitylife.com
25 Race Ave 888-654-7100 [Phone] 5718 [Ext]
Lancaster, PA 17608

SERFF Tracking Number: SLIA-127086932 State: Arkansas
 Filing Company: Security Life Insurance Company of America State Tracking Number: 48318
 Company Tracking Number:
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
 Product Name: Premier Choice - STD
 Project Name/Number: /

Filing Company Information

Security Life Insurance Company of America CoCode: 68721 State of Domicile: Minnesota
 10901 Red Circle Drive Group Code: 492 Company Type: Life, Accident & Health
 Minnetonka, MN 55343-9137 Group Name: State ID Number:
 (952) 544-2121 ext. 3589[Phone] FEIN Number: 41-0808596

Filing Fees

Fee Required? Yes
 Fee Amount: \$400.00
 Retaliatory? No
 Fee Explanation: \$50.00 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Security Life Insurance Company of America	\$400.00	03/23/2011	45895912

SERFF Tracking Number: SLIA-127086932 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number: 48318
Company Tracking Number:
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
Product Name: Premier Choice - STD
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/24/2011	03/24/2011

SERFF Tracking Number: SLIA-127086932 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number: 48318
Company Tracking Number:
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
Product Name: Premier Choice - STD
Project Name/Number: /

Disposition

Disposition Date: 03/24/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: SLIA-127086932 State: Arkansas
 Filing Company: Security Life Insurance Company of America State Tracking Number: 48318
 Company Tracking Number:
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
 Product Name: Premier Choice - STD
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum	Approved-Closed	No
Form	STD 2-9 Product Addendum	Approved-Closed	Yes
Form	STD Product Addendum	Approved-Closed	Yes
Form	Voluntary STD Product Addendum	Approved-Closed	Yes
Form	STD Core/BuyUp Product Addendum	Approved-Closed	Yes
Form	STD Schedule of Benefits	Approved-Closed	Yes
Form	STD Benefit Provisions	Approved-Closed	Yes
Form	Voluntary STD Schedule of Benefits	Approved-Closed	Yes
Form	Voluntary STD Benefit Provisions	Approved-Closed	Yes

SERFF Tracking Number: SLIA-127086932 State: Arkansas
 Filing Company: Security Life Insurance Company of America State Tracking Number: 48318
 Company Tracking Number:
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
 Product Name: Premier Choice - STD
 Project Name/Number: /

Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	ELHERAP PSTD2-03/24/2011	Application/STD 2-9 Product Enrollment Form	Form	Initial		0.000	ELHERAPPS TD2-9.2010.pdf
Approved-Closed	ELHERAP PSTD.2010-03/24/2011	Application/STD Product Enrollment Form	Form	Initial		0.000	ELHERAPPS TD.2010.pdf
Approved-Closed	ELHERAP PVOLSTD.03/24/2011	Application/Voluntary STD Enrollment Form	Product Addendum	Initial		0.000	ELHERAPPV OLSTD.2010.pdf
Approved-Closed	ELHERAP PSTDCOR-03/24/2011	Application/STD Core/BuyUp Enrollment Form	Product Addendum	Initial		0.000	ELHERAPPS TDCOREBuy UP.2010.pdf
Approved-Closed	GP2010SS B-03/24/2011	Schedule Pages	STD Schedule of Benefits	Initial		0.000	GP2010SSB.pdf
Approved-Closed	GP2010SB P-03/24/2011	Certificate	STD Benefit Provisions	Initial		0.000	GP2010SBP.pdf
Approved-Closed	GP2010VS SB-03/24/2011	Schedule Pages	Voluntary STD Schedule of Benefits	Initial		0.000	GP2010VSSB.pdf
Approved-Closed	GP2010VS BP-03/24/2011	Certificate	Voluntary STD Benefit Provisions	Initial		0.000	GP2010VSBP.pdf

**Security Life Insurance Company of America
Short Term Disability Insurance 2 to 9 Addendum**

Group Information	
Name of Employer:	Requested Effective Date:
Number of Eligible Employees:	Number of Employees Enrolling:
<p>Do you currently have Group Short Term Disability Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If "Yes," list current carrier and attach a copy of the certificate and the latest billing statement.</p> <p>Current Carrier:</p>	
<p>Will this coverage applied for replace the current coverage, if any? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "No," provide explanation:</p>	
<p>W-2 preparation for Third Party Sick Pay Benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Tax ID # is required:</p>	

Coverage Information	
Class Description:	Weekly Work Hours Required for Eligibility (min. 30 hours):
<p>Does Employee Contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes," Amount EMPLOYEE Contributes: _____% If employee contributes, premiums are paid on:</p> <p style="padding-left: 100px;"><input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis</p>	
<p>Eligibility Waiting Period (minimum 30 days):</p> <p><input type="checkbox"/> _____ days from date of hire <input type="checkbox"/> First of month following _____ days from date of hire</p>	

Plan Information
<p>Benefit Amount:</p> <p><input type="checkbox"/> _____% of weekly earnings* to a maximum of \$_____ per week</p> <p><input type="checkbox"/> Flat \$_____ not to exceed 66 2/3% of weekly earnings*</p> <p><small>*excludes commissions, bonuses, overtime and other extra compensation</small></p>
<p>Frequency of Benefit Payments: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly</p>
<p>Elimination Period (benefits begin on): Injury: Day _____ Illness: Day _____</p>
<p>Benefit Duration: <input type="checkbox"/> 13 weeks <input type="checkbox"/> 26 weeks</p>
<p>Pre-Existing Condition Limitation: Included</p>
<p>Work Incentive Benefit: <input type="checkbox"/> Included <input type="checkbox"/> Not Included</p>

Short Term Disability Insurance 2 to 9 Product Addendum

Actively at Work — Employee Information

Are there any employees who, on the date this application is signed, have been out of work for at least 5 consecutive working days? Yes No

If Yes, give details below.

Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence

If more space is needed, attach a separate sheet signed and dated by the Applicant.

To the best of the employer's knowledge, during the past 12 months, has any employee incurred medical expenses that exceeded \$10,000? Yes No

If Yes, give details below.

Name of Employee	Approximate Amount of Medical Expenses Incurred	Describe Nature of Injury/Illness

If more space is needed, attach a separate sheet signed and dated by the Applicant.

Declaration

I understand that partial disability and residual disability benefits are not included.

To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.

Signature of Officer or Owner

Date

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

**Security Life Insurance Company of America
Short Term Disability Insurance 10+ Product Addendum**

Group Information	
Name of Employer:	Requested Effective Date:
Number of Eligible Employees:	Number of Employees Enrolling:
Do you currently have Group Short Term Disability Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes Current Carrier: <small>(If yes, attach a copy of the certificate and the latest billing statement.)</small>	
W-2 preparation for Third Party Sick Pay Benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>If Yes, Tax ID # is required:</small>	

Coverage Information	
Class A	Class B
Class Description:	Class Description:
Weekly Work Hours Required for Eligibility: _____	Weekly Work Hours Required for Eligibility: _____
Does Employee Contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does Employee Contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," Amount EMPLOYEE Contributes: _____ %	If "Yes," Amount EMPLOYEE Contributes: _____ %
If employee contributes, premiums are paid on: <input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis	If employee contributes, premiums are paid on: <input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis
Eligibility Waiting Period:	Eligibility Waiting Period:
<input type="checkbox"/> _____ days from date of hire	<input type="checkbox"/> _____ days from date of hire
<input type="checkbox"/> First of month following _____ days from date of hire	<input type="checkbox"/> First of month following _____ days from date of hire

Plan Information	
Class A	Class B
Benefit Amount:	Benefit Amount:
<input type="checkbox"/> _____ % to a maximum of \$ _____ per week	<input type="checkbox"/> _____ % to a maximum of \$ _____ per week
<input type="checkbox"/> Flat \$ _____ not to exceed 66 ² / ₃ % of weekly earnings	<input type="checkbox"/> Flat \$ _____ not to exceed 66 ² / ₃ % of weekly earnings
Frequency of Benefit Payments:	Frequency of Benefit Payments:
<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly
Weekly Earnings Definition:	Weekly Earnings Definition:
<input type="checkbox"/> Base Weekly Earnings	<input type="checkbox"/> Base Weekly Earnings
<input type="checkbox"/> Base Weekly Earnings plus averaged commissions	<input type="checkbox"/> Base Weekly Earnings plus averaged commissions
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
Elimination Period: (benefits begin on)	Elimination Period: (benefits begin on)
Injury: Day _____ Illness: Day _____	Injury: Day _____ Illness: Day _____
1st Day Hospital Benefit: <input type="checkbox"/> Included <input type="checkbox"/> Not Included	1st Day Hospital Benefit: <input type="checkbox"/> Included <input type="checkbox"/> Not Included
Benefit Duration: <input type="checkbox"/> 13 weeks <input type="checkbox"/> 26 weeks	Benefit Duration: <input type="checkbox"/> 13 weeks <input type="checkbox"/> 26 weeks
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Short Term Disability Insurance 10+ Product Addendum

Plan Information (Continued)		
Pre-Existing Condition Limitation:	<input type="checkbox"/> Not Included	<input type="checkbox"/> Included for all
	<input type="checkbox"/> New Hires Only	<input type="checkbox"/> Late Enrollees Only
	<input type="checkbox"/> Late Enrollees/New Hires Only	
Additional Benefit Options:		
Recovery Expense Benefit	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
Accidental Dismemberment and Loss of Sight Benefit	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
Survivor Benefit	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included
Work Incentive Benefit	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included

Actively at Work — Employee Information		
Are there any employees who, on the date this application is signed, have been out of work for at least 5 consecutive working days? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, give details below.		
Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence
If more space is needed, attach a separate sheet signed and dated by the Applicant.		

Declaration	
To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.	
_____	_____
Signature of Officer or Owner	Date

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

Voluntary Short Term Disability Insurance 10+ Product Addendum

Actively at Work — Employee Information

Are there any employees who, on the date this application is signed, have been out of work for at least 5 consecutive working days? Yes No

If Yes, give details below.

Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence

If more space is needed, attach a separate sheet signed and dated by the Applicant.

Declaration

To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.

Signature of Officer or Owner

Date

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

**Security Life Insurance Company of America
Short Term Disability Insurance Core/Buy-up Product Addendum**

Group Information	
Name of Employer:	Requested Effective Date:
Number of Eligible Employees:	Number of Employees Enrolling:
Do you currently have Group Short Term Disability Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes Current Carrier: <small>(If yes, attach a copy of the certificate and the latest billing statement.)</small>	
W-2 preparation for Third Party Sick Pay Benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>If Yes, Tax ID # is required:</small>	

Coverage Information	
Class Description:	Weekly Work Hours Required for Eligibility: _____
Eligibility Waiting Period: <input type="checkbox"/> _____ days from date of hire <input type="checkbox"/> First of month following _____ days from date of hire	
CORE Plan: EMPLOYER Contributes: 100%	
OPTIONAL (Buy-up) Plan: EMPLOYEE Contributes: 100% Premiums are paid on: <input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis	

Plan Information	
CORE Benefit Amount: <input type="checkbox"/> _____% to a maximum of \$_____ per week <input type="checkbox"/> Flat \$_____ per week, not to exceed the benefit percentage elected in the optional benefit amount.	
OPTIONAL (Buy-up) Benefit Amount: <input type="checkbox"/> _____% to a maximum of \$_____ per week, minus the core benefit amount.	
Frequency of Benefit Payments: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly	
Weekly Earnings Definition: <input type="checkbox"/> Base Weekly Earnings <input type="checkbox"/> Base Weekly Earnings plus averaged commissions <input type="checkbox"/> Other _____	
Elimination Period: (benefits begin on) Injury: Day _____ Illness: Day _____	
1st Day Hospital Benefit: <input type="checkbox"/> Included <input type="checkbox"/> Not Included	
Benefit Duration: <input type="checkbox"/> 13 weeks <input type="checkbox"/> 26 weeks <input type="checkbox"/> Other _____	

Short Term Disability Insurance Core/Buy-up Product Addendum

Plan Information (Continued)	
Pre-Existing Condition Limitation:	<input type="checkbox"/> Not Included <input type="checkbox"/> Included for all <input type="checkbox"/> Late Enrollees Only <input type="checkbox"/> New Hires Only <input type="checkbox"/> Late Enrollees/New Hires Only
Additional Benefit Options:	
Recovery Expense Benefit	<input type="checkbox"/> Included <input type="checkbox"/> Not Included
Accidental Dismemberment and Loss of Sight Benefit	<input type="checkbox"/> Included <input type="checkbox"/> Not Included
Survivor Benefit	<input type="checkbox"/> Included <input type="checkbox"/> Not Included
Work Incentive Benefit	<input type="checkbox"/> Included <input type="checkbox"/> Not Included

Actively at Work — Employee Information		
Are there any employees who, on the date this application is signed, have been out of work for at least 5 consecutive working days? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, give details below.		
Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence
If more space is needed, attach a separate sheet signed and dated by the Applicant.		

