Long Term Disability

TO: Somerville Employees

FROM: Barbara Brown, Benefits Manager

RE: Long Term Disability Program Enrollment Packet

The City of Somerville is pleased to offer to its employees a Group Long Term Disability Program, provided through SunLife Financial. The program is designed to pay monetary benefits (60% of your salary income tax free) for extended periods of time when an injury or illness prevents you from earning an income. In essence, it is income protection insurance. This program is completely voluntary and employees pay 100% of the premium of the plan in order to keep any potential benefit income tax free. Attached is a detailed outline of the benefits and of our LTD program

You may enroll at anytime, however you will be required to provide evidence of insurability and are not guaranteed a policy.

MOSSE & MOSSE
SCHOOL AND MUNICIPAL SERVICES

City of Somerville

Long Term Disability Plan Outline – New Hire Enrollment Packet

- ***Guaranteed Issue.*** The benefit is a guaranteed issue product, meaning if you sign up in your first 30 days of employment, you cannot be denied access to the plan for any reason. However, if you do not elect the coverage when you are first offered it and then wish to join the plan at a later date, you have to prove evidence of insurability and you may be denied access to the plan.

- **LTD monthly benefit is 60%** of gross pay to a maximum of $10,000 per month. All benefits will be paid ***income tax free***, both federal and state, because the employees are paying the premium with post tax payroll deductions.

- **Elimination Period: 90 Calendar days.** This is the length of time that one has to be out of work due to a disability before collecting benefits.

- **Maximum Benefit Duration:** benefits payable for disability to Social Security Retirement Age (age 60 and older follow ADEA schedule, see attached).

- **Exclusions:**
  - Intentional self-inflicted injury
  - War, declared or undeclared, or any act of war
  - Active participation in a riot, rebellion or insurrection
  - Committing or attempting to commit an assault, felony or other illegal act

- **Two year limitation** on benefits for:
  - Outpatient drug and alcohol abuse
  - Outpatient mental and nervous disorder

- **Residual/Partial Benefit:** During elimination and benefit period, an employee showing a 20% or greater earnings loss due to disability is benefit eligible. In the elimination period, the days worked on partial basis count towards fulfillment of period. After the elimination period, employee will receive partial benefits not to exceed 100% of pre-disability earnings.

- **Integration/Minimum benefit:** the "double dip rule" - plan offsets with other forms of income including workers' compensation, social security and retirement awards. Minimum benefit is $100 per month or 10% of benefit.

- **Two Year Own Occupation.** This is the definition of disability and states that employees are considered disabled if, due to injury or illness, they can no longer perform the duties of their own occupation for first 24 months of disability.

- **3/12 pre-existing condition clause.** Benefits will not be paid for any disability which begins in the first 12 months of being insured which is due to, or results from, a pre-existing condition. A pre-existing condition is a sickness or injury for which the employee has received treatment, took prescribed drugs or medicines, or consulted a physician during the 3 months prior to the employee's effective date of coverage. Once an active employee with a pre-existing condition is enrolled in the program for 12 months, that pre-existing condition is then covered going forward.

How much does the plan cost?

The rate for our plan is the most competitive in the marketplace for the benefits in our contract. Below are several examples of the costs associated with our plan but the actual cost will be tailored specifically to each employee's individual annual salary. Rates are based on each employee's age and employees will attain new banded rate as they age. Rates are guaranteed for at least 3 years from the effective date of the program.

Age Band		Rates
< 24		$0.083
25-29		$0.158
30-34		$0.285
35-39		$0.413
40-44		$0.623
45-49		$0.825
50-54		$0.938
55-59		$1.065
60-64		$1.080
65-69		$0.705
70+		$0.660

Formula for individual cost:

Annual Salary / $100 x Rate = Annual Premium

Annual Premium / 12 = Monthly Cost

Cost Example: Age 45, earning $50,000:

$50,000 / $100 x $0.825 = $412.50 Annual Cost

$412.50 / 12 = $34.38 Monthly Cost

How do I sign up?

There are two ways an employee may enroll in the LTD program:

Paper enrollment form - If you wish to take advantage of this coverage, please complete the enrollment form on the last page of this packet by filling out your **Name**, **Date of Birth, Job Title, and Annual Salary and check "I Elect"** next to Long Term Disability and **sign** the bottom of the form. If you do not wish to enter the program simply check "I refuse" and sign the bottom of the form. **All paper enrollment forms need to be submitted to the Personnel Office within the first 30 days of employment.**

If you'd like additional information or have any questions, free to contact our consultant at Mosse & Mosse Associates, Brian Fitzgerald, at 781-224-1709 x139 or brf@mosseservices.com. He would be happy to answer any questions you may have about the program.

