Short & Long Term Disability Income Protection Insurance Highlights

MTA Benefits, Inc. - Policy # 570975

Please read carefully the following description of your ***voluntary*** Unum Short and Long Term Disability Income Protection insurance plan. For a copy of the Plan Certificate, visit *www.mtabenefits.com*.

Eligibility

You are eligible for coverage under these plans if you are: (a) a member of the Massachusetts Teachers Association; and (b) employed by a School Department in the Commonwealth of Massachusetts; (c) which allows your premium to be remitted, post tax, on a salary reduction basis or via bank draft; (d) you are actively working full time, 18.5 hours or more per week.

You may choose the following Income Protection Plans: STD - 60% of your weekly covered salary and/or LTD – 60% of your monthly covered salary.
Should you decide not to enroll, you will be unable to join the plan(s) until the next annual enrollment period as defined by MTA Benefits.

This is a special open enrollment for all eligible members. All currently insured members and new enrollees may choose to purchase either of the income protection plans offered during this special enrollment. However, any increase to current coverage amounts are subject to a pre-existing condition provision.

Elimination Period

The Elimination Period is the length of time of continuous disability which must be satisfied before you are eligible to receive benefits. Your **STD EP is 30 days**. STD benefits would begin after 30 days if your disability is the result of an injury or sickness that occurs while you are covered under the plan. **LTD benefits would begin after 180 days** if your disability is the result of an injury or sickness that occurs while you are covered under the plan.

NOTE: Under this plan, you can satisfy the elimination period, as long as you have a 20% or more loss in your pre-disability earnings and you are limited from performing the material and substantial duties of your regular occupation.

Benefit Amount

If you meet the definition of disability, you would be eligible to receive a benefit of:

- **STD**: 60% of your basic weekly earnings, to a weekly maximum of $1,150 per week.
- **LTD**: 60% of your basic monthly earnings to a maximum of $5,000 per month.

Benefit Duration

STD: If you meet the definition of disability you may receive a benefit for 22 weeks (from benefit commencement date). Your employer will continue to deduct premiums up to 22 weeks, provided you continue to meet the definition of disability and you are receiving weekly benefits.

LTD: Your duration of benefits is based on your age when the disability occurs. Your LTD benefits are payable for the period during which you continue to meet the definition of disability up to age 65, but not less than 5 years. If your disability occurs at or after age 61, benefits would be paid for a reduced period of time.

Definition of Disability

You are disabled when Unum determines that:

STD & LTD:

- you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
- you have a 20% or more loss in weekly and/or monthly earnings due to the same sickness or injury.

	AND….. • after LTD benefits have been paid for 24 months, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience;
Gainful Occupation LTD ONLY	Gainful occupation means an occupation that is or can be expected to provide you with an income within 12 months of your return to work that exceeds: • 80% of your indexed monthly earnings, if you are working • 60% of your indexed monthly earnings, if you are not working
Maternity Coverage STD	The standard benefit for both a normal vaginal delivery and cesarean section is 6 weeks. Should you work to the date of the delivery, the elimination period and maternity benefit are satisfied at the same time. Therefore, you may only collect a 2 week benefit. Complications of maternity could extend benefits. Benefits are payable upon a medical and a pre-existing condition review.
Waiver of Premium LTD ONLY	You will not be required to pay LTD premiums as long as you are receiving LTD benefits.
Pre-existing Condition Exclusion for STD & LTD	These plans do not cover a disability that is caused by or is a result of a pre-existing condition. You have a pre-existing condition if: • the disability begins in the first 12 months after your effective date of coverage; and • you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 12 months just prior to your effective date of coverage; or • you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 12 months just prior to your effective date of coverage.
Mental and Nervous and Self-Reported Disabilities – LTD ONLY	Long Term Disabilities due to a sickness or injury which are primarily based on self-reported symptoms have a limited payment period of 12 months. Long Term Disabilities due to mental illness have a limited payment period of 24 months per lifetime. Mental and nervous benefits would continue beyond 24 months only if you are institutionalized or hospitalized as a result of the disability.
Benefit Offsets	**Your disability benefit may be reduced by deductible sources of income and any earnings you have while disabled.** Deductible sources of income may include disability income or other amounts you receive or are entitled to receive under: workers compensation; automobile liability insurance; legal judgments and settlements; certain retirement plans; other group insurance; and amounts you or your family receive or are entitled to receive from Social Security or similar governmental programs.
How to Apply	To apply for coverage, complete and return your enrollment form using the enclosed envelope.
Effective Date of Coverage	Please check your confirmation letter for your effective date of coverage.
Delayed Effective Date of Coverage	Insurance will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