Declaration	
To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.	
_____	_____
Signature of Officer or Owner	Date

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

Short Term Disability Insurance

Schedule of Benefits

Eligible Class	[Class A] – [All Employees]
Coverage Effective Date	[06/01/2010]
Plan Effective Date	[06/01/2010]
Open Enrollment Period	[Not Available][October 1 – October 31]
Work Hours Required for Eligibility	Your regularly scheduled work hours must be at least [30] hours per week.
Waiting Period	<p>For your coverage: [90] [days] [months]</p> <p>[Coverage will become effective on the first day of the month following the waiting period if all other requirements for coverage to become effective are satisfied.]</p> <p>[There will be no waiting period for employees who are Actively at Work and are part of the initial enrollment.]</p>
Your Premium Contribution	You are [not] required to contribute towards the cost of your coverage . [You are required to contribute towards the cost of your Optional Weekly Benefit Amount.]
Your Weekly Benefit Amount	<p>[Your [Core] Weekly Benefit Amount will be equal to the lesser of:</p> <ol style="list-style-type: none">1. [66 2/3%] of your weekly earnings[, rounded to the nearest dollar]; or2. [\$750] maximum weekly benefit, <p>minus any income listed in Benefit Reductions.]</p> <p>[Your [Core] Weekly Benefit Amount will be equal to [\$250] not to exceed [66 2/3%] of your weekly earnings minus any income listed in Benefit Reductions.]</p> <p>[Your Weekly Benefit Amount is available in increments of [\$50,] [up to \$700], and cannot exceed [66 2/3%] of your weekly earnings when combined with your employer sponsored benefit.</p> <p>Your Weekly Benefit Amount will be reduced by any income listed in Benefit Reductions.]</p>

Short Term Disability Insurance

Schedule of Benefits

[Your optional Weekly Benefit Amount, if **you** enrolled, will be equal to the lesser of:

1. [80%] of **your weekly earnings**[, rounded to the nearest dollar]; or
2. [\$900] maximum weekly benefit,

minus **your** Core Weekly Benefit Amount and any income listed in Benefit Reductions.]

[Your optional Weekly Benefit Amount, if **you** enrolled, is [\$500] not to exceed [66 2/3%] of **your weekly earnings**, minus **your** Core Weekly Benefit Amount and any income listed in the Benefit Reductions.]

[Your minimum weekly benefit will be [\$25].]

[Weekly Benefit Amounts in excess of [\$500] will be subject to **our** approval of **your evidence of insurability**.]

Frequency of Benefit Payments

[weekly]

Elimination Period

Benefits will begin after [the later of:]

1. [0 days] of [**partial disability** or] **total disability** when due to an **injury**.
2. [7 days] of [**partial disability** or] **total disability** when due to an **illness**.
3. [[0 days] when **you** are confined in a hospital for 24 or more hours.]
4. [the end of **your** accumulated sick leave with the **covered employer**.]

Maximum Benefit Period

[52] weeks for any period of disability.

Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence

[Temporary Layoff – Up to the end of the month that immediately follows the month in which **your** temporary layoff begins.]

Injury or Illness – Up to [3] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act.).

Other Leave of Absence – Up to [2] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act).

Partial Disability Benefit

[Included.] [Not Included.]

Short Term Disability Insurance

Schedule of Benefits

Residual Disability Benefit	[Included. The elimination period can be satisfied with days of partial or total disability .] [Not Included.]
Maternity Coverage	[Both normal pregnancy and complications of pregnancy are covered.] [Only complications of pregnancy (and not normal pregnancy) are covered.]
[Survivor Benefit	Included.]
[Minimum Indemnity for Accidental Dismemberment and Loss of Sight	Included.]
[Reasonable Accommodation Expense Benefit	Included.]
[Recovery Expense Benefit	Included.]
Pre-Existing Condition Limitation	[Included.] [Not Included.] [Included for Late Enrollment .] [Included for employee's hired after the Plan Effective Date]
Work Related Injuries and Illnesses	This policy does not cover an injury or illness that arises in the course of employment for wage or profit for which benefits are paid or payable by Workers' Compensation or similar laws, except for those of an owner or officer who is not covered under or who has opted out of Workers' Compensation if we have agreed in writing to provide this exception.

Appropriate Care

You:

1. regularly visit a **physician** as frequently as medically required according to standard medical practice to effectively treat and manage **your** disabling condition(s);
 2. receive care or **treatment** appropriate for the disabling condition(s), conforming with standard medical practice, by a **physician** whose specialty or experience is most appropriate for the disabling condition(s) according to standard medical practice; and
 3. have the obligation to minimize **your** disabling condition including corrective **treatment** or minor surgery.
-

Disability, Disabled

Total Disability [or **Partial Disability**] and **Totally Disabled** [or **Partially Disabled**].

Disability Earnings

The earnings which **you** receive while **you** are **disabled** and working, plus the earnings **you** could receive if **you** were working to **your maximum capacity**.

[Eligible Survivor

Your spouse, if living; otherwise **your** children under age 25. Any payment due **your** children will be paid in equal shares. Payment may be made to a person named by **us** to receive the payment on **your** children's behalf. This payment will be valid against all claims by others representing or claiming to represent the children.]

Elimination Period

The initial number of consecutive days of a **period of disability** for which no benefit is payable under the **policy**.

We will count only those days **you** are **totally disabled** to satisfy the **elimination period**. If a Residual Disability Benefit is included as shown in the Schedule of Benefits, **we** will also include those days that **you** are **partially disabled**. If **you** return to work full-time for no more than [14] calendar days during the **elimination period**, **we** will treat the **disability** as continuous. The Elimination Period is shown in the Schedule of Benefits.

Evidence of Insurability

A statement of **your** medical history and evidence of good health which **we** will use to determine if **you** are approved for **coverage**.

Evidence of insurability will be provided at **your** expense.

Gross Weekly Benefit

Your benefit before adjustments for Benefit Reductions and **disability earnings**.

Short Term Disability Insurance

Defined Terms

Illness

Your medically determinable sickness or disease. [**Coverage** for normal pregnancy is included if this is indicated in the Schedule of Benefits.]

Disability resulting from **illness** must begin while **you** are covered under the **policy**.

Injury

Your medically determinable bodily impairment caused by and resulting directly from an accident, and independent of all other causes.

Injury which occurs before **you** are covered under the **policy** will be treated as an **illness**. **Disability** must begin while **you** are covered under the **policy**.

Late Enrollment

You enroll for **coverage** more than 31 days after the date **you** initially become eligible for **coverage**.

Material and Substantial Duties

Duties that:

1. are normally required for the performance of **your regular occupation**; and
2. cannot be reasonably omitted or modified, except that if **you** are required to work an average in excess of 40 hours per week, **we** will consider **you** able to perform that requirement if **you** are working and have the capacity to work 40 hours per week.

Maximum Capacity

The greatest extent of work **you** are able to do in **your regular occupation** based on **your** restrictions and limitations.

Net Weekly Benefit

Your benefit after all adjustments, including but not limited to, Benefit Reductions and **disability earnings**.

New Coverage

New coverage is either:

1. a newly acquired **coverage** under the **policy**; or
2. an increase in the amount of an in force **coverage**, including any increase in **coverage** due to an increase in **weekly earnings** of 10% or more.

[Partial Disability, Partially Disabled

While receiving **appropriate care** because of a medically determinable **injury** or **illness**;

1. **you** are performing or able to perform at least one, but not all, of the **material and substantial duties** of **your regular occupation** or another occupation on a full-time basis or at least one of these duties on a part-time basis, and

Short Term Disability Insurance

Defined Terms

2. **your disability earnings** are less than 80% of **your weekly earnings** due to the same **injury** or **illness**.

Period of Disability

The entire time that **you** are **[partially disabled or] totally disabled**.

Any **period of disability** resulting from one or more causes will be considered a single **period of disability**.

Physician

A person who:

1. is licensed to practice medicine and prescribe and administer drugs or to perform surgery and is operating within the scope of his or her license; or
2. is legally qualified as a medical practitioner and required to be recognized by the insurance laws of the governing jurisdiction.

A **physician** may not be a member of **your** family. Members of **your** family include **your** parents, step-parents, including in-laws, spouse or former spouse, [domestic partner,] children, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents, and guardians.

Pre-Existing Condition

Any **injury** or **illness** for which **you** have received **treatment**[,or for which an ordinarily prudent person would have received **treatment**,] at any time within the [3 months] immediately prior to the date **your coverage** or any **new coverage** became effective[,whether or not that condition is diagnosed at all or is misdiagnosed during that period of time stated in the **policy**].

[Reasonable Accommodation

Modifications or changes in **your** work environment or in a way a job is performed which allows **you** to perform the **material and substantial duties** of **your** job.]

Recurrent Disability

A **[partial disability or] total disability** that resulted from the same or a related **injury** or **illness** as a prior **[partial disability or] total disability** for which a benefit was payable under the **policy**.

Regular Occupation

The occupation **you** are routinely performing when **your disability** begins. **We** will look at **your** occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

Short Term Disability Insurance

Defined Terms

Total Disability, Totally Disabled

While receiving **appropriate care** because of a medically determinable **injury** or **illness; you**

1. are unable to perform the **material and substantial duties** of your **regular occupation**; and
2. are not being paid for performing any work or service.

You will not be considered **totally disabled** from work in an occupation solely because of the loss, suspension, restriction, surrender, or failure to maintain a required license or certification to engage in the occupation.

Treatment

Includes:

1. consulting with or receiving advice from a **physician**;
2. receiving care or services from a **physician** or from other medical professionals a **physician** recommends **you** see;
3. being prescribed medicines, whether or not **you** choose to take them;
4. refilling prescribed medicines; or
5. receiving diagnostic measures or services.

Weekly Earnings

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions calculated as the weekly average of **your** gross annual earnings prior to the date **your disability** began, but excluding commissions, bonuses, overtime pay and other extra compensation.]

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions calculated as the weekly average of **your** gross annual earnings including commissions averaged over the [24] month period (or the number of months worked if that period is less than [24] months) prior to the date **your disability** began, but excluding bonuses, overtime pay and other extra compensation.]

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions calculated as the weekly average of **your** gross annual earnings including commissions and bonuses averaged over the [24] month period (or the number of months worked if that period is less than [24] months) prior to the date **your disability** began, but excluding overtime pay and other extra compensation.]

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions calculated as the weekly average of **your** gross annual earnings including bonuses averaged over the [24] month period (or the number of months worked if that period is less than [24] months) prior to the date **your disability** began, but excluding commissions, overtime pay and other extra compensation.]

[**Your** gross earnings from the **covered employer** as shown on **your** W-2 from the **covered employer** for the preceding **calendar year**, divided by the lesser of: (a) 52; or (b) the number of weeks worked.]

[For 1099 income, **your** average earnings from the **covered employer** as reported on the 1099-Misc of **your** federal income tax return filed for the preceding **calendar year** or tax year. If **you** did not file a 1099-Misc for the preceding **calendar year** or tax year, **we** will average **your** earnings over the number of weeks worked.]

For partners, **your** average earnings from the partnership calculated from the "net earnings from self-employment" section on Schedule K-1 of **your** federal income tax return filed for the preceding **calendar year** or tax year. If **you** did not file a Schedule K-1 for the preceding **calendar year** or tax year, **we** will average **your** earnings over the number of weeks worked.

For sole proprietors, **your** weekly net profit as shown on **your** Form 1040-C for the preceding **calendar year** or tax year excluding depreciation and expenses for business use of **your** home. If **you** did not file a Form 1040-C for the preceding **calendar year** or tax year, **we** will average **your** earnings over the number of weeks worked.

For shareholders of an S Corporation, **your** average earnings as an insured shareholder based on:

1. the "Wages, Tips and Other Compensation" of **your** Form W-2 and including compensation deferral reported on **your** Form W-2 received from the **covered employer**:
 - a. for the **calendar year** immediately prior to **your** date of **disability**; or
 - b. for the period of employment with the **covered employer** if **you** did not receive a W-2 Form prior to the date of **your disability**; and
2. **your** ordinary income or loss from trade or business activities from Schedule K-1 of **your** federal income tax return from the **covered employer** for the year immediately prior to **your** date of **disability**.

If **you** have not been a shareholder for the year for which the most recent S Corporation federal income tax return was filed, **your weekly earnings** will be based on the period of actual employment during which **you** were a shareholder.

Weekly earnings does not include income received from sources other than as a shareholder of the **covered employer**.

Short Term Disability Coverage

Effective Date of your Short Term Disability Coverage

If **your covered employer** pays 100% of the cost of **your coverage** under the **policy**, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the date **you** are eligible for **coverage**.

If **you** and **your covered employer** share the cost of **your coverage** under the **policy** or if **you** pay 100% of the cost, **your coverage** or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement; and
4. the Evidence of Insurability Requirement, if applicable.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the later of:

1. the date **you** are eligible for **coverage** or any **new coverage**, if **you** enroll on or before that date or within 31 days after **your eligibility date**; or
2. the date **we** approve **your** evidence of insurability, if applicable.

Increases or decreases in **your** Weekly Benefit Amount due to changes in class or earnings will become effective on the date **you** begin **active work** in the new class or at the new earnings level.