Cost Examples based on various Annual Salaries

Age	Rate/ $100	$20,000 Annual Cost	$20,000 Cost/ 52 pays	$20,000 Cost/ 21 pays	$30,000 Annual Cost	$30,000 Cost/ 52 pays	$30,000 Cost/ 21 pays	$40,000 Annual Cost	$40,000 Cost/ 52 pays	$40,000 Cost/ 21 pays	$50,000 Annual Cost	$50,000 Cost/ 52 pays	$50,000 Cost/ 21 pays
Under 25	$0.083	$17	$0.32	$0.79	$25	$0.48	$1.19	$33	$0.64	$1.58	$42	$0.80	$1.98
25-29	$0.158	$32	$0.61	$1.50	$47	$0.91	$2.26	$63	$1.22	$3.01	$79	$1.52	$3.76
30-34	$0.285	$57	$1.10	$2.71	$86	$1.64	$4.07	$114	$2.19	$5.43	$143	$2.74	$6.79
35-39	$0.413	$83	$1.59	$3.93	$124	$2.38	$5.90	$165	$3.18	$7.87	$207	$3.97	$9.83
40-44	$0.623	$125	$2.40	$5.93	$187	$3.59	$8.90	$249	$4.79	$11.87	$312	$5.99	$14.83
45-49	$0.825	$165	$3.17	$7.86	$248	$4.76	$11.79	$330	$6.35	$15.71	$413	$7.93	$19.64
50-54	$0.938	$188	$3.61	$8.93	$281	$5.41	$13.40	$375	$7.22	$17.87	$469	$9.02	$22.33
55-59	$1.065	$213	$4.10	$10.14	$320	$6.14	$15.21	$426	$8.19	$20.29	$533	$10.24	$25.36
60-64	$1.080	$216	$4.15	$10.29	$324	$6.23	$15.43	$432	$8.31	$20.57	$540	$10.38	$25.71
65-69	$0.705	$141	$2.71	$6.71	$212	$4.07	$10.07	$282	$5.42	$13.43	$353	$6.78	$16.79
70+	$0.660	$132	$2.54	$6.29	$198	$3.81	$9.43	$264	$5.08	$12.57	$330	$6.35	$15.71

Age	Rate/ $100	$60,000 Annual Cost	$60,000 Cost/ 52 pays	$60,000 Cost/ 21 pays	$70,000 Annual Cost	$70,000 Cost/ 52 pays	$70,000 Cost/ 21 pays	$80,000 Annual Cost	$80,000 Cost/ 52 pays	$80,000 Cost/ 21 pays	$90,000 Annual Cost	$90,000 Cost/ 52 pays	$90,000 Cost/ 21 pays
Under 25	$0.083	$50	$0.96	$2.37	$58	$1.12	$2.77	$66	$1.28	$3.16	$75	$1.44	$3.56
25-29	$0.158	$95	$1.82	$4.51	$111	$2.13	$5.27	$126	$2.43	$6.02	$142	$2.73	$6.77
30-34	$0.285	$171	$3.29	$8.14	$200	$3.84	$9.50	$228	$4.38	$10.86	$257	$4.93	$12.21
35-39	$0.413	$248	$4.77	$11.80	$289	$5.56	$13.77	$330	$6.35	$15.73	$372	$7.15	$17.70
40-44	$0.623	$374	$7.19	$17.80	$436	$8.39	$20.77	$498	$9.58	$23.73	$561	$10.78	$26.70
45-49	$0.825	$495	$9.52	$23.57	$578	$11.11	$27.50	$660	$12.69	$31.43	$743	$14.28	$35.36
50-54	$0.938	$563	$10.82	$26.80	$657	$12.63	$31.27	$750	$14.43	$35.73	$844	$16.23	$40.20
55-59	$1.065	$639	$12.29	$30.43	$746	$14.34	$35.50	$852	$16.38	$40.57	$959	$18.43	$45.64
60-64	$1.080	$648	$12.46	$30.86	$756	$14.54	$36.00	$864	$16.62	$41.14	$972	$18.69	$46.29
65-69	$0.705	$423	$8.13	$20.14	$494	$9.49	$23.50	$564	$10.85	$26.86	$635	$12.20	$30.21
70+	$0.660	$396	$7.62	$18.86	$462	$8.88	$22.00	$528	$10.15	$25.14	$594	$11.42	$28.29

Annual Premium Calculation: Annual Salary / 100 x Rate = Annual Premium

Maximum Benefit Duration Schedule

Duration of Benefit Schedule - SSNRA

Year of Birth	Normal Retirement Age
Before 1938	Age 65
1938	Age 65 and 2 months
1939	Age 65 and 4 months
1940	Age 65 and 6 months
1941	Age 65 and 8 months
1942	Age 65 and 10 months
1943 through 1954	Age 66
1955	Age 66 and 2 months
1956	Age 66 and 4 months
1957	Age 66 and 6 months
1958	Age 66 and 8 months
1959	Age 66 and 10 months
After 1959	Age 67

