GRANVILLE

EXEMPTED VILLAGE SCHOOLS

BENEFIT PLAN TOOLS & RESOURCES

Your Benefit Resources

Life Insurance - American United Life Insurance

* The district providers at no cost to you a Basic Life & ADD benefit. Benefits vary by class so check with Payroll & Benefits on the amount of coverage you are eligible for.
* You may also purchase additional Optional Life insurance through American United Life.

Voluntary Life Insurance - Mutual of Omaha

www.mutualofomaha.com 800.775.8805

Voluntary Disability Insurance - Mutual of Omaha

www.mutualofomaha.com 800.877.5176

Additional Worksite Benefits

www.explainmybenefits.biz/granville 888.734.6937 Option 2

* These are Individual polices that you own and purchase via payroll deduction.
* If you need to file a claim or have questions about these benefits, please visit www.explainmybenefits.biz/granville or call 888.734.6937 Option 2, or you may email service@explainmybenefits.biz.

How to make the most of your benefits!

Take 20 minutes to review the Benefit Summaries so you have an idea of what your co-payments, deductibles and out-of-pocket costs will be. Benefit Summaries can be found on www.explainmybenefits.biz/granville.

Take 15 minutes to register on the carrier's website. Don't just register, but go exploring to see what online tools are available to you. You will be able to find providers, view your claims and explanation of benefits, even check out treatment costs!

Have an elective procedure coming up and want to know what it will cost? If you have the procedure codes, most carriers can process a "test claim" and tell you exactly what it will cost you, or at the very least what the allowed amount will be.

Shop for lower cost settings when you have a future scheduled visit for procedures like MRI's, Cat Scans, sleep studies, Physical and Occupational Therapy. Often physicians will refer patients to hospital-based providers for these serivces, who typically charge more than a free-standing facility or provider. Just call Medical Mutual and speak to a Customer Service Representative who can help you.

Always use Network Providers. Out of Nework providers can bill you for the difference between their billed charges and what the carrier would have paid had they been a Network provider.

If you have a question, ask! You can always call Customer Service at the carrier. It is a best practice to jot down who you talked with and the date.

Use Mobile Apps! Mobile Apps can store your ID card, give you instant access to benefit and coverage summaries, and even let you send pictures of claims for FSA reimbursement!

See a list of qualified, eligible expenses for FSA reimbursement at www.discovery benefits.com; a partial list shown in this guide; or by visiting www.irs.gov and searching for Publication 502.

Read through this guide and the carrier's brochures to learn all that you can and make your benefits work for you!

Life Events

Qualified Events are listed below. You have 31 days from the date of the event to notify HR and make coverage changes to add or remove dependents from coverage.

Notify Human Resources within 31 days of getting married. You may enroll your spouse and dependent children within 31 days from the date of marriage. Also, don't forget to review your Life Insurance needs as well. You will have 31 days to make changes to your Life Insurance policies or enroll a spouse or child(ren) in Dependent Life Insurance.

Notify Human Resources within 31 days after a divorce. You have 31 days to cancel coverage for your spouse, and benefits will cancel as of the date of the divorce. Your spouse may have the right to Port or Convert Voluntary Life Insurance, if enrolled, and will need to contact the Life Insurance carrier for information on how to apply and rates.

Notify Human Resources within 31 days of a birth or adoption. Coverage for your new bundle of joy will be effective the date of birth or the date of adoption. If you are given guardianship over a dependent child, also notify HR within 31 days and coverage will begin the date of guardianship.

Yikes!
LOSS OF COVERAGE

If you need to enroll a dependent spouse (or child/ren) because they have had a reduction in work hours or otherwise lost benefits or eligibility at their place of employment, you have 31 days from the date of the event to enroll them as a dependent on your plan.

Benefits that are payroll deducted under a pre-tax 125 Plan cannot be changed or cancelled throughout the benefit plan year without certain Life Events such as marriage, birth or divorce.

Taking Advantage of Special Enrollment Opportunities

What is Special Enrollment?

Special enrollment allows individuals who previously declined health coverage to enroll for coverage. Special enrollment rights arise regardless of a plan's open enrollment period.

There are two types of special enrollment – upon loss of eligibility for other coverage and upon certain life events. Under the first, employees and dependents who decline coverage due to other health coverage and then lose eligibility or lose employer contributions have special enrollment rights. For instance, an employee turns down health benefits for herself and her family because the family already has coverage through her spouse's plan. Coverage under the spouse's plan ceases. That employee then can request enrollment in her own company's plan for herself and her dependents.