Eligibility Requirement

You will be eligible for **coverage** on the date **you** have satisfied the following:

1. **you** are in an **eligible class**; and
2. **you** meet the Work Hours Required for Eligibility; and
3. **you** have completed the **waiting period**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must be **actively at work** to be eligible and will not be eligible due solely to position or title.

Actively at Work Requirement

You must be **actively at work** for **your coverage** or any **new coverage** to become effective. If **you** are not **actively at work** when **your coverage** or **new coverage** is scheduled to become effective, **your coverage** or **new coverage** will be deferred until **you** return to **active work** for at least 1 full day.

You meet the **actively at work** requirement if **you** were absent from **active work** because of a regularly scheduled day off, holiday, or vacation day.

Short Term Disability Coverage

You will not be considered **actively at work** if **your** employment status is being continued under a severance or termination agreement.

Enrollment Requirement

[**You** are required to enroll for **your coverage** or any **new coverage** to become effective. In the case of a **late enrollment**, if **you** contribute toward the cost of **your coverage** or any **new coverage**, **you** must satisfy the Evidence of Insurability Requirement for **your coverage** or any **new coverage** to become effective]

[**You** are required to enroll for **your coverage** or any **new coverage** to become effective. In the case of **late enrollment**:

1. **you** must satisfy the Evidence of Insurability Requirement for **your coverage** or any **new coverage** to become effective; and
2. **you** can enroll only during the Open Enrollment Period shown in the Schedule of Benefits.]

Evidence of Insurability Requirement

When **we** request **evidence of insurability** as a condition for **your coverage** or for any **new coverage**:

1. **you** must submit the proof to **us** in the form **we** request; and
2. **we** may require a physical examination as a part of this proof. If so, it will be at **your** expense.

We will require **evidence of insurability**:

1. for **late enrollment**; or
2. if **you** voluntarily terminated **your coverage** and are re-enrolling; or
3. for amounts **you** request to increase **your** Weekly Benefit Amount; or
4. for an increase in coverage due to an increase in **weekly earnings** of 10% or more.

If approved, **your coverage** or **new coverage** will become effective on the date **we** approve **your** application.

Recurrent Disability

While **your coverage** is effective, successive **periods of disability** will be considered one **period of disability** unless the periods are separated by **your** return to **active work** for [30] consecutive calendar days or more.

This provision will apply only if:

1. **your** disability resulted from the same or a related **injury** or **illness** as the prior disability; and
2. **you** have received benefits under the **policy** for the prior disability; and
3. **you** have re-enrolled for **coverage** upon return to **active work**.

Recurrent Disability will no longer apply on the earlier of:

Short Term Disability Coverage

1. the date **you** are eligible for **coverage** under any other group short term disability policy; or
2. the date this group short term disability **policy** is terminated.

Termination of your Short Term Disability Coverage

Your coverage will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date the **policy** is terminated; or
2. the date **your eligible class** is no longer covered; or
3. the date **you** are no longer a member of an **eligible class**; or
4. the last date for which **you** make a required premium payment; or
5. the date **you** are no longer **actively at work**, except as provided under Continuation of Coverage during [Temporary Layoff], Injury, Illness, or other Leave of Absence.

Termination of **your coverage** will not affect **your** rights if **you** become entitled to a benefit under the **policy** due to a **[partial disability or] total disability** that began prior to the date of the termination.

Continuation of Coverage during [Temporary Layoff], Injury, Illness or other Leave of Absence

While the **policy** is in-force, if **you** cease **active work** due to [temporary layoff,] **injury, illness** or other leave of absence, and if **your covered employer** continues to make premium payments on **your** behalf, **you** will be covered for the period shown in the Schedule of Benefits.

If **you** do not return to **active work**, **coverage** will terminate at the end of the Continuation of Coverage Period shown in the Schedule of Benefits.

While **your coverage** continues as shown in the Schedule of Benefits, **your** benefit amount will be based on the benefits of **your eligible class** on **your** last day of **active work** and is subject to the reductions in benefits of that **eligible class**.

Your normal vacation time or any **period of disability** is not considered a [temporary layoff or] leave of absence.

Reinstatement

If **your coverage** under the **policy** terminates due to termination of employment, **illness, injury** or an approved leave of absence or layoff, **your coverage** may be reinstated on the date **you** return to **active work**. **We** will apply any prior period of work with **your covered employer** toward the **waiting period**. The following conditions will apply:

1. **you** return to **active work** must occur within 12 months following **coverage** termination; and
2. **you** must apply for **coverage** within 31 days following **your** return to **active work**; and
3. **you** must satisfy a new **pre-existing condition** period, if a Pre-Existing Condition Limitation is included; and

4. the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured.

All other **policy** provisions apply.

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group short term disability insurance plan (the "Prior Plan"); and
2. **you** were covered under the Prior Plan on the day before **your coverage** under the **policy** became effective; and
3. **you** have been continuously insured under the **policy** from the effective date of the **policy** through the date **your disability** began.

[We will credit the period from the date **you** were continuously insured under the Prior Plan to the date **you** become insured under the **policy** towards satisfaction of the Pre-Existing Condition Limitation under the **policy**:

1. if **you** are no longer subject to the **policy's** Pre-Existing Condition Limitation, any benefit payable under the **policy** will be paid without applying the Pre-Existing Condition Limitation; and
2. If **you** are subject to the **policy's** Pre-Existing Condition Limitation the Prior Plan's **pre-existing condition** exclusion will be applied. The benefits **we** pay **you** under the **policy** will then be the lesser of:
 - a. the amount, if any, that **you** would have received for that condition under the Prior Plan if it had remained in effect; or
 - b. the amount that **you** would have received under the **policy**, if **you** had no **pre-existing condition**.]

[In order to receive a payment, **you** must satisfy the **pre-existing condition** provision under:

1. **our policy**; or
2. the Prior Plan, if benefits would have been paid had that policy remained in force.

If **you** satisfy the **pre-existing condition** provision of **our policy**, **we** will determine **your** payments according to **our policy's** provisions.

If **you** do not satisfy the **pre-existing condition** provision of this **policy**, but **you** do satisfy the Prior Plan's **pre-existing condition** provision:

1. **your** weekly payment will be the lesser of :
 - a. the weekly payment that would have been payable under the terms of the Prior Plan if it had remained in force; or
 - b. the weekly payment under **our policy**; and
2. benefits will end on the earlier of:
 - a. the date benefits end under **our policy**, as described under the Benefit Termination provision; or

Short Term Disability Coverage

- b. the date benefits would have ended under the Prior Plan if it had remained in force.

If **you** do not satisfy either **our policy's** or the Prior Plan's **pre-existing condition** provision, **we** will not make any payments.

We will require proof that **you** were insured under the prior policy.

All other provisions of **our policy** will apply.]

[If **you** are not **actively at work** due to [injury][,][or] [illness][,][or][leave of absence][,][or][temporary layoff] on the effective date of the **policy**, **we** will provide Continuity of Coverage if **your** coverage under the Prior Plan was substantially the same as **your coverage** under the **policy**. **We** will provide limited coverage under this Continuity of Coverage provision.

Your Continuity of Coverage will begin on the effective date of the **policy** and will continue, subject to payment of premium for **your coverage**, until the earliest of:

1. the [end of the month following the] date **you** return to **active work**; or
2. the last day of any period during which **your coverage** is extended or continued under the Prior Plan; or
3. the date **your coverage** would end according to the terms of the **policy**.

We will provide **coverage** according to the terms of the Prior Plan, less any benefits for which the Prior Plan is liable.

If **you** do not qualify for Continuity of Coverage, **your coverage** under the **policy** will not begin before **you** return to **active work**.]]

Conditions for Payment of Short Term Disability Benefit

We will pay **you** a short term disability benefit if **you** become [**partially disabled or**] **totally disabled**, while **you** are covered under the **policy**.

We will require proof, at **your** expense, that **you** are **disabled** in order to qualify for the benefit and at reasonable intervals thereafter. At **our** expense, **we** may also require that **you** be examined by **our** choice of **physicians** and/or vocational experts. **We** may also require **you** to be interviewed by an authorized company representative.

We will not pay **you** any short term disability benefit if **you** refuse a job with the **covered employer** for which **you** are or could be reasonably fitted by training, education, experience, and physical/mental capacity. Any job where work site modifications were made to allow **you** to perform the **material and substantial duties** of **your** job is included in this requirement.

Benefit Payment

Your Weekly Benefit Amount will be paid [weekly] beginning [one week] after the **Elimination Period** ends for the prior [one week] period. **You** will be paid a benefit for a **period of disability** up to the maximum weekly benefit. Benefits will be paid until **you** are no longer **disabled** up to the Maximum Benefit Period.

If **you** are **disabled** for less than a full week, **we** will pay **you** [1/7th] of the Weekly Benefit Amount for each day of [**partial disability or**] **total disability**.

Determining Weekly Benefit Amount for a Total Disability

To determine **your total disability** Weekly Benefit Amount:

1. multiply **your weekly earnings** by the benefit percentage shown in the Schedule of Benefits; and
2. take the lesser of: (a) the amount figured in step 1; or (b) the maximum weekly benefit shown in the Schedule of Benefits; and then
3. subtract the amount of Benefit Reductions.

The weekly benefit will never be less than the minimum weekly benefit shown in the Schedule of Benefits.

[Work Incentive Benefit

While **you** are **partially disabled**, **your** Weekly Benefit Amount for **your partial disability** will be based on the **total disability** Weekly Benefit Amount for a **total disability**, but will not be reduced by any **disability earnings you** receive until **your** weekly benefit amount plus **your disability earnings** exceed 100% of **your weekly earnings**. If **your** Weekly Benefit Amount plus **your disability earnings** exceed 100% of **your weekly earnings**, **we** will subtract the amount of earnings over 100% from **your** Weekly Benefit Amount. Any employment under this provision must be approved by **us** as reasonably leading to **your** return to **active work**.

If **we** do not approve a Work Incentive Benefit, **your partial disability** will be determined as described in Determining Weekly Benefit Amount for a Partial Disability.]

[Determining Weekly Benefit Amount for a Partial Disability

To determine **your partial disability** Weekly Benefit Amount:

1. determine **your total disability** Weekly Benefit Amount; and
2. subtract 50% of **disability earnings** during the **period of disability**;
3. the **partial disability** Weekly Benefit is the greater of the amount from step 2 or the minimum weekly benefit shown in the Schedule of Benefits.]

[Determining Weekly Benefit Amount for a Partial Disability

To determine **your partial disability** Weekly Benefit Amount:

1. subtract any **disability earnings** from **your weekly earnings**; and
 2. divide the amount figured in step 1 by **your weekly earnings**; and then
 3. multiply the amount figured in step 2 by **your Total Disability Benefit Amount** as determined above.
 4. the **partial disability** Weekly Benefit Amount is the greater of the amount from step 3 or the minimum weekly benefit shown in the Schedule of Benefits.]
-

[Benefit Reductions

Your short term disability benefit will be reduced by income from any of the following sources that **you** receive or are eligible to receive as a result of **your [partial disability or] total disability** or retirement:

1. MISCELLANEOUS BENEFITS. Benefits for which **you** are eligible under:
 - a. any unemployment compensation law; or
 - b. any occupational disease law; or
 - c. any compulsory benefit law; or
 - d. [any workers' compensation law; or]
 - e. any other law of similar intent.
2. MOTOR VEHICLE DISABILITY BENEFITS. Benefits for which **you** are eligible under the mandatory portion of any "no fault" motor vehicle plan, or any other law of similar intent.
3. SOCIAL SECURITY BENEFITS. Any benefits that **you** receive or are eligible to receive as disability payments or as retirement payments under the United States Social Security Act or any other country's equivalent of that act.

We will not reduce **your** payment by **your** Social Security Retirement income if **your** disability begins after **your** Social Security Normal Retirement date and **you** are already receiving Social Security Retirement payments.
4. DISABILITY INCOME BENEFITS: Any disability income benefits that **you** receive under any group insurance plan of the **covered employer** or any employer, any government retirement system related to **your** employment with the **covered employer**[, any formal or informal salary continuation or sick leave program of the **covered employer**].
5. [1099 INCOME:]Any amount **you** receive from any form of employment, including but not limited to renewal commissions and residual sales commissions.]
6. OTHER INCOME. Any amount **you** receive as income replacement from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.
7. RETIREMENT BENEFITS. Retirement benefits from a plan

sponsored by the **covered employer** or any state or federal government.

RETIREMENT BENEFITS: Reference to "retirement benefits" is limited to employer sponsored benefits that:

1. do not represent contributions that **you** made (payments that represent **your** contributions are deemed to be received over **your** expected remaining lifetime, regardless of when those payments are actually received); and
2. are payable upon:
 - a. early or normal retirement after **your** disability begins; or
 - b. disability, provided the payment does not reduce the amount of benefits that would have been paid by the plan at **your** normal retirement age.

LUMP SUM PAYMENTS: Benefit Reductions that are paid in a lump sum will be prorated on a weekly basis over the time period for which the sum was paid or, if less, the **policy's** applicable Maximum Benefit Period. If no time period is stated, the sum will be prorated over **your** expected lifetime as determined by **us**, using appropriate actuarial tables.