Duration of Benefit Schedule – ADEA

Age at Disablement	Duration of Benefit
Age 59 or less	To Age 65, but not less than 60 months
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 or older	12 months

*****Maximum Benefit Period is SSNRA or ADEA whichever is greater

Sun Life Assurance Company of Canada
Group Enrollment Form

Employer Name	Policy Number	Effective Date	Occupation (Title)
City of Somerville	902386		

Employee's Full Legal Name (First, MI, Last)		Date of Birth	Annual Salary	# of Pay Periods
	☐ Male ☐ Female			

Please elect or refuse coverage below one time by placing a check mark in the appropriate box. All employees must be actively at work and not on any leave of absence to enroll in the program.

Long Term Disability Plan ☐ I Elect ☐ I Refuse

Note: Medical Evidence of Insurability will be required for any employee who applies for coverage more than 31 days past his/her eligibility date and later requests to be covered. Medical Evidence of Insurability is obtained at the employee's expense.

By signing below, you are verifying that the information you have provided is true and correct.

X _____ _____

Employee Signature | Today's Date

You must sign and date this form to become covered.

Employees: Make a copy of of this form for your records before submitting it to your employer.
Employers: This original enrollment form should remain at the employer's site. Family status, coverage or beneficiary changes should be recorded on another enrollment form.

Sun Life Assurance Company of Canada

Evidence of Insurability Cover Page

Sun Life Financial®

Employer Instructions

Complete this cover page and provide it to the employee. The employee may complete the Evidence of Insurability (EOI) application either online or on paper:

- **Online at www.sunlife-usa.com/planmembers**
  Our secure online system allows employees to provide all of the information needed for Evidence of Insurability in about 10 to 15 minutes. Following completion of the application, the employee receives confirmation by email. The employee then will receive notification of our decision by email or mail.
- **Printable EOI application**
  If submitting the EOI application on paper, the applicant must include this Cover Page with his/her submission. Failure to include a completed Cover Page could delay the EOI process.

Employee/Dependent Information (To be completed by employer)

Employee Name (first, middle initial, last)	Group Policy Number 902386
Social Security Number (last four digits) | | |	Approval ☐ Employee ☐ Spouse Requested for ☐ Dependent Child(ren): No. of Children:

Coverage(s) Subject to Evidence of Insurability (To be completed by employer)

Select coverage(s) for which EOI is required. Fill in Current Amount of coverage, or the Guaranteed Issue (GI) amount of the plan. Then fill in Requested Amount and Amount Subject to EOI. Sign and date here if employee is submitting the printable EOI form.

Life Insurance

	Current Amount of Coverage (or GI)	Requested Amount	Amount Subject to EOI
☐ Employee Basic	$	$	$
☐ Employee Optional	$	$	$
☐ Spouse Basic	$	$	$
☐ Spouse Optional	$	$	$
☐ Child Optional	$	$	$

Other Coverages

☐ Short Term Disability	
☐ Long Term Disability	
☐ Buy-Up LTD:	$

Signature of person completing this cover page (Employer) X	Date

Need help determining EOI? Please see your **Group Policy** and the **Administrator's Guide**.

Employee Instructions

Complete and submit either the Online EOI Application or the Printable EOI Application, but <u>not both</u>.

- **Online EOI Application**
  1. Go to www.sunlife-usa.com/planmembers and click on Evidence of Insurability
  2. Follow the instructions on the web site. Enter height weight, date of birth and medical history for you and any dependents on this application. Use the information supplied by your employer above to complete the Coverage Information section of the online application. Your application will not be submitted until you click the Submit for Review button on the last screen.
- **Printable EOI Application**
  1. Complete pages 1 and 2 of the EOI Application according to the instructions. You may type your answers into the fillable form and then print the document. Please remember to sign and date the form.
  2. Mail or Fax the EOI Application and this Employer Cover Page to us:

MAIL TO: Sun Life Assurance Company of Canada
Group Medical Underwriting, SC 7190
15 Rye Street
Portsmouth, NH 03801

-or-

FAX TO: (781) 446-1517

Sun Life Assurance Company of Canada

Evidence of Insurability Application – Health Questionnaire

Sun Life Financial®

I Applicant Information (Please print clearly)

Complete and return pages 1 and 2 of this form, along with the employer cover page to:

Sun Life Financial
Group Medical Underwriting
SC7190
15 Rye Street
Portsmouth, NH 03801

Fax: (781) 446-1517

Your name (first, middle initial, last)	Name of your employer City of Somerville	Group policy no. 902386

Your street address	City	State	Zip Code

Social Security number – –	Daytime phone number	E-mail address

This Application is for: ☐ Employee ☐ Spouse ☐ Child ☐ Male ☐ Female

Name (if different than above)	Date of birth (m/d/y)	Height ft. in.	Weight lbs.