Under the second, employees, spouses, and new dependents are permitted to special enroll because of marriage, birth, adoption, or placement for adoption.

For both types, the employee must request enrollment within 30 days of the loss of coverage or life event triggering the special enrollment.

A special enrollment right also arises for employees and their dependents who lose coverage under a State Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

What are some examples of events that can trigger a loss of eligibility for coverage?

Loss of eligibility for coverage may occur when:

- Divorce or legal separation results in you losing coverage under your spouse's health insurance;
- A young dependent, because of age, work, or school status, is no longer a covered "dependent" under a parent's plan;
- Your spouse's death leaves you without coverage under his or her plan;
- Your spouse's employment ends, as does coverage under his employer's health plan;
- Your employer reduces your work hours to the point where you are no longer covered by the health plan;
- Your plan decides it will no longer offer coverage to a certain group of individuals (for example, those who work part time);
- You no longer live or work in the HMO's service area;
- You have a health claim that would meet or exceed the plan's lifetime limit on all benefits.

These should give you some idea of the types of situations that may entitle you to a special enrollment right.

How long do I have to request special enrollment?

It depends on what triggers your right to special enrollment. The employee or dependent must request enrollment within 30 days after losing eligibility for coverage or after a marriage, birth, adoption, or placement for adoption.

The employee or dependent must request enrollment within 60 days of the loss of coverage under a State CHIP or Medicaid program or the determination of eligibility for premium assistance under those programs.

For More Information Here is the link to the US Department of Labor:

http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html

Eligibility

Eligibility Rules for you and your dependents are listed below.

For more information, please refer to your Certificate of Coverage, Plan Description, or the additional information included in this guide.

	You	Your Dependents
 Medical Insurance	Your benefits begin on your Date of Hire unless you waive coverage.	Your dependent children are eligible to the end of the month they turn age 26. They may continue to age 28 if they are unmarried; your natural child, step child or adopted child of you or your spouse; a resident of Ohio or a Full Time Student attending an accredited institution of higher learning; is not eligible for coverage under their employers health plan; and not eligible for coverage under Medicare or Medicaid.
 Dental Insurance	Your benefits begin on your Date of Hire unless you waive coverage.	Your dependent children are eligible to the end of the year they turn age 19 or if unmarried, to the end of the calendar year in which they turn 25 if a Full Time Student and eligible to be claims as an IRS dependent.
 Vision Insurance	1st of the month following date of hire, unless date of hire is the 1st of the month, then coverage is effective date of hire.	Your dependent children are eligible to the end of the month they turn age 19 or if a Full Time Student the end of the month they turn age 25.
 Flexible Spending Account	You may participate in this plan once you satisfy the eligibility conditions for the Group Medical plan and have consented to pre-tax payroll deductions of an amount of your choosing.	A Dependent Care account allows you to put aside pre-tax dollars to pay for child care for children age 12 and younger, or other dependents who are unable to care for themselves. Check with your Tax Advisor for contribution rules if you are divorced or if your spouse also contributes to a Dependent Care account.
	For additional information on Flexible Spending Accounts, please refer to the information in this booklet or the Summary Plan Description	

Benefits that are payroll deducted under a pre-tax 125 Plan cannot be changed or cancelled throughout the benefit plan year without certain Life Events, such as marriage, birth, divorce.

FSA Employee Handout

Who couldn't use a little more money? That's what you'll receive when you take advantage of a Flexible Spending Account (FSA). An FSA allows you to set aside a portion of your salary, before taxes, to pay for qualified medical or dependent care expenses. Because that portion of your income is not taxed, you end up with more money in your pocket.

Healthcare Flexible Spending Account (FSA)

A Healthcare FSA allows you to budget and save for qualified medical expenses incurred over the course of your upcoming plan year. It is a great savings tool for you and your family. The expense must be primarily to alleviate or prevent a physical or mental defect or illness and cannot be reimbursed by insurance or any other source. Your entire election amount is available the first day of your plan year.

Eligible Expenses*

- Prescription medicines and drugs
- Hearing aids
- Orthopedic goods and prosthetic devices
- Doctors
- Dentists and orthodontics
- Osteopaths
- Chiropractors
- Optometrists, ophthalmologists, opticians and eyeglasses
- Over-the-counter medicines and drugs
- Chiropodists and podiatrists
- Nursing and personal care facilities
- Medical and dental laboratories
- Medical services and health practitioners
- Ambulance services, equipment and supplies

*Some of the expenses on this list may require a prescription or doctor's note.