COST OF LIVING FREEZE: **We** will not reduce **your** Weekly Benefit Amount if the amount of benefits **you** receive from any source, except earnings from any form of employment, changes because of a cost of living increase that occurs automatically at any time after **you** satisfy the **elimination period**.

To determine the weekly Benefit Reduction amount of income listed above that is paid or payable to **you** monthly, **we** will divide that income amount by 4.33 to determine the weekly reduction amount.

SOURCES OF INCOME THAT DO NOT REDUCE BENEFITS: **We** will not subtract from **your** gross disability benefit, income **you** receive from the following:

1. 401(k) plans;
2. profit sharing plans;
3. thrift plans;
4. tax sheltered annuities;
5. stock ownership plans;
6. non-qualified plans of deferred compensation;
7. pension plans for partners;
8. military pension and disability income plans;
9. credit disability insurance;
10. franchise disability income plans;
11. no fault automobile insurance plans, except where required by law;
12. individual disability plans paid by the employer;
13. a retirement plan from another employer;
14. individual retirement accounts (IRA).]

[Survivor Benefit

We will pay a benefit to **your eligible survivor** if **we** receive proof that **your** death occurred:

1. while weekly benefits were being paid to **you** for a **period of disability**; and
2. **your period of disability** had continued for 14 or more consecutive days.

This benefit will be paid [weekly] for the number of weekly payments remaining from the time of death to the end of the Maximum Benefit Period.

We will first apply the Survivor Benefit to any overpayment which may exist on **your** claim.

If **you** have no **eligible survivors**, this benefit will not be payable.]

[Minimum Indemnity for Accidental Dismemberment and Loss of Sight

If **you** suffer an **injury** that results in any of the losses shown below within 90 days of the date of the accident, **we** will pay **you** the Weekly Benefit Amount for the number of weeks shown below.

Payment of this benefit will not be subject to satisfying the **elimination period**. However, after the **elimination period** has been completed, this benefit will be paid in lieu of the regular weekly payment, not in addition to it. If **you** remain **disabled** beyond the number of weekly payments under this provision, benefits may continue as provided under the **policy**. The weeks **you** receive benefits under this provision will be excluded in computing the number of weeks **you** receive payments for **disability** and in computing any remaining Maximum Benefit Period for **disability**. If **you** die, this benefit will cease.

FOR LOSS OF:	NUMBER OF WEEKLY PAYMENTS:
Sight of Both Eyes	26
Both Hands	26
Both Feet	26
One Hand and One Foot	26
One Hand and Sight of One Eye	26
One Foot and Sight of One Eye	26
One Hand or One Foot	13
Sight of One Eye	13
Thumb and Index Finger of Either Hand	8

The maximum number of weekly payments for all losses suffered in any one accident shall be limited to that one loss for which the greatest number of weekly payments is provided in the above schedule.

Loss of hands and feet means loss by severance at or above the wrist or ankle joint. Loss of sight means legal blindness. Loss of thumb and index finger means actual severance at or above the knuckles joining each hand.]

[Reasonable Accommodation Expense Benefit

If **you** return to work in any occupation for any employer, not including self-employment, as a result of a **reasonable accommodation** made by such employer, **we** will pay that employer a Reasonable Accommodation Expense Benefit up to the lesser of [\$750] or the equivalent of [2] weeks of **your** weekly benefit; but not to exceed the expenses incurred.

The Reasonable Accommodation Expense Benefit is payable only if the **reasonable accommodation** is approved by **us** in writing prior to its implementation. This benefit is available to **you** one time while **you** are insured under the **policy**.]

[Recovery Expense Benefit

We will reimburse **you** for out-of-pocket recovery expenses that **you** incur during **your** period of covered [**partial** or] **total disability**, subject to the following conditions:

1. **your** recovery expenses are incurred in connection with **appropriate care** of **your** disabling condition; and
2. **your** recovery expenses are incurred based on **treatment** prescribed by **your** treating **physician**; and
3. **you** are receiving benefits for [**partial** or] **total disability** at the time the recovery expense is incurred; and
4. **you** provide proof of the incurred recovery expenses, subject to **our** approval.

We will reimburse **you** [\$25] for the recovery expenses **you** incur each week, not to exceed **your** actual out-of-pocket recovery expenses incurred during the week. The Recovery Expenses Benefit will be paid no more often than monthly. Only one payment will be considered for each incurred expense.

Eligible recovery expenses include:

1. amounts **you** are required to pay as co-payments, deductibles and coinsurance under medical or prescription drug insurance plans; or
2. expenses **you** incur for medical services or prescription drugs that are considered deductible for purposes of United States federal income tax purposes, but for which **you** have no insurance coverage.

Eligible recovery expenses do not include expenses that are paid to **you** or on **your** behalf by any benefit plan.]

[Waiver of Premium

Premium payment for **your coverage** will be waived while **you** are receiving benefits under the **policy**.]

[Pre-Existing Condition Limitation

We will not pay **you** the Weekly Benefit Amount for a [partial disability or] **total disability** that is both:

1. caused by, contributed by, or that results, in whole or in part, from a **pre-existing condition**; and
2. begins in the first [12 months] after the effective date of **your coverage** or any **new coverage** under the **policy** [unless **you** have been **treatment** free for [12] consecutive months after **your** effective date of **coverage**].

If **your** benefits under the **policy** are increased, **you** will not be paid the increased benefit amount (but **you** will receive the benefit in effect prior to the increase) for any **disability** caused by, contributed by, or that results, in whole or in part, from a **pre-existing condition** that begins in the first [12 months] after the increase became effective [unless **you** have been **treatment** free for [12] consecutive months after the increase became effective].]

Exclusions

The **policy** will not cover any **period of disability** caused by, attributed to , or resulting from **your**:

1. elective procedure or surgery; or
2. engaging in any illegal or fraudulent occupation, work, or employment; or
3. traveling or flying on any aircraft operated by or under the authority of military or any aircraft being used for experimental purposes; or
4. participation in a war, or an act of war, declared or undeclared or any act of war; or
5. active military duty; or
6. active participation in a riot, rebellion or insurrection; or
7. attempting to commit, or committing, or participating in, an assault or felony; or
8. commission of a crime for which **you** have been convicted; or
9. intentionally self-inflicted **injury** or **illness**, while sane or insane; or
10. attempted suicide, while sane or insane[.]; or]
11. [being legally intoxicated[.]; or]
12. [being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a **physician**[.]; or]
13. [occupational **illness** or **injury**, which is an **illness** or **injury** caused by or aggravated by any employment for pay or profit.]

We will not pay any benefits for any period that **you** are confined to any facility because **you** were convicted of a crime or other illegal act.

Notice

We encourage **you** to notify **us** of **your** claim as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date the **injury** or **illness** begins, or as soon as reasonably possible.

Forms

You should use a claim form for filing a proof of loss. These forms will be supplied to **you** within 15 days of notice of an **injury** or **illness**.

If **you** do not receive a claim form within this 15-day period, **you** may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character, and extent of the **treatment**.

Proof of Loss

You must send **us** a proof of loss within 90 days after the end of the **elimination period**.

We will not decline or reduce a claim if: (a) it is not reasonably possible to give proof within that time; and (b) the proof is submitted within one year from the date of loss or incurral. This one-year period will not apply when **you** are not legally capable of submitting proof.

All proofs of loss must be satisfactory to **us**. **Your** proof of loss must show:

1. that **you** are under the **appropriate care** of a **physician**; and
2. the date **your disability** began; and
3. the cause of **your disability**; and
4. the appropriate documentation of **your weekly earnings** and **your activities**; and
5. the extent of **your disability**, including restrictions and limitations preventing **you** from performing **your regular occupation**; and
6. the name and address of any **hospital** or institution where **you** received **treatment**, including all attending **physicians**; and
7. documentation of prior disability coverage if applicable.

We may request that **you** send proof of continuing **disability** indicating that **you** are under the continuous care and **treatment** of a **physician**. This proof, provided at **your** expense, must be received within 30 days of a request by **us**.

Time of Claim Payment

When **we** receive and approve **your** proof of loss, **we** will pay any benefits **we** owe **you** under the **policy**. All benefits to which **you** are entitled will be paid [weekly] during **your period of disability**. Any balance remaining unpaid at the end of that period will be paid as soon as possible after **we** receive the proof of loss.

Payment of Claims

All benefits are payable to **you**.

If **you** are not legally capable of accepting a benefit, all or part of the benefit can be paid to **your** spouse, **your** estate (if applicable), or a recognized guardian as determined by **us**. That payment, made in good faith, fully discharges **us** to the extent of the payment.

Benefits accrued but unpaid before **your** death will be paid to **your** estate. If any benefit is payable to **your** estate, **we** may pay up to \$1,000 of that benefit to a relative of **yours**, by blood or marriage, that **we** determine to be entitled to the benefit. That payment, made in good faith, fully discharges **us** to the extent of the payment.

[Claims for loss of life will be paid according to the Survivor Benefit in the Short Term Disability Benefit section].

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **you** have sent **us** a written proof of loss; or
2. after 3 years from the time **you** were required to send **us** a written proof of loss.

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify **you** if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** do not agree with the reasons given, **you** may request a reconsideration of that claim.

To do so, **you** should write to **us** within [180] days after **you** receive the notice of denial. **You** should say why **you** believe the claim denial was not proper. **You** should include any data, questions or comments that **you** think are appropriate. Unless **we** request additional material, **you** will be advised of **our** decision within [45] days after **we** receive **your** letter.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **you** return the overpayment to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

Recovery and Subrogation

When **your injury** or **illness** appears to be someone else's fault, any benefits otherwise due under the **policy** for a resulting **period of disability** will not be paid unless **you** agree:

1. to repay **us** for those benefits to the extent that they are for losses for which **you** are compensated by or on behalf of the person at fault; and
2. to sign and give **us** any documentation that **we** request to secure these rights.

Further, when **we** have paid benefits to **you**, **we** will be subrogated to all rights of recovery that **you** have against the person at fault, except where prohibited by law. Such subrogation will extend only to recovery of the benefits **we** paid.

Voluntary Short Term Disability Insurance

Schedule of Benefits

Eligible Class	[Class A] – [All Employees]
Coverage Effective Date	[06/01/2010]
Plan Effective Date	[06/01/2010]
Open Enrollment Period	[October 1 – October 31] Refer to Enrollment Requirement for details and evidence requirements.
Work Hours Required for Eligibility	Your regularly scheduled work hours must be at least [30] hours per week.
Waiting Period	For your coverage : [90] [days] [months] [Coverage will become effective on the first day of the month following the waiting period if all other requirements for coverage to become effective are satisfied.] [There will be no waiting period for employees who are Actively at Work and are part of the initial enrollment.]
Your Premium Contribution	[You are required to pay the entire premium for your coverage .] [You are required to contribute towards the cost of your coverage .]
Your Weekly Benefit Amount	[Your Weekly Benefit Amount will be equal to the lesser of: 1. [66 2/3%] of your weekly earnings [, rounded to the nearest dollar]; or 2. [\$750] maximum weekly benefit,] [Your Weekly Benefit Amount will be equal to [\$250] not to exceed [66 2/3%] of your weekly earnings [, rounded to the nearest dollar],] [Your Weekly Benefit Amount is available in increments of [\$100], up to [\$500], not to exceed [66 2/3%] of your weekly earnings ,] minus any income listed in Benefit Reductions. [Your Weekly Benefit Amount is available in increments of [\$50,] [up to \$700], and cannot exceed [66 2/3%] of your weekly earnings when combined with your employer sponsored benefit. Your Weekly Benefit Amount will be reduce by any income listed in Benefit Reductions.]

Voluntary Short Term Disability Insurance

Schedule of Benefits

[Your minimum weekly benefit will be [\$25].]

[Weekly Benefit Amounts in excess of [\$500] will be subject to **our** approval of **your evidence of insurability.**]

Frequency of Benefit Payments

[weekly]

Elimination Period

Benefits will begin after [the later of:]

1. [0 days] of [**partial disability** or] **total disability** when due to an **injury.**
2. [7 days] of [**partial disability** or] **total disability** when due to an **illness.**
3. [[0 days] when **you** are confined in a hospital for 24 or more hours.]
4. [the end of **your** accumulated sick leave with the **covered employer.**]

Maximum Benefit Period

[52] weeks for any period of disability.

Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence

[Temporary Layoff – Up to the end of the month that immediately follows the month in which **your** temporary layoff begins.]

Injury or **Illness** – Up to [3] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act).

Other Leave of Absence – Up to [2] months after **your** last day of **active work** (up to 12 weeks for a leave under the Family and Medical Leave Act).

Partial Disability Benefit

[Included.] [Not Included.]

Residual Disability Benefit

[Included. The **elimination period** can be satisfied with days of **partial** or **total disability.**] [Not Included.]

Maternity Coverage

[Both normal pregnancy and complications of pregnancy are covered.]
[Only complications of pregnancy (and not normal pregnancy) are covered.]

[Survivor Benefit

Included.]