This plan highlight is a summary provided to help you understand your insurance coverage from Unum. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Underwritten by:
Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122, *www.unum.com*

Underwritten by:
Unum Life Insurance Company of America

SHORT TERM & LONG TERM DISABILITY INCOME PROTECTION INSURANCE ENROLLMENT FORM

for

MTA Members

Policy#: 570975

MTA BENEFITS
Massachusetts Teachers Association

BENEFIT COUNSELOR:_____

Eff Date: _____ **Monthly Cost: LTD** _____ **STD** _____

For internal use

Member Name: _____

Address: _____

_____

_____

Payroll Frequency _____ **(10, 12, 24, 26, 52)**

Home Phone: (____) _____

Work Phone: (____) _____

E-mail Address: _____

Social Security #: _____

Date of MTA Membership: __ __ / __ __ / __ __ __ __

MTA Membership Number: _____

School District/Name: _____

Date of Hire: __ __ / __ __ / __ __ __ __

Date of Birth: __ __ / __ __ / __ __ __ __

Gender: _____ **Male** _____ **Female**

Annual Earnings: $_____

Hours Worked per Week: _____

You may choose from two Income Protection Plans: Short Term Disability and/or Long Term Disability.

Please check the option(s) you wish to choose:

STD: 60% of your weekly salary to a maximum weekly benefit of $1,750

- ☐ 14-Day Elimination Period
- ☐ 30-Day Elimination Period

Cost per pay period $_____ (see reverse for rates and calculation instructions)

LTD: ☐ 60% of your monthly salary to a maximum monthly benefit of $7,500

Cost per pay period $_____ (see reverse for rates and calculation instructions)

☐ **Yes, I would like to participate in the plan(s) I checked above.** I authorize my employer to deduct from my salary or wages the necessary premium for this coverage. My signature verifies the accuracy of information contained on this form. I understand that my premium is based on my current salary and will increase as my salary increases. I understand a confirmation of coverage statement will be provided to me prior to the policy effective date and that I may obtain the Plan Certificate at any time on *www.mtabenefits.com* under Disability Insurance.

I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective. **I have also read and understand the information in the Enrollment Kit, including all statements regarding exclusions.**

☐ **Yes, I am interested, please have an MTA Benefits representative contact me at** _____ **(Phone #).**

Member Signature: _____ **Date:** __ __/__ __/__ __ __ __

Return this form using the enclosed envelope or mail to:

MTA Disability, c/o Vista Financial Group, P.O. Box 447, Grafton, MA 01519

1.877.401.4083

mta@vistafg.com

Or, fax to 1.850.521.0111

Age Band*	Enhanced STD Rate – 14 Day Elimination	Standard STD Rate – 30 Day Elimination	LTD Rate
< 25	$0.88	$0.58	$0.33
25 – 29	$0.91	$0.60	$0.36
30 – 34	$0.94	$0.62	$0.40
35 – 39	$1.06	$0.70	$0.51
40 – 44	$1.36	$0.90	$0.66
45 – 49	$1.62	$1.07	$0.88
50 – 54	$1.86	$1.23	$1.27
55 – 59	$2.55	$1.68	$1.51
60 – 64	$3.23	$2.14	$1.65
65 – 69	$3.70	$2.45	$1.85
70+	$3.70	$2.45	$2.61

Your age as of the next July 1st

To calculate your per-paycheck cost for the STD coverage, first choose your elimination period to determine your rate. Then complete the calculation below:

Annual Salary _____ ÷ 52 = Weekly Salary $_____ x 60 % = $ _____ Weekly Benefit

Weekly Benefit $ _____ ÷ 10 = $_____ x Rate _____ = $ _____ Monthly Cost

Monthly Cost $ _____ x 12 = Annual Cost $_____ ÷ ____# of Paycycles = _____ Cost Per Pay Period**

To calculate your per-paycheck cost for the LTD coverage, complete the calculation below:

