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Mosse & Mosse Associates

Employee Benefit Consulting & Brokerage

AN NFP COMPANY

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Tantasqua Regional School District
Long Term Disability Plan

- Guaranteed Issue. The benefit is a guaranteed issue product, meaning if you sign up when you are first offered the coverage, 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.

- Benefit: 60% of gross pay to a maximum of $7,500 per month. All benefits will be paid tax free, both federal and state, because the employees are paying the premium.

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

- Benefit Duration: benefits payable for disability to age 65 (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: plan offsets with workers' compensation social security and disability retirement awards. Minimum benefit is $100 per month

- Own Occupation to age 65 for all teachers, principals and administrators. Two year own occupation protection for all other employees.

- 3% Cost of Living Adjustment is included in the benefit each year an employee is collecting benefits to maximum of 5 adjustments.

- 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.

How much does the plan cost?

The rate for our plan is the most competitive in the marketplace for the benefits in our contract. The rate is $0.50 per $100 of income and each employee will have the same rate regardless of age or salary. 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.

Annual Salary	Annual Cost	Cost Per Pay Period (based on 24 pays)
$20,000	$100.00	$4.17
$30,000	$150.00	$6.25
$40,000	$200.00	$8.33
$50,000	$250.00	$10.42
$60,000	$300.00	$12.50

Formula for cost per pay period: Annual Salary x $0.0050 / Number of Pay Periods

Example of an Employee earning $40,000 with 24 pay periods:

1. $40,000 x $0.0050 = $200 annual premium
2. $200 / 24 pay periods = $8.33 per pay period

How do I sign up?

If you wish to take advantage of this coverage, please complete the **Assurant Form** by filling out your name, date of birth, check the "Yes" box under "Acceptance" and sign the bottom of the form. If you do not choose to enter the program, simply check "No" under "Refusal" and sign the bottom of the form. All employees need to complete a form. Unlike other group insurance programs, staff may only receive guaranteed coverage in the program when it is initially offered. If you decide against electing coverage in this initial offering and wish to sign up later, you are not guaranteed coverage in the plan.

If you have any questions about our LTD plan, please feel free to contact our consultant at Mosse & Mosse Associates, Brian Fitzgerald, at 781-224-1709 x139. He will be happy to go over the program with you in more detail and answer any questions you may have.

Voluntary Group Long Term Disability
Employee Application

ASSURANT Employee Benefits

Group no. _____ Account no. _____ Cert no. _____

(Please print or type.)

Proposed effective date _____

Name of employer TANTASQUA REGIONAL SCHOOL DISTRICT

Employee Information—Failure to accurately complete the questions on this application may affect the existence or amount of coverage requested.

Name _____ Social Security no. _____
LAST FIRST MI

Date of birth ___/___/___ Sex: ☐ Male ☐ Female

Basic earnings $_____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly *(Check one.)*

Hours worked per week _____ Hire date _____ Job title _____

Work location _____
CITY STATE

ACCEPTANCE

☐ **Yes,** I would like to participate in the Union Security Insurance Company Voluntary Group Long Term Disability Insurance plan. I understand that by signing and submitting this form to elect coverage, I am authorizing payroll deductions from my salary. I further certify that any information disclosed on this application is accurate and that my answers to any questions are true, accurate and complete, to the best of my knowledge and belief. I understand that I must be actively at work on the effective date or coverage will be deferred until I return to work.

REFUSAL

☐ **No,** I do not wish to participate. I understand that I will not be entitled to any benefits under this coverage and will not be able to apply at a later date without providing proof of good health satisfactory to Union Security Insurance Company and that I can be turned down for coverage on the basis of my health. **Coverages not elected will be assumed refused, even if not specifically refused.**

Notice: For this group insurance plan to become effective, a minimum number of employees must apply. Your coverage will not go into effect unless the minimum requirement is met. Payroll deductions may begin prior to the effective date of your insurance.

_____ _____
EMPLOYEE SIGNATURE DATE

Insurance Company use only *(Do not complete.)*

Age _____ Premium _____ Effective date _____ Coverage amount $_____

Union Security Insurance Company
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