[Minimum Indemnity for Accidental Dismemberment and Loss of Sight

Included.]

Voluntary Short Term Disability Insurance

Schedule of Benefits

[Reasonable Accommodation Expense Benefit Included.]

[Recovery Expense Benefit Included.]

Pre-Existing Condition Limitation [Included.] [Not Included.]

Work Related Injuries and Illnesses

This policy does not cover an **injury** or **illness** that arises in the course of employment for wage or profit for which benefits are paid or payable by Workers' Compensation or similar laws, except for those of an owner or officer who is not covered under or who has opted out of Workers' Compensation if we have agreed in writing to provide this exception.

Voluntary Short Term Disability Insurance

Defined Terms

Appropriate Care

You:

1. regularly visit a **physician** as frequently as medically required according to standard medical practice to effectively treat and manage **your** disabling condition(s);
2. receive care or **treatment** appropriate for the disabling condition(s), conforming with standard medical practice, by a **physician** whose specialty or experience is most appropriate for the disabling condition(s) according to standard medical practice; and
3. have the obligation to minimize **your** disabling condition including corrective **treatment** or minor surgery.

Disability, Disabled

Total Disability [or **Partial Disability**] and **Totally Disabled** [or **Partially Disabled**].

Disability Earnings

The earnings which **you** receive while **you** are **disabled** and working, plus the earnings **you** could receive if **you** were working to **your maximum capacity**.

[Eligible Survivor

Your spouse, if living; otherwise **your** children under age 25. Any payment due **your** children will be paid in equal shares. Payment may be made to a person named by **us** to receive the payment on **your** children's behalf. This payment will be valid against all claims by others representing or claiming to represent the children.]

Elimination Period

The initial number of consecutive days of a **period of disability** for which no benefit is payable under the **policy**.

We will count only those days **you** are **totally disabled** to satisfy the **elimination period**. If a Residual Disability Benefit is included as shown in the Schedule of Benefits, **we** will also include those days that **you** are **partially disabled**. If **you** return to work full-time for no more than [14] calendar days during the **elimination period**, **we** will treat the **disability** as continuous. The Elimination Period is shown in the Schedule of Benefits.

[Evidence of Insurability

A statement of **your** medical history and evidence of good health which **we** will use to determine if **you** are approved for **coverage**.

Evidence of insurability will be provided at **your** expense.]

Gross Weekly Benefit

Your benefit before adjustments for Benefit Reductions and **disability earnings**.

Illness

Your medically determinable sickness or disease. [**Coverage** for normal pregnancy is included if this is indicated in the Schedule of Benefits.]

Voluntary Short Term Disability Insurance

Defined Terms

Disability resulting from **illness** must begin while **you** are covered under the **policy**.

Injury

Your medically determinable bodily impairment caused by and resulting directly from an accident, and independent of all other causes.

Injury which occurs before **you** are covered under the **policy** will be treated as an **illness**. **Disability** must begin while **you** are covered under the **policy**.

Material and Substantial Duties

Duties that:

1. are normally required for the performance of **your regular occupation**; and
2. cannot be reasonably omitted or modified, except that if **you** are required to work an average in excess of 40 hours per week, **we** will consider **you** able to perform that requirement if **you** are working and have the capacity to work 40 hours per week.

Maximum Capacity

The greatest extent of work **you** are able to do in **your regular occupation** based on **your** restrictions and limitations.

Net Weekly Benefit

Your benefit after all adjustments, including but not limited to, Benefit Reductions and **disability earnings**.

New Coverage

New coverage is either:

1. a newly acquired **coverage** under the **policy**; or
2. an increase in the amount of an in force **coverage**, including any increase in **coverage** due to an increase in **weekly earnings** of 10% or more.

[Partial Disability, Partially Disabled

While receiving **appropriate care** because of a medically determinable **injury** or **illness**;

1. **you** are performing or able to perform at least one, but not all, of the **material and substantial duties** of **your regular occupation** or another occupation on a full-time basis or at least one of these duties on a part-time basis, and
2. **your disability earnings** are less than 80% of **your weekly earnings** due to the same **injury** or **illness**.]

Voluntary Short Term Disability Insurance

Defined Terms

Period of Disability	<p>The entire time that you are [partially disabled or] totally disabled.</p> <p>Any period of disability resulting from one or more causes will be considered a single period of disability.</p>
Physician	<p>A person who:</p> <ol style="list-style-type: none">1. is licensed to practice medicine and prescribe and administer drugs or to perform surgery and is operating within the scope of his or her license; or2. is legally qualified as a medical practitioner and required to be recognized by the insurance laws of the governing jurisdiction. <p>A physician may not be a member of your family. Members of your family include your parents, step-parents, including in-laws, spouse or former spouse, [domestic partner,] children, including in-laws, siblings, including in-laws, aunts, uncles, cousins, nieces, nephews, grandparents and guardians.</p>
Pre-Existing Condition	<p>Any injury or illness for which you have received treatment [, or for which an ordinarily prudent person would have received treatment,] at any time within the [3 months] immediately prior to the date your coverage or any new coverage became effective[, whether or not that condition is diagnosed at all or is misdiagnosed during that period of time stated in the policy].</p>
[Reasonable Accommodation	<p>Modifications or changes in your work environment or in a way a job is performed which allows you to perform the material and substantial duties of your job.]</p>
Recurrent Disability	<p>A [partial disability or] total disability that resulted from the same or a related injury or illness as a prior [partial disability or] total disability for which a benefit was payable under the policy.</p>
Regular Occupation	<p>The occupation you are routinely performing when your disability begins. We will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.</p>
Total Disability, Totally Disabled	<p>While receiving appropriate care because of a medically determinable injury or illness; you</p> <ol style="list-style-type: none">1. are unable to perform the material and substantial duties of your regular occupation; and2. are not being paid for performing any work or service. <p>You will not be considered totally disabled from work in an occupation solely because of the loss, suspension, restriction, surrender, or failure to maintain a</p>

Voluntary Short Term Disability Insurance

Defined Terms

required license or certification to engage in the occupation.

Treatment

Includes:

1. consulting with or receiving advice from a **physician**;
2. receiving care or services from a **physician** or from other medical professionals a **physician** recommends **you** see;
3. being prescribed medicines, whether or not **you** choose to take them;
4. refilling prescribed medicines; or
5. receiving diagnostic measures or services.

Weekly Earnings

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions calculated as the weekly average of **your** gross annual earnings prior to the date **your disability** began, but excluding commissions, bonuses, overtime pay and other extra compensation.]

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions calculated as the weekly average of **your** gross annual earnings including commissions averaged over the [24] month period (or the number of months worked if that period is less than [24] months) prior to the date **your disability** began, but excluding bonuses, overtime pay and other extra compensation.]

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions calculated as the weekly average of **your** gross annual earnings including commissions and bonuses averaged over the [24] month period (or the number of months worked if that period is less than [24] months) prior to the date **your disability** began, but excluding overtime pay and other extra compensation.]

[**Your** regularly scheduled earnings from the **covered employer** before taxes and any pre-tax deductions calculated as the weekly average of **your** gross annual earnings including bonuses averaged over the [24] month period (or the number of months worked if that period is less than [24] months) prior to the date **your disability** began, but excluding commissions, overtime pay and other extra compensation.]

[**Your** gross earnings from the **covered employer** as shown on **your** W-2 from the **covered employer** for the preceding **calendar year**, divided by the lesser of: (a) 52; or (b) the number of weeks worked.]

[For 1099 income, **your** average earnings from the **covered employer** as reported on the 1099-Misc of **your** federal income tax return filed for the preceding **calendar year** or tax year. If **you** did not file a 1099-Misc for the preceding **calendar year** or tax year, **we** will average **your** earnings over the number of weeks worked.]

For partners, **your** average earnings from the partnership calculated from the

"net earnings from self-employment" section on Schedule K-1 of **your** federal income tax return filed for the preceding **calendar year** or tax year. If **you** did not file a Schedule K-1 for the preceding **calendar year** or tax year, **we** will average **your** earnings over the number of weeks worked.

For sole proprietors, **your** weekly net profit as shown on **your** Form 1040-C for the preceding **calendar year** or tax year excluding depreciation and expenses for business use of **your** home. If **you** did not file a Form 1040-C for the preceding **calendar year** or tax year, **we** will average **your** earnings over the number of weeks worked.

For shareholders of an S Corporation, **your** average earnings as an insured shareholder based on:

1. the "Wages, Tips and Other Compensation" of **your** Form W-2 and including compensation deferral reported on **your** Form W-2 received from the **covered employer**:
 - a. for the **calendar year** immediately prior to **your** date of **disability**; or
 - b. for the period of employment with the **covered employer** if **you** did not receive a W-2 Form prior to the date of **your disability**; and
2. **your** ordinary income or loss from trade or business activities from Schedule K-1 of **your** federal income tax return from the **covered employer** for the year immediately prior to **your** date of **disability**.

If **you** have not been a shareholder for the year for which the most recent S Corporation federal income tax return was filed, **your weekly earnings** will be based on the period of actual employment during which **you** were a shareholder.

Weekly earnings does not include income received from sources other than as a shareholder of the **covered employer**.

Voluntary Short Term Disability Insurance

Short Term Disability Coverage

Effective Date of your Short Term Disability Coverage

If **you** are under the age of 70, **your coverage**, or any **new coverage** will become effective when **you** have satisfied the following:

1. the Eligibility Requirement; and
2. the Actively at Work Requirement; and
3. the Enrollment Requirement; and
4. the Evidence of Insurability Requirement, if applicable; and
5. **you** have paid the first premium when due.

When **you** have satisfied the above requirements, **you** will be covered at 12:00 a.m. on the later of:

1. the date **you** are eligible for **coverage** or any **new coverage**, if **you** enroll on or before that date or within 31 days after **your eligibility date**; or
2. the date **we** approve **your** evidence of insurability, if applicable.

[If **you** enroll more than 31 days after **you** become eligible, **your coverage** will become effective on the first day of the month following the Open Enrollment Period shown in the Schedule of Benefits.]

Increases or decreases in **your** Weekly Benefit Amount due to changes in class or earnings will become effective on the date **you** begin **active work** in the new class or at the new earnings level.

Eligibility Requirement

If **you** enroll within 31 days after **you** become eligible, **your coverage** will become effective on the date **you** have satisfied the following:

1. **you** are in an **eligible class**; and
2. **you** meet the Work Hours Required for Eligibility; and
3. **you** have completed the **waiting period**.

A corporate officer, director, partner, sole proprietor, business owner or elected official must be **actively at work** to be eligible and will not be eligible due solely to position or title.

Actively at Work Requirement

You must be **actively at work** for **your coverage** or any **new coverage** to become effective. If **you** are not **actively at work** when **your coverage** or **new coverage** is scheduled to become effective, **your coverage** or **new coverage** will be deferred until **you** return to **active work** for at least 1 full day.

You meet the **actively at work** requirement if **you** were absent from **active work** because of a regularly scheduled day off, holiday, or vacation day.

You will not be considered **actively at work** if **your** employment status is being continued under a severance or termination agreement.

Voluntary Short Term Disability Insurance

Short Term Disability Coverage

Enrollment Requirement

You are required to enroll for **your coverage** or any **new coverage** to become effective. In the case of a late enrollment:

1. **You** must satisfy the Evidence of Insurability Requirement for **your coverage** or any **new coverage** to become effective; and
2. **You** can enroll only during the Open Enrollment Period shown in the Schedule of Benefits.

[Evidence of Insurability Requirement

When **we** request **evidence of insurability** as a condition for **your coverage** or for any **new coverage**:

1. **you** must submit the proof to **us** in the form **we** request; and
2. **we** may require a physical examination as a part of this proof. If so, it will be at **your** expense.

We will require **evidence of insurability**:

1. if **you** enroll during the Open Enrollment Period shown on the Schedule of Benefits; or
2. if you voluntarily terminated **your coverage** and are re-enrolling; or
3. for amounts **you** request to increase **your** Weekly Benefit Amount.

If approved, **your coverage** or **new coverage** will become effective on the date **we** approve **your** application.]

Recurrent Disability

While **your coverage** is effective, successive **periods of disability** will be considered one **period of disability** unless the periods are separated by **your** return to **active work** for [30] consecutive calendar days or more.

This provision will apply only if:

1. **your** disability resulted from the same or a related **injury** or **illness** as the prior disability; and
2. **you** have received benefits under the **policy** for the prior disability; and
3. **you** have re-enrolled for **coverage** upon return to **active work**.

Recurrent Disability will no longer apply on the earlier of:

1. the date **you** are eligible for **coverage** under any other group short term disability policy; or
2. the date this group short term disability **policy** is terminated.

Termination of your Short Term Disability Coverage

Your coverage will terminate at 11:59 p.m. on the earliest of the following dates:

1. the date the **policy** is terminated; or
2. the date **your eligible class** is no longer covered; or
3. the date **you** are no longer a member of an **eligible class**; or

Voluntary Short Term Disability Insurance

Short Term Disability Coverage

4. the last date for which **you** make a required premium payment; or
5. the date **you** are no longer **actively at work**, except as provided under Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence; or
6. the date **you** reach age 70.