II Health History (The information in sections II, III and IV is confidential and will not be shared with your employer)

Important: You must answer all questions. If you answer "Yes" to any question, please use the space in Section IV on page 2 to provide the details of your condition. Failure to provide the details of your condition will cause a delay in the review of your application.

1. In the past five years, have you:

a. Had transplant surgery, other surgery, injuries or been treated in a hospital? ☐ Yes ☐ No
b. Been treated for alcoholism or advised by a physician to change your drinking habits? ☐ Yes ☐ No
c. Used heroin, marijuana, cocaine, LSD, amphetamines, or any other narcotic? ☐ Yes ☐ No
d. Been off work for more than five consecutive days due to illness or injury? ☐ Yes ☐ No
e. Lost 20 lbs. or more over a 12 month period? ☐ Yes ☐ No

2. In the past five years, have you been diagnosed with, treated for or had any symptoms relating to any of the conditions listed below?

a. Dizzy spells, epilepsy, a nervous or neurological disorder, migraines or a mental disorder ☐ Yes ☐ No
b. Asthma, bronchitis, emphysema, chronic cough, shortness of breath, Chronic Obstructive Pulmonary Disease (COPD) or lung disorder ☐ Yes ☐ No
c. Abnormal blood pressure, chest pain, heart murmur, heart disease or heart attack ☐ Yes ☐ No
d. Ulcer, liver disorder, colitis, diarrhea or any complaint of the digestive organs ☐ Yes ☐ No
e. Arthritis, gout, rheumatism, back disorder, disc disease or joint or bone disorder ☐ Yes ☐ No
f. Cancer, tumor, enlarged glands, enlarged lymph nodes or lupus ☐ Yes ☐ No
g. Sugar in urine, diabetes, kidney or bladder disorder ☐ Yes ☐ No
h. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV) ☐ Yes ☐ No
i. Anemia, blood vessel disease, bleeding or any other blood disease or disorder ☐ Yes ☐ No
j. Disorders of the eyes or ears ☐ Yes ☐ No
k. Chronic fatigue or fibromyalgia ☐ Yes ☐ No

3. Are you currently pregnant? ☐ Yes ☐ No

Domiciliary State – Michigan

Continued on next page

III Activities

Important: If you answer "Yes" to any question, use the space in section IV to list each activity, how often you participate in it and the last time you participated in it.

Do you engage in any of the following activities?

a. Skydiving ☐ Yes ☐ No
b. Scuba diving ☐ Yes ☐ No
c. Vehicle or boat racing ☐ Yes ☐ No
d. Piloting an aircraft ☐ Yes ☐ No

IV Detail (Provide detail below about any "Yes" answer from sections II and III.)

Question number	Description/History of Condition (e.g. high blood pressure, recent BP reading etc.)	Date Condition Began	Duration of Condition/ Treatment	Treatment	Fully Recovered?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

If you need more room, check here ☐ and attach a separate sheet.

V Signature

Please read the Certification and sign and date the form below.

If an Authorization form is included in this package, please remember to sign and date all pages of the form and return it with your completed EOI Application.

Certification

I hereby certify, to the best of my knowledge and belief, that:

- The information I have provided in the Evidence of Insurability (EOI) Application is true, accurate and complete.
- I have read, or had read to me, the completed EOI Application, and understand that any false statements or misrepresentation made in it may result in a loss of coverage under the Group Insurance Policy.
- I have read or had read to me the Fraud Warning for my state on Page 3.

I also hereby confirm my understanding that:

- My EOI Application may be denied and I may be refused insurance if Sun Life Assurance Company of Canada ("The Company") determines that I am not insurable. If The Company determines that I am not insurable, it will explain in writing the basis of its determination.
- I may ask The Company in writing to: (a) obtain certain information from the EOI Application file relating to me (a fee may be charged); (b) correct, amend or delete information in the EOI Application file relating to me (as permitted by applicable law); (c) file my own statement of facts if I believe any information in the EOI Application file relating to me is incorrect; and (d) provide me with a copy of my EOI Application.
- If I have any questions regarding my EOI Application, I can write to Sun Life Assurance Company of Canada, Group Medical Underwriting – SC 7190, 15 Rye Street, Portsmouth, NH 03801.

Signature of Employee X	Date signed
Signature of Spouse (If Application is for spouse) X	Date signed

Sun Life Assurance Company of Canada

Please read the applicable fraud warning before signing this form.

State Law requires us to notify you of the following:

Fraud Warning (for all states except those listed separately below): 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 Warning – 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 Warning – Louisiana: 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 Warning – 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 Warning – Oklahoma: 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 Warning – Virginia: Any person who, with 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 may have violated state law.

Fraud Warning –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.