Dependent Care Account (DCA)

A Dependent Care Account is a simple way to save money on care for your dependents. It allows you to set aside pre-tax dollars to pay for day care expenses. The annual IRS limit for this type of account is $5,000. If you are married and file separate returns, you can each elect $2,500 for the calendar year. To be eligible for this type of account, both you and your spouse (if applicable) must work, be looking for work or be full-time students. You may receive reimbursement up to the current balance in your account at the time the request is made.

Eligible Dependents

- Children under age 13 who are claimed as a dependent for tax purposes
- Disabled spouse or disabled dependent of any age

Ineligible Expenses

- Costs claimed as a dependent care tax credit on your tax return
- Services provided by one of your dependents
- Expenses for nighttime babysitting
- Expenses paid for school (Kindergarten and above)

View an expanded list of eligible medical expenses and information about using the benefits debit card at **www.discoverybenefits.com.**

Check out our mobile application!

Discovery Benefits is proud to offer a free mobile app for iPhone (including iPad, iPod, and iTouch) and Android devices.

- Stay secure with password protection
- Keep information safe — it will not be stored on your phone
- Check account balance(s)
- Upload receipts
- View final filing dates
- View claim details
- Contact customer service
- Sign up for text alerts

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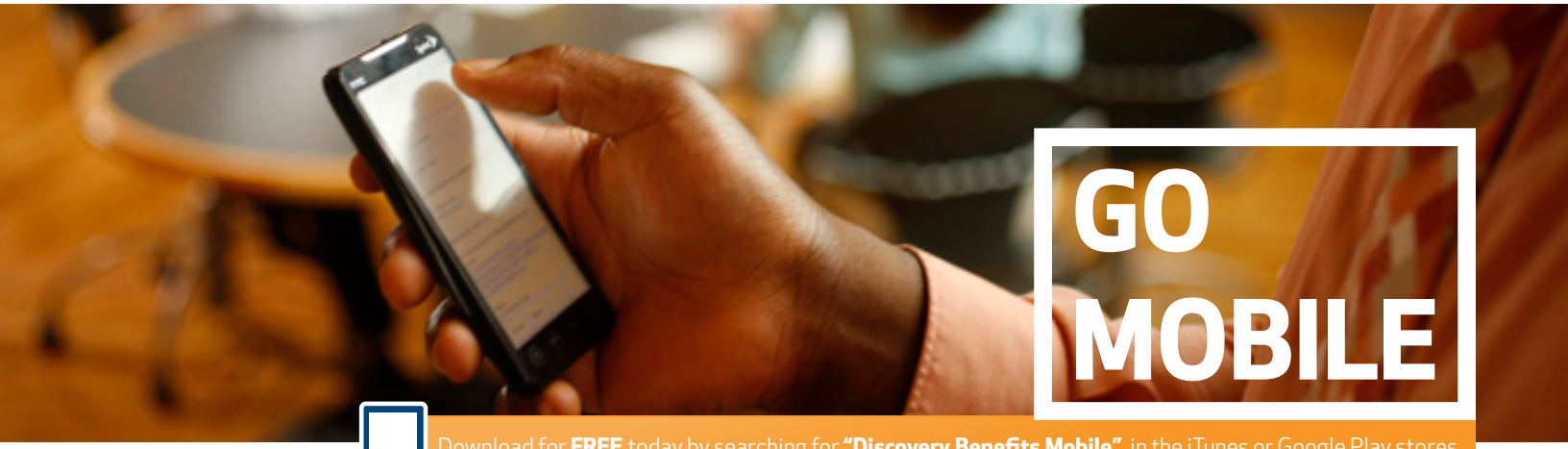
www.DiscoveryBenefits.com

Discovery Benefits Mobile Application Handout



Download for **FREE** today by searching for **"Discovery Benefits Mobile"** in the iTunes or Google Play stores.

Our mobile app lets you upload receipts, check balances, file claims, view filing dates and contact customer service all from the palm of your hand!

What are the benefits of using the Discovery Benefits mobile app?

The app allows you to manage your Flexible Spending Account, Health Savings Account, Health Reimbursement Arrangement or Commuter Benefits information on the go, with convenient access to your Discovery Benefits account information. Need to submit documentation or view details about a claim? Trying to report a lost or stolen debit card? Want to make a contribution or request a distribution? No problem. Open up our mobile application and do it all from your mobile device.