Termination of **your coverage** will not affect **your** rights if **you** become entitled to a benefit under the **policy** due to a **[partial disability or] total disability** that began prior to the date of the termination.

Continuation of Coverage during [Temporary Layoff,] Injury, Illness or other Leave of Absence

While the **policy** is in force, if **you** cease **active work** due to [temporary layoff,] **injury, illness**, or other leave of absence, and if **your covered employer** continues to make premium payments on **your** behalf, **you** will be covered for the period shown in the Schedule of Benefits.

If **you** do not return to **active work**, **coverage** will terminate at the end of the Continuation of Coverage Period.

While **your coverage** continues as shown in the Schedule of Benefits, **your** benefit amount will be based on the benefits of **your eligible class** on **your** last day of **active work** and is subject to the reductions in benefits of that **eligible class**.

Your normal vacation time or any **period of disability** is not considered a [temporary layoff or] leave of absence.

Reinstatement

If **your coverage** under the **policy** terminates due to termination of employment, **illness, injury** or an approved leave of absence or layoff, **your coverage** may be reinstated on the date **you** return to **active work**. **We** will apply any prior period of work with **your covered employer** toward the **waiting period**. The following conditions will apply:

1. **you** return to **active work** must occur within 12 months following **coverage** termination; and
2. **you** must apply for **coverage** within 31 days following **your** return to **active work**; and
3. **you** must satisfy a new **pre-existing condition** period, if a Pre-Existing Condition Limitation is included; and the maximum benefits reinstated will not exceed the maximum benefits which would have been available had **you** been continuously insured.

All other **policy** provisions apply.

[Continuity of Coverage

This provision applies if:

1. **your covered employer** has chosen the **coverage** described in the **policy** to replace a previous group short term disability insurance plan (the "Prior Plan"); and

Short Term Disability Coverage

2. **you** were covered under the Prior Plan on the day before **your coverage** under the **policy** became effective; and
3. **you** have been continuously insured under the **policy** from the effective date of the **policy** through the date **your disability** began.

[**We** will credit the period from the date **you** were continuously insured under the Prior Plan to the date **you** become insured under the **policy** towards satisfaction of the Pre-Existing Condition Limitation under the **policy**:

1. if **you** are no longer subject to the **policy's** Pre-Existing Condition Limitation, any benefit payable under the **policy** will be paid without applying the Pre-Existing Condition Limitation; and
2. If **you** are subject to the **policy's** Pre-Existing Condition Limitation the Prior Plan's **pre-existing condition** exclusion will be applied. The benefits **we** pay **you** under the **policy** will then be the lesser of:
 - a. the amount, if any, that **you** would have received for that condition under the Prior Plan if it had remained in effect; or
 - b. the amount that **you** would have received under the **policy**, if **you** had no **pre-existing condition**.]

[In order to receive a payment, **you** must satisfy the **pre-existing condition** provision under:

1. **our policy**; or
2. the Prior Plan, if benefits would have been paid had that policy remained in force.

If **you** satisfy the **pre-existing condition** provision of **our policy**, **we** will determine **your** payments according to **our policy's** provisions.

If **you** do not satisfy the **pre-existing condition** provision of this **policy**, but **you** do satisfy the Prior Plan's **pre-existing condition** provision:

1. **your** weekly payment will be the lesser of :
 - a. the weekly payment that would have been payable under the terms of the Prior Plan if it had remained in force; or
 - b. the weekly payment under **our policy**; and
2. benefits will end on the earlier of:
 - a. the date benefits end under **our policy**, as described under the Benefit Termination provision; or
 - b. the date benefits would have ended under the Prior Plan if it had remained in force.

If **you** do not satisfy either **our policy's** or the Prior Plan's **pre-existing condition** provision, **we** will not make any payments.

We will require proof that **you** were insured under the prior policy.

All other provisions of **our policy** will apply.]

[If **you** are not **actively at work** due to [injury][,][or] [illness][,][or][leave of absence][,][or][temporary layoff] on the effective date of the **policy**, **we** will

Short Term Disability Coverage

provide Continuity of Coverage if **your** coverage under the Prior Plan was substantially the same as **your coverage** under the **policy**. **We** will provide limited coverage under this Continuity of Coverage provision.

Your Continuity of Coverage will begin on the effective date of the **policy** and will continue, subject to payment of premium for **your coverage**, until the earliest of:

1. the [end of the month following the] date **you** return to **active work**; or
2. the last day of any period during which **your coverage** is extended or continued under the Prior Plan; or
3. the date **your coverage** would end according to the terms of the **policy**.

We will provide **coverage** according to the terms of the Prior Plan, less any benefits for which the Prior Plan is liable.

If **you** do not qualify for Continuity of Coverage, **your coverage** under the **policy** will not begin before **you** return to **active work**.]]

Voluntary Short Term Disability Insurance

Short Term Disability Benefit

Conditions for Payment of Short Term Disability Benefit

We will pay **you** a short term disability benefit if **you** become [**partially disabled** or] **totally disabled**, while **you** are covered under the **policy**.

We will require proof, at **your** expense, that **you** are **disabled** in order to qualify for the benefit and at reasonable intervals thereafter. At **our** expense, **we** may also require that **you** be examined by **our** choice of **physicians** and/or vocational experts. **We** may also require **you** to be interviewed by an authorized company representative.

We will not pay **you** any short term disability benefit if **you** refuse a job with the **covered employer** for which **you** are or could be reasonably fitted by training, education, experience, and physical/mental capacity. Any job where work site modifications were made to allow **you** to perform the material and substantial duties of **your** job is included in this requirement.

Benefit Payment

Your Weekly Benefit Amount will be paid [weekly] beginning [one week] after the **Elimination Period** ends for the prior [one week] period. **You** will be paid a benefit for a **period of disability** up to the maximum weekly benefit. Benefits will be paid until **you** are no longer **disabled** up to the Maximum Benefit Period.

If **you** are **disabled** for less than a full week, **we** will pay **you** [1/7th] of the Weekly Benefit Amount for each day of [**partial disability** or] **total disability**.

Determining Weekly Benefit Amount for a Total Disability

To determine **your total disability** Weekly Benefit Amount:

1. multiply **your weekly earnings** by the benefit percentage shown in the Schedule of Benefits; and
2. take the lesser of: (a) the amount figured in step 1; or (b) the maximum weekly benefit shown in the Schedule of Benefits; and then
3. subtract the amount of Benefit Reductions.

The weekly benefit will never be less than the minimum weekly benefit shown in the Schedule of Benefits.

[Work Incentive Benefit

While **you** are **partially disabled**, **your** Weekly Benefit Amount for **your partial disability** will be based on the **total disability** Weekly Benefit Amount for a **total disability**, but will not be reduced by any **disability earnings** you receive until **your** weekly benefit amount plus **your disability earnings** exceed 100% of **your weekly earnings**. If **your** Weekly Benefit Amount plus **your disability earnings** exceed 100% of **your weekly earnings**, **we** will subtract the amount of earnings over 100% from **your** Weekly Benefit Amount. Any employment under this provision must be approved by **us** as reasonably leading to **your** return to **active work**.

If **we** do not approve a Work Incentive Benefit, **your partial disability** will be determined as described in Determining Weekly Benefit Amount for a Partial Disability.]

[Determining Weekly Benefit Amount for a Partial Disability]

To determine **your partial disability** Weekly Benefit Amount:

1. determine **your total disability** Weekly Benefit Amount; and
2. subtract 50% of **disability earnings** during the **period of disability**;
3. the **partial disability** Weekly Benefit is the greater of the amount from step 2 or the minimum weekly benefit shown in the Schedule of Benefits.]

[Determining Weekly Benefit Amount for a Partial Disability]

To determine **your partial disability** Weekly Benefit Amount:

1. subtract any **disability earnings** from **your weekly earnings**; and
2. divide the amount figured in step 1 by **your weekly earnings**; and then
3. multiply the amount figured in step 2 by **your Total Disability Benefit Amount** as determined above.
4. the **partial disability** Weekly Benefit Amount is the greater of the amount from step 3 or the minimum weekly benefit shown in the Schedule of Benefits.]

[Benefit Reductions]

Your short term disability benefit will be reduced by income from any of the following sources that **you** receive or are eligible to receive as a result of **your [partial disability or] total disability** or retirement:

1. MISCELLANEOUS BENEFITS. Benefits for which **you** are eligible under:
 - a. any unemployment compensation law; or
 - b. any occupational disease law; or
 - c. any compulsory benefit law; or
 - d. [any workers' compensation law; or]
 - e. any other law of similar intent.
2. MOTOR VEHICLE DISABILITY BENEFITS. Benefits for which **you** are eligible under the mandatory portion of any "no fault" motor vehicle plan, or any other law of similar intent.
3. SOCIAL SECURITY BENEFITS. Any benefits that **you** receive or are eligible to receive as disability payments or as retirement payments under the United States Social Security Act or any other country's equivalent of that act.

We will not reduce **your** payment by **your** Social Security Retirement income if **your** disability begins after **your** Social Security Normal Retirement date and **you** are already receiving Social Security Retirement payments.

4. DISABILITY INCOME BENEFITS: Any disability income benefits that **you** receive under any group insurance plan of the **covered employer**

or any employer, any government retirement system related to **your** employment with the **covered employer**[, any formal or informal salary continuation or sick leave program of the **covered employer**].

- [5. [1099 INCOME:]Any amount **you** receive as income from any form of employment, including but not limited to renewal commissions and residual sales commissions.]
6. OTHER INCOME. Any amount **you** receive as income replacement from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.
7. RETIREMENT BENEFITS. Retirement benefits from a plan sponsored by the **covered employer** or any state or federal government.

RETIREMENT BENEFITS: Reference to "retirement benefits" is limited to employer sponsored benefits that:

1. do not represent contributions that **you** made (payments that represent **your** contributions are deemed to be received over **your** expected remaining lifetime, regardless of when those payments are actually received); and
2. are payable upon:
 - a. early or normal retirement after **your** disability begins; or
 - b. disability, provided the payment does not reduce the amount of benefits that would have been paid by the plan at **your** normal retirement age.

LUMP SUM PAYMENTS: Benefit Reductions that are paid in a lump sum will be prorated on a weekly basis over the time period for which the sum was paid or, if less, the **policy's** applicable Maximum Benefit Period. If no time period is stated, the sum will be prorated over **your** expected lifetime as determined by **us**, using appropriate actuarial tables.

COST OF LIVING FREEZE: **We** will not reduce **your** Weekly Benefit Amount if the amount of benefits **you** receive from any source, except earnings from any form of employment, changes because of a cost of living increase that occurs automatically at any time after **you** satisfy the **elimination period**.

To determine the weekly Benefit Reduction amount of income listed above that is paid or payable to **you** monthly, **we** will divide that income amount by 4.33 to determine the weekly reduction amount.

SOURCES OF INCOME THAT DO NOT REDUCE BENEFITS: **We** will not subtract from **your** gross disability benefit, income **you** receive from the following:

1. 401(k) plans;
2. profit sharing plans;

Voluntary Short Term Disability Insurance

Short Term Disability Benefit

3. thrift plans;
4. tax sheltered annuities;
5. stock ownership plans;
6. non-qualified plans of deferred compensation;
7. pension plans for partners;
8. military pension and disability income plans;
9. credit disability insurance;
10. franchise disability income plans;
11. no fault automobile insurance plans, except where required by law;
12. individual disability plans paid by the employee;
13. a retirement plan from another employer;
14. individual retirement accounts (IRA).]

[Survivor Benefit

We will pay a benefit to **your eligible survivor** if **we** receive proof that **your** death occurred:

1. while weekly benefits were being paid to **you** for a **period of disability**; and
2. **your period of disability** had continued for 14 or more consecutive days.

This benefit will be paid [weekly] for the number of weekly payments remaining from the time of death to the end of the Maximum Benefit Period.

We will first apply the Survivor Benefit to any overpayment which may exist on **your** claim.

If **you** have no **eligible survivors**, this benefit will not be payable.]

[Minimum Indemnity for Accidental Dismemberment and Loss of Sight

If **you** suffer an **injury** that results in any of the losses shown below within 90 days of the date of the accident, **we** will pay **you** the Weekly Benefit Amount for the number of weeks shown below.

Payment of this benefit will not be subject to satisfying the **elimination period**. However, after the **elimination period** has been completed, this benefit will be paid in lieu of the regular weekly payment, not in addition to it. If **you** remain **disabled** beyond the number of weekly payments under this provision, benefits may continue as provided under the **policy**. The weeks **you** receive benefits under this provision will be excluded in computing the number of weeks **you** receive payments for **disability** and in computing any remaining Maximum Benefit Period for **disability**. If **you** die, this benefit will cease.

FOR LOSS OF:

NUMBER OF WEEKLY PAYMENTS:

Sight of Both Eyes	26
Both Hands	26
Both Feet	26
One Hand and One Foot	26
One Hand and Sight of One Eye	26
One Foot and Sight of One Eye	26

Voluntary Short Term Disability Insurance

Short Term Disability Benefit

One Hand or One Foot	13
Sight of One Eye	13
Thumb and Index Finger of Either Hand	8

The maximum number of weekly payments for all losses suffered in any one accident shall be limited to that one loss for which the greatest number of weekly payments is provided in the above schedule.