Annual Salary _____ ÷ 100 = _____ x _____ (Rate) = Your Annual Cost ($) _____

Your Annual Cost ($) _____ ÷ _____ (# of Paycycles per Year) = ($) _____ Cost Per Pay Period **

For example, if you are age 45, earn $45,000 annually, and are paid in 26 paycycles per year, your calculation would be as follows:

STD: $45,000 (Annual Salary) ÷ 52 = 865.38 x 60% = $519.23 Your Weekly Benefit
$519.23 (Your Weekly Benefit) ÷ 10 = $51.92 x 1.07 (Rate) = $55.55 Monthly Cost
$55.55 (Monthly Cost) x12 = $666.60 (Annual Cost) ÷ 26 (# of Paycycles) = $25.64 Per Pay Period**

LTD: $45,000 (Annual Salary) ÷ 100 = 450 x .88 (Rate) = $396.00 (Your Annual Cost)
$396.00 ÷ 26 (# of Paycycles Per Year) = $15.23 Per Pay Period**

*** Final cost may vary slightly due to rounding differences. Your premium is based on your current salary and will increase as your salary increases.*

Age Band*	STD Rate	LTD Rate
< 25	$0.58	$0.33
25 – 29	0.60	0.36
30 – 34	0.62	0.40
35 – 39	0.70	0.51
40 – 44	0.90	0.66
45 – 49	1.07	0.88
50 – 54	1.23	1.27
55 – 59	1.68	1.51
60 – 64	2.14	1.65
65 – 69	2.45	1.85
70+	2.45	2.61

Your age as of the next July 1st

To calculate your per-paycheck cost for the STD coverage, complete the calculation below:

Annual Salary _____ ÷ 52 = Weekly Salary $_____ x 60 % = $ _____ Weekly Benefit

Weekly Benefit $ _____ ÷ 10 = $_____ x Rate _____ = $ _____ Monthly Cost

Monthly Cost $ _____ x 12 = Annual Cost $_____ ÷ ____# of Paycycles = _____ Cost Per Pay Period**

To calculate your per-paycheck cost for the LTD coverage, complete the calculation below:

Annual Salary _____ ÷ 100 = _____ x _____ (Rate) = Your Annual Cost ($) _____

Your Annual Cost ($) _____ ÷ _____ (# of Paycycles per Year) = ($) _____ Cost Per Pay Period **

For example, if you are age 45, earn $45,000 annually, and are paid in 26 paycycles per year, your calculation would be as follows:

STD: $45,000 (Annual Salary) ÷ 52 = 865.38 x 60% = $519.23 Your Weekly Benefit
$519.23 (Your Weekly Benefit) ÷ 10 = $51.92 x 1.07 (Rate) = $55.55 Monthly Cost
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LTD: $45,000 (Annual Salary) ÷ 100 = 450 x .88 (Rate) = $396.00 (Your Annual Cost)
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** *Final cost may vary slightly due to rounding differences. Your premium is based on your current salary and will increase as your salary increases.*

Life Insurance

Waiver of Coverage: Please sign and date this form where indicated below.

Please Use Ink or Type | GROUP ID:

E. Dependent and Other Insurance Information (Complete ONLY for Dental Enrollment)

List Dependents to be Covered for Dental Benefits (if applicable)

	Last Name	First Name	MI	Sex	Birth Date
EMPLOYEE:					
SPOUSE:					
CHILDREN:					

Are you or any of your eligible dependents covered by any other dental plan? ☐ Yes ☐ No If YES, please list:

Name of Insured	Insurance Company Name & Phone Number	Employer

Is coverage through other dental plan? ☐ Single ☐ Family

F. WAIVER OF COVERAGE (Complete ONLY for Waiver of Group Insurance Coverage)

The group program has been offered to me, and after carefully considering its benefits, I have decided:

(Please indicate your choice)

☐ (a) not to enroll myself or dependents in the Program
☐ (b) not to enroll my dependents in the Program

I understand that if I desire to participate in the Program at some future date, my coverage or my dependents' coverage will not be effective until after Evidence of Insurability is submitted and approved. I understand if a physical examination or further medical information is required, it will be at my own expense.

Employee Signature _____ Date Signed _____

Note: A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping to defraud) an insurance company.