Will my information be safe?

Most definitely. The data transfer in our app is completely secure, as we utilize 128-bit SSL on all mobile transmissions and require a passcode each time you enter the app. No pictures will be stored on your phone, so you can rest assured that your information is safe.

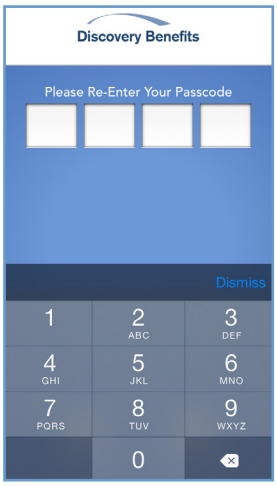
Which devices support the app?

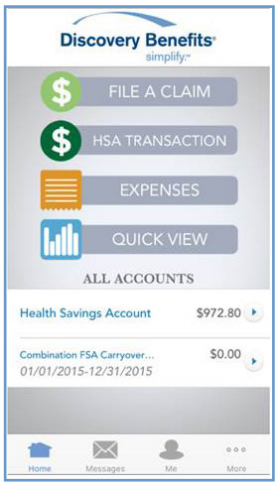
Our mobile app is available for iPhone, iPad and Android devices.

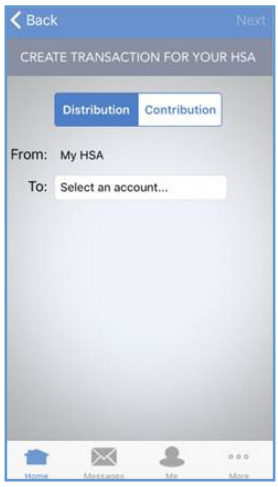
How much does it cost?

The app is completely free to download in the iTunes or Google Play stores.

What does the interface look like?







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www.DiscoveryBenefits.com

Mobile App Installation and Login Instructions (SSO)

Our mobile app is a convenient and secure way to manage your account on the go. It can be used to file claims, upload receipts, check your balance(s), view account activity, access your message center and more! It is compatible with Android and Apple devices.

Installation:

There are a few different ways to download and install the mobile app. You can do so by following any of the bullet points below:

- Get the Apple app by clicking here or get the Android app by clicking here.
- The participant portal contains a direct link to the mobile apps as well. After entering your account, hover your mouse over the PROFILE tab and click the Mobile Access link that populates to find a direct link to each app.
- Search for "Discovery Benefits" in the Apple App or Google Play store on your device and install the "Discovery Benefits Mobile" app. The app icon will appear as:

Logging In:

1. Launch the Discovery Benefits Mobile app on your device.
2. You will be prompted to enter your username and password. Due to additional features on your account, an alternate username and password is needed to log in to your mobile app. Your username and password will be the first initial of your first name (lower case), your full last name (lower case), date of birth (including zeros), and the last four digits of your social security number.
    - For example, an individual with the following information would use "jdoe010119901234" as their username and password:
        - First Name: John
        - Last Name: Doe
        - Date of Birth: January 1st, 1990
        - Social Security Number: 111-11-1234
    - **Please note,** if you previously logged in to your account directly through www.discoverybenefits.com, use the same username and password from that site to log in to the mobile app.
3. After your username and password are entered, click Save.
4. You will now be prompted to create your passcode and re-enter your passcode.
5. After entering your passcode, you will be logged in to your account and the passcode is the only item needed to log in moving forward.
    - **Please note,** if you're not able to log in, add a 1 after your username and use the same password outlined above. If you are not able to log in to the mobile app, contact Customer Service at the contact information outlined in the upper right hand corner of this document.

Exciting news for your FSA! On October 31, 2013 the US Treasury Department modified its flexible spending account (FSA) “use-it-or-lose-it” provision to allow carryover of unused Healthcare FSA funds.

This is great news for you, because:

- You can now carryover up to $500 of unused Healthcare FSA funds at the end of the plan year.
- The amount you carryover is in addition to your regular annual election.
- The money you put in an FSA is not taxed, so assuming you pay a combined 40% state and federal tax rate, you are saving 40% off healthcare expenses funded through the account.

If you chose not to participate in the FSA program because of the "use it or lose it" mandate, it's time to take another look.