Loss of hands and feet means loss by severance at or above the wrist or ankle joint. Loss of sight means legal blindness. Loss of thumb and index finger means actual severance at or above the knuckles joining each hand.]

[Reasonable Accommodation Expense Benefit

If **you** return to work in any occupation for any employer, not including self-employment, as a result of a **reasonable accommodation** made by such employer, **we** will pay that employer a Reasonable Accommodation Expense Benefit up to the lesser of [\$750] or the equivalent of [2] weeks of **your** weekly benefit; but not to exceed the expenses incurred.

The Reasonable Accommodation Expense Benefit is payable only if the **reasonable accommodation** is approved by **us** in writing prior to its implementation. This benefit is available to **you** one time while **you** are insured under the **policy**.]

[Recovery Expense Benefit

We will reimburse **you** for out-of-pocket recovery expenses that **you** incur during **your** period of covered [**partial** or] **total disability**, subject to the following conditions:

1. **your** recovery expenses are incurred in connection with **appropriate care** of **your** disabling condition; and
2. **your** recovery expenses are incurred based on **treatment** prescribed by **your** treating **physician**; and
3. **you** are receiving benefits for [**partial** or] **total disability** at the time the recovery expense is incurred; and
4. **you** provide proof of the incurred recovery expenses, subject to **our** approval.

We will reimburse **you** [\$25] for the recovery expenses **you** incur each week, not to exceed **your** actual out-of-pocket recovery expenses incurred during the week. The Recovery Expenses Benefit will be paid no more often than monthly. Only one payment will be considered for each incurred expense.

Eligible recovery expenses include:

1. amounts **you** are required to pay as co-payments, deductibles and coinsurance under medical or prescription drug insurance plans; or
2. expenses **you** incur for medical services or prescription drugs that are considered deductible for purposes of United States federal income tax purposes, but for which **you** have no insurance coverage.

Eligible recovery expenses do not include expenses that are paid to **you** or on

Voluntary Short Term Disability Insurance

Short Term Disability Benefit

your behalf by any benefit plan.]

Waiver of Premium

Premium payment for **your coverage** will be waived while **you** are receiving benefits under the **policy**.

[Pre-Existing Condition Limitation

We will not pay **you** the Weekly Benefit Amount for a [partial disability or] **total disability** that is both:

1. caused by, contributed by, or that results, in whole or in part, from a **pre-existing condition**; and
2. begins in the first [12 months] after the effective date of **your coverage** or any **new coverage** under the **policy** [unless **you** have been **treatment** free for [12] consecutive months after **your** effective date of **coverage**].

If **your** benefits under the **policy** are increased, **you** will not be paid the increased benefit amount (but **you** will receive the benefit in effect prior to the increase) for any **disability** caused by, contributed by, or that results, in whole or in part, from a **pre-existing condition** that begins in the first [12 months] after the increase became effective [unless **you** have been **treatment** free for [12] consecutive months after the increase became effective].]

Exclusions

The **policy** will not cover any **period of disability** caused by, attributed to, or resulting from **your**:

1. elective procedure or surgery; or
2. engaging in any illegal or fraudulent occupation, work, or employment; or
3. traveling or flying on any aircraft operated by or under the authority of military or any aircraft being used for experimental purposes; or
4. participation in a war, or an act of war, declared or undeclared or any act of war; or
5. active military duty; or
6. active participation in a riot, rebellion or insurrection; or
7. attempting to commit, or committing, or participating in, an assault or felony; or
8. commission of a crime for which **you** have been convicted; or
9. intentionally self-inflicted **injury** or **illness**, while sane or insane; or
10. attempted suicide, while sane or insane[.]; or]
11. [being legally intoxicated[.]; or]
12. [being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a **physician**[.]; or]
13. [occupational **illness** or **injury**, which is an **illness** or **injury** caused by or aggravated by any employment for pay or profit.]

We will not pay any benefits for any period that **you** are confined to any facility because **you** were convicted of a crime or other illegal act.

Voluntary Short Term Disability Insurance

Claims Provisions

Notice

We encourage **you** to notify **us** of **your** claim as soon as possible so that a claim decision can be made in a timely manner. Notice must be given to **us** at **our home office** within 30 days of the date the **injury** or **illness** begins, or as soon as reasonably possible.

Forms

You should use a claim form for filing a proof of loss. These forms will be supplied to **you** within 15 days of notice of an **injury** or **illness**.

If **you** do not receive a claim form within this 15-day period, **you** may submit a proof of loss by sending **us** the information in writing, describing the occurrence, character, and extent of the **treatment**.

Proof of Loss

You must send **us** a proof of loss within 90 days after the end of the **elimination period**.

We will not decline or reduce a claim if: (a) it is not reasonably possible to give proof within that time; and (b) the proof is submitted within one year from the date of loss or incurral. This one-year period will not apply when **you** are not legally capable of submitting proof.

All proofs of loss must be satisfactory to **us**. **Your** proof of loss must show:

1. that **you** are under the **appropriate care** of a **physician**; and
2. the date **your disability** began; and
3. the cause of **your disability**; and
4. the appropriate documentation of **your weekly earnings** and **your activities**; and
5. the extent of **your disability**, including restrictions and limitations preventing **you** from performing **your regular occupation**; and
6. the name and address of any hospital or institution where **you** received **treatment**, including all attending **physicians**; and
7. documentation of prior disability coverage if applicable.

We may request that **you** send proof of continuing **disability** indicating that **you** are under the continuous care and **treatment** of a **physician**. This proof, provided at **your** expense, must be received within 30 days of a request by **us**.

Time of Claim Payment

When **we** receive and approve **your** proof of loss, **we** will pay any benefits **we** owe **you** under the **policy**. All benefits to which **you** are entitled will be paid [weekly] during **your period of disability**. Any balance remaining unpaid at the end of that period will be paid as soon as possible after **we** receive the proof of loss.

Payment of Claims

All benefits are payable to **you**.

If **you** are not legally capable of accepting a benefit, all or part of the benefit can be paid to **your** spouse, **your** estate (if applicable), or a recognized guardian as determined by **us**. That payment, made in good faith, fully

discharges **us** to the extent of the payment.

Benefits accrued but unpaid before **your** death will be paid to **your** estate. If any benefit is payable to **your** estate, **we** may pay up to \$1,000 of that benefit to a relative of **yours**, by blood or marriage, that **we** determine to be entitled to the benefit. That payment, made in good faith, fully discharges **us** to the extent of the payment.

[Claims for loss of life will be paid according to the Survivor Benefit in the Short Term Disability Benefit section].

Legal Actions

No legal action may be brought to recover under the **policy**:

1. within 60 days after **you** have sent **us** a written proof of loss; or
2. after 3 years from the time **you** were required to send **us** a written proof of loss.

Legal action with respect to a claim that has been denied, in whole or in part, will be contingent upon having obtained **our** reconsideration of that claim.

Reconsideration of a Denied Claim

We will notify **you** if **we** deny **your** claim in whole or in part. In that written notice **we** will explain the reasons for **our** denial. If **you** do not agree with the reasons given, **you** may request a reconsideration of that claim.

To do so, **you** should write to **us** within [180] days after **you** receive the notice of denial. **You** should say why **you** believe the claim denial was not proper. **You** should include any data, questions or comments that **you** think are appropriate. Unless **we** request additional material, **you** will be advised of **our** decision within [45] days after **we** receive **your** letter.

Overpayment of Benefits

Upon discovery that **we** have paid any benefit that should not have been paid or that should have been paid in a lesser amount, **we** may require that **you** return the overpayment to **us**.

If such a repayment is not made in 60 days, **we** will reduce any future benefit payments until **we** recover the overpayment.

Recovery and Subrogation

When **your injury** or **illness** appears to be someone else's fault, any benefits otherwise due under the **policy** for a resulting **period of disability** will not be paid unless **you** agree:

1. to repay **us** for those benefits to the extent that they are for losses for which **you** are compensated by or on behalf of the person at fault; and
2. to sign and give **us** any documentation that **we** request to secure these rights.

Further, when **we** have paid benefits to **you**, **we** will be subrogated to all rights of recovery that **you** have against the person at fault, except where prohibited by law. Such subrogation will extend only to recovery of the benefits **we** paid.

SERFF Tracking Number: SLIA-127086932 State: Arkansas
 Filing Company: Security Life Insurance Company of America State Tracking Number: 48318
 Company Tracking Number:
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
 Product Name: Premier Choice - STD
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: AR Certificate of Readability - STD.pdf AR Certificate of Compliance - STD.pdf AR Consumer Notice.pdf	Approved-Closed	03/24/2011
Satisfied - Item: Application Comments: Approved 3/9/11 Attachment: ERAPP.2010.pdf	Approved-Closed	03/24/2011
Satisfied - Item: Statement of Variability Comments: Attachment: STD SOV Final.pdf	Approved-Closed	03/24/2011

Arkansas Certificate of Readability

I hereby certify, that the forms listed below have the following readability scores as calculated by the Flesch Reading Ease Test.

Form Number	Score
GP2010SBP	40.0
GP2010VSBP	40.2



Bryan Anderson, Executive VP - Operations

March 22, 2011

Date

Arkansas Certificate of Compliance

I hereby certify that Security Life Insurance Company of America will adhere to and comply with the following:

1. Pursuant to Rule and Regulation 49, the Life and Health Guaranty Notice will accompany every policy issued in the State of Arkansas; and
2. This submission meets the provisions of Rule and Regulation 19, as well as all applicable requirements of the Department; and
3. Pursuant to ACA 23-79-138 and Bulletin 11-88, the Arkansas Consumer Information Notice will accompany every policy issued in the State of Arkansas.



Bryan Anderson, Executive VP - Operations

March 22, 2011
Date

ARKANSAS CONSUMER INFORMATION NOTICE

If we at Security Life Insurance Company of America fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Service Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone: 1-800-852-5494 or (501) 371-2640

PLEASE PRINT CLEARLY

General Information		
Employer's Full Legal Name (exactly as it will appear in the Contract): _____		
Coverages Requested (complete and attach an addendum for each coverage selected): <input type="checkbox"/> Life <input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Business is: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other _____		
State of Incorporation: _____		
Tax ID Number:	Years in Business:	
Nature of Business:	SIC Code:	
For groups with 2 to 9 eligible employees: Is this a home based business? <input type="checkbox"/> Yes <input type="checkbox"/> No	For groups with 2 to 9 eligible employees: Are 90% or more of the employees <input type="checkbox"/> Yes <input type="checkbox"/> No in the same family?	
Complete Street Address: Street _____ City _____ State _____ Zip _____ County _____		
Complete Mailing Address (if different): Street _____ City _____ State _____ Zip _____ County _____		
Contact Person:	Title:	
Email:	Telephone Number:	Fax Number:
Who should receive the initial Certificates and Administration Materials? <input type="checkbox"/> Employer— <i>Email required:</i> _____ <input type="checkbox"/> Producing Agent		
Type of Bill Requested: <input type="checkbox"/> List Bill <input type="checkbox"/> Self-Administered (Not available to groups <100 lives or groups applying for Dental or Vision)		
Billing Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly (Not available for Dental or Vision)		
Easy-Pay Method (electronic transfer of premium): <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, then Form# [EZPAY2008] must be completed.		

Subsidiaries to be Included

Subsidiaries or Other Business Locations to be covered: No Yes; if Yes, complete the following:

Subsidiary Name: _____

Complete Street Address: _____

Nature of Business:

Same Other _____

Number of employees _____

Subsidiary Name: _____

Complete Street Address: _____

Nature of Business:

Same Other _____

Number of employees _____

FRAUD STATEMENT: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit, if false information materially related to a claim was provided by the applicant.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KENTUCKY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF NEW MEXICO

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OHIO

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OREGON AND TEXAS

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF TENNESSEE, VIRGINIA, AND WASHINGTON

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Declarations**APPLICANT'S DECLARATION**

1. To the best of my knowledge and belief, all the statements and answers given in this application are true and complete.
2. I understand and agree that (a) no agent may change or waive any of the provisions of this application or of any plan of insurance; (b) any change or waiver may be made only by an officer of Security Life Insurance Company of America; and (c) this application will be accepted or declined partly on the basis of the statements and answers given in this application.

Signature of Officer or Owner

Print Name of Officer or Owner

Date

PRODUCING AGENT'S DECLARATION

1. To the best of my/our knowledge and belief, all the statements and answers given in this application are true and complete.
2. I/we have no knowledge or information about the Applicant, its employees, the dependents of these employees, or any continued persons that is not fully stated in this application.

Signature of Agent

Print Name of Agent

Date

Address:

Telephone #:

License #:

Email:

HOME OFFICE USE:

Statement of Variability

GP2010SSB – Short Term Disability Schedule of Benefits

Page #	Provision	Variables
1	Eligible Class	Class name and description of class as defined by the policyholder.
1	Coverage Effective Date	Effective date of group contract.
1	Plan Effective Date	Effective date of insured's coverage.
1	Open Enrollment Period	Variable will either be "Not Available" or will include a date range
1	Work Hours Required for Eligibility	Hours range [15-40]
1	Waiting Period	Day range [0-365] or month range [0-36] Statements will be in or out based on whether or not there is a waiting period.
1	Your Premium Contribution	Word and statement will be in or out based on policyholder selection.
1-2	Your Weekly Benefit Amount	<p>Statements and/or words will be in or out based on policyholder selection</p> <p>Core: VARIABLE – Percentage range [20% - 75%] VARIABLE – Dollar range [\$50 - \$3,000]</p> <p>Core: VARIABLE – Dollar range [\$50 - \$1,500] VARIABLE – Percentage range [50% - 75%]</p> <p>Employer Sponsored: VARIABLE – Increments [\$50-\$250], up to [\$50-\$1500] VARIABLE – Percentage range [50%-75%]</p> <p>Optional: VARIABLE – Percentage range [40% - 80%] VARIABLE – Dollar range [\$100 - \$5,000]</p> <p>Optional: VARIABLE – Dollar range [\$100 - \$5,000] VARIABLE – Percentage range [50% - 80%]</p> <p>Minimum weekly benefit: VARIABLE – Dollar range [\$15 - \$150]</p> <p>Weekly Benefit Amounts in excess: VARIABLE – Dollar range [\$0 - \$3,000]</p>

2	Frequency of Benefit Payments	VARIABLE – [weekly] or [bi-weekly] or [monthly]
2	Elimination Period	Phrases [the later of:], [partial disability or], [#3] and [#4] will be in or out based on policyholder selection. VARIABLE - Day range [0 - 31] VARIABLE - Day range [0 - 31] VARIABLE - Day range [0-31]
2	Maximum Benefit Period	VARIABLE - Week range [4 – 104]
2	Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or other Leave of Absence	[Temporary Layoff] variable to be included based on policyholder selection. VARIABLE - Month range [0-12] VARIABLE - Month range [0-12]
2	Partial Disability Benefit	[Included.] or [Not Included.] based on policyholder selection.
3	Residual Disability Benefit	[Included.] or [Not Included.] based on policyholder selection.
3	Maternity Coverage	Statement included is based on policyholder selection.
3	Survivor Benefit	If available, Benefit included, if selected by policyholder.
3	Minimum Indemnity for Accidental Dismemberment and Loss of Sight	If available, Benefit included, if selected by policyholder.
3	Reasonable Accommodation Expense Benefit	If available, Benefit included, if selected by policyholder.
3	Recovery Expense Benefit	If available, Benefit included, if selected by policyholder.
3	Pre-Existing Condition Limitation	Option included is based on policyholder selection.

GP2010SBP – Short Term Disability Benefit Provisions

Page #	Provision	Variables
1	Disability, Disabled	Phrase included or not included based on policyholder selection
1	Eligible Survivor	Definition included if Survivor Benefit has been selected by policyholder.
1	Elimination Period	VARIABLE – Day range [7-21]
1	Illness	Statement will be included based on policyholder selection with regard to pregnancy
2	Partial Disability, Partially Disabled	Definition included if Partial Disability benefits have been selected by policyholder.

3	Period of Disability	Phrase will be in or out based on policyholder selection.
3	Physician	Statement in or out based on policyholder selection.
3	Pre-Existing Condition	Statements in or out based on policyholder selection. VARIABLE – Month range [3 – 24]
3	Reasonable Accommodation	Definition included if Reasonable Accommodation Expense Benefit was selected by policyholder.
3	Recurrent Disability	Phrases will be in or out based on policyholder selection.
4-5	Weekly Earnings	Statements will be in or out based on policyholder selection. VARIABLE – Month range [12 - 36] VARIABLE – Month range [12 - 36]
7	Enrollment Requirement	Statement included is based on whether there is an Open Enrollment Period as selected by policyholder.
7	Recurrent Disability	VARIABLE – Day range [14 – 45]
8	Termination of your Short Term Disability Coverage	Phrases will be in or out based on policyholder selection.
8	Continuation of Coverage during [Temporary Layoff,] Injury, Illness or Leave of Absence	Phrase will be in or out based on policyholder selection.
8	Reinstatement	Phrase not standardly included, based on policyholder selection.
9	Continuity of Coverage	Provision will be in or out based on policyholder selection.
10	Conditions for Payment of Short Term Disability Benefits	[partially disabled or] will be in or out based on policyholder selection.
10	Benefit Payment	VARIABLE#1 – [weekly] or [bi-weekly] or [monthly] VARIABLE#2 – [one week, two weeks or 30 days] VARIABLE#3 – [one week, two weeks or 30 days] VARIABLE#4 – [1/7 th , 1/14 th , or 1/30 th] [partial disability or] will be in or out based on policyholder selection.
10	Work Incentive Benefit	Provision will be in or out based on policyholder selection.
11	Determining Weekly Benefit Amount for a Partial Disability	Provision will be in or out based on policyholder selection.
12-13	Benefit Reductions	Provision and statements will be in or out

		based on policyholder selection.
14	Survivor Benefit	Provision will be in or out based on policyholder selection. VARIABLE – [weekly] or [bi-weekly] or [monthly]
14	Minimum Indemnity for Accidental Dismemberment and Loss of Sight	Provision will be in or out based on policyholder selection.
14	Reasonable Accommodation Expense Benefit	Provision will be in or out based on policyholder selection. VARIABLE – Dollar range [\$500 - \$2,500] VARIABLE – Week range [1 – 6]
15	Recovery Expense Benefit	Provision and statement will be in or out based on policyholder selection. VARIABLE – Dollar range [20-100]
15	Waiver of Premium	Provision will be in or out based on policyholder selection.
16	Pre-Existing Condition Limitation	Provision and statements will be in or out based on policyholder selection. VARIABLE #1 – Month range [12-24] VARIABLE #2 – Month range [6 – 24] VARIABLE #3 – Month range [12 – 24] VARIABLE #4 – Month range [6-24]
16	Exclusions	Statements will be in or out, based on underwriting selection and proposed benefits
17	Time of Claim Payment	VARIABLE – [weekly] or [bi-weekly] or [monthly]
18	Payment of Claims	Phrase will be in or out based on whether the Survivor Benefit provision has been selected by the policyholder.
18	Reconsideration of a Denied Claim	VARIABLE – [60-180] VARIABLE – [45-180]

GP2010VSSB - Voluntary Short Term Disability Schedule of Benefits

Page #	Provision	Variables
1	Eligible Class	Class name and description of class as defined by the policyholder.
1	Coverage Effective Date	Effective date of group contract.
1	Plan Effective Date	Effective date of insured's coverage.
1	Open Enrollment Period	Variable will include a date range
1	Work Hours Required for Eligibility	Hours range [15-40]
1	Waiting Period	Day range [0-365] or month range [0-36]

		Statements will be in or out based on whether or not there is a waiting period.
1	Your Premium Contribution	Statements will be in or out based on policyholder selection.
1	Your Weekly Benefit Amount	<p>Statements and/or words will be in or out based on policyholder selection.</p> <p>Weekly Benefit Amount: VARIABLE – Percentage range [20% - 75%] VARIABLE – Dollar range [\$50 - \$3,000]</p> <p>Weekly Benefit Amount: VARIABLE – Dollar range [\$50 - \$1,500] VARIABLE – Percentage range [50% - 75%]</p> <p>Weekly Benefit Amount in increments: VARIABLE – Dollar increment [\$50] or [\$100] VARIABLE – Dollar range [\$50 - \$1,500] VARIABLE – Percentage range [50% - 75%]</p> <p>Employer Sponsored: VARIABLE – Increments [\$50-\$250], up to [\$50-\$1500] VARIABLE – Percentage range [50%-75%]</p> <p>Minimum Weekly Benefit: VARIABLE – Dollar range [\$15 - \$150]</p> <p>Weekly Benefit Amounts in excess VARIABLE – Dollar range [\$0 - \$3,000]</p>
2	Frequency of Benefit Payments	VARIABLE – [weekly] or [bi-weekly] or [monthly]
2	Elimination Period	<p>Phrases [the later of:], [partial disability or], [#3] and [#4] will be in or out based on policyholder selection.</p> <p>VARIABLE - Day range [0 - 31] VARIABLE - Day range [0 - 31] VARIABLE - Day range [0 -8]</p>
2	Maximum Benefit Period	VARIABLE - Week range [9 – 104]
2	Continuation of Coverage Period during [Temporary Layoff,] Injury, Illness or Other Leave of Absence	<p>[Temporary Layoff] variable to be included based on policyholder selection.</p> <p>VARIABLE - Month range [0 - 12] VARIABLE - Month range [0 - 12]</p>
2	Partial Disability Benefit	[Included.] or [Not Included.] based on policyholder selection.
2	Residual Disability Benefit	[Included.] or [Not Included.] based on policyholder selection.
2	Maternity Coverage	Statement included is based on policyholder selection.
2	Survivor Benefit	Benefit included, if selected by policyholder.

2	Minimum Indemnity for Accidental Dismemberment and Loss of Sight	Benefit included, if selected by policyholder.
3	Reasonable Accommodation Expense Benefit	Benefit included, if selected by policyholder.
3	Recovery Expense Benefit	Benefit included, if selected by policyholder.
3	Pre-Existing Condition Limitation	Option included is based on policyholder selection.

GP2010VSBP – Voluntary Short Term Disability Benefit Provisions

Page #	Provision	Variables
1	Disability, Disabled	Phrase included or not included based on policyholder selection
1	Eligible Survivor	Definition included if Survivor Benefit has been selected by policyholder.
1	Elimination Period	VARIABLE – Day range [7-21]
1	Evidence of Insurability	Definition will be in or out based on underwriting selection and proposed benefits.
1	Illness	Statement will be included based on policyholder selection with regard to pregnancy
2	Partial Disability, Partially Disabled	Definition included if Partial Disability benefits have been selected by policyholder.
3	Period of Disability	Phrase will be in or out based on policyholder selection.
3	Physician	Statement in or out based on policyholder selection.
3	Pre-Existing Condition	Statements in or out based on policyholder selection. VARIABLE – Month range [3 – 24]
3	Reasonable Accommodation	Definition included if Reasonable Accommodation Expense Benefit was selected by policyholder.
3	Recurrent Disability	Phrases will be in or out based on policyholder selection.
4-5	Weekly Earnings	Statements will be in or out based on policyholder selection. VARIABLE – Month range [12 - 36] VARIABLE – Month range [12 - 36]
6	Effective Date of Your Short	Statement included based on policyholder

	Term Disability Coverage	selection.
7	Evidence of Insurability Requirement	Provision will be in or out based on policyholder selection
7	Recurrent Disability	VARIABLE – Day range [14 – 45]
7	Termination of your Short Term Disability Coverage	Phrases will be in or out based on policyholder selection.
8	Continuation of Coverage during [Temporary Layoff,] Injury, Illness or Other Leave of Absence	Phrase will be in or out based on policyholder selection.
8	Reinstatement	Phrase not standardly included, based on policyholder selection.
9	Continuity of Coverage	Provision will be in or out based on policyholder selection.
10	Conditions for Payment of Short Term Disability Benefits	[partially disabled or] will be in or out based on policyholder selection.
10	Benefit Payment	VARIABLE#1 – [weekly] or [bi-weekly] or [monthly] VARIABLE#2 – [one week, two weeks, 30 days] VARIABLE#3 – [one week, two weeks, 30 days] VARIABLE#4 – [1/7, 1/14, 1/30] [partial disability or] will be in or out based on policyholder selection.
10	Work Incentive Benefit	Provision will be in or out based on policyholder selection.
11	Determining Weekly Benefit Amount for a Partial Disability	Provision will be in or out based on policyholder selection.
11-13	Benefit Reductions	Provision and statements will be in or out based on policyholder selection.
13	Survivor Benefit	Provision will be in or out based on policyholder selection. VARIABLE – [weekly] or [bi-weekly] or [monthly]
13	Minimum Indemnity for Accidental Dismemberment and Loss of Sight	Provision will be in or out based on policyholder selection.
13-14	Reasonable Accommodation Expense Benefit	Provision will be in or out based on policyholder selection. VARIABLE – Dollar range [\$500 - \$2,500] VARIABLE – Week range [1 – 6]
14	Recovery Expense Benefit	Provision and statement will be in or out based on policyholder selection. VARIABLE – Dollar range [20-100]
15	Pre-Existing Condition Limitation	Provision and statements will be in or out based on policyholder selection. VARIABLE #1 – Month range [12-24] VARIABLE #2 – Month range [6 – 24] VARIABLE #3 – Month range [12 – 24]

		VARIABLE #4 – Month range [6-24]
15	Exclusions	Statements will be in or out underwriting selection and proposed benefits
16	Time of Claim Payment	VARIABLE – [weekly] or [bi-weekly] or [monthly]
16-17	Payment of Claims	Phrase will be in or out based on whether the Survivor Benefit provision has been selected by the policyholder.
17	Reconsideration of a Denied Claim	VARIABLE – [60-180] VARIABLE – [45-180]