Use your Benefits Debit Card to make spending your FSA dollars even easier. Present your Debit Card at the time of service when purchasing eligible FSA expenses. Payment is made directly from your spending account. When you use your card, the card is swiped by the provider, just like your debit card, sending the date, dollar amount and provider name to Discovery Benefits.

View a full list of eligible medical expenses and information about using the Benefits Debit Card to pay for these expenses directly from your flexible spending account at www.discoverybenefits.com/eligibleexpenses.

Don’t forget to check out the free Discovery Benefits Mobile App!

Discovery Benefits
FSA • HSA • HRA • TSA • COBRA • Billing Solutions
www.DiscoveryBenefits.com
Phone: 866-451-3399 • Fax: 866-451-3245
PO Box 2926 • Fargo, ND 58108-2926
customerservice@discoverybenefits.com

Recurring Dependent Care Request Form

Completion Guide

Step 1: Participant Information

- Complete the required fields (*).
- Changes to your profile can be made by logging in to your account at www.discoverybenefits.com.
- Please write legibly. Missing information may delay the processing of your claim.

Step 2: Recurring Dependent Care Account (DCA) Information

- Select one option:
  Start Recurring DCA: Select this box if you are starting a new recurring reimbursement for dependent care expenses.
  Change Recurring DCA Information: Select this box if you need to change information on a current recurring reimbursement.
  Stop Recurring DCA: Select this box to stop receiving recurring reimbursement.

Step 3: Dependent Care Provider Information and Signature

This section needs to be completed by your dependent care provider

- Dependent Name: Name of the dependent(s) receiving care, each dependent listed separately
- Start Date: First day of the plan year that your dependent(s) received care
- End Date: Last day of the plan year that your dependent(s) will receive care
- Provider's Signature: Signature of dependent care provider
- Cost per week: Total dependent care expenses per week

Step 4: Participant Certification

Read the certification and submit the completed Recurring Dependent Care Form to Discovery Benefits.

- Send your claim to:
  Mail: PO Box 2926; Fargo, ND 58108-2926
  Fax: 1-866-451-3245

Documentation Requirements

Documentation must be retained for your records and provided to Discovery Benefits when requested to do so.

Documentation for dependent care expenses, required by the IRS, includes a third party receipt containing the following information (please be advised if a receipt is unavailable a signature from the provider is sufficient):

- Incurred dates of service
- Dollar amount
- Name of day care provider

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid dependent care/eligible expenses where services have not yet occurred

Direct Deposit

Signing up for free direct deposit through www.discoverybenefits.com your online account will allow funds to be sent electronically to a checking or savings account. **Note**: No reimbursement limit applies to direct deposit.

By completing the online steps for establishing direct deposit, you are certifying the information provided is accurate. Further, the completion and submission of this information authorizes Discovery Benefits to issue payment directly to the specified account unless notified to do otherwise. You understand and agree that Discovery Benefits reserves the right to reverse any ACH deposit where an error occurs, in accordance with banking regulations.

Discovery Benefits
FSA • HSA • HRA • TSA • COBRA • Billing Solutions

www.DiscoveryBenefits.com
Phone: 866-451-3399 • Fax: 866-451-3245
PO Box 2926 • Fargo, ND 58108-2926
customerservice@discoverybenefits.com

Recurring Dependent Care Request Form

This form is to be completed each plan year and as changes occur when the participant wants to receive recurring reimbursement of dependent care expenses. In order to qualify for recurring reimbursements, your cost of dependent care per month must meet or exceed your monthly payroll deductions. If that is the case, reimbursements will be made to you as your payroll deductions post to your Dependent Care Account. Documentation must be retained for your records and provided to Discovery Benefits when requested to do so. If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care Request Form.

*= Required Fields

Step 1: Participant Information

*Participant Name (First, MI, Last)

*Social Security Number

*Employer Name

*Employee ID

Updates or changes to your information can be made by logging into your account at www.discoverybenefits.com

Step 2: Recurring Dependent Care Account (DCA) Information

*Please select only one.

	Start Recurring DCA: Please start my recurring reimbursement with the information provided in Step 3.	**Effective Date** *(mm/dd/yyyy)*
	Change Recurring DCA Information: Please update my recurring reimbursement with the provided information as of the provided Effective Date.	
	Stop Recurring DCA: Please stop my recurring reimbursement with the provided information as of the provided Effective Date.	

Step 3: Dependent Care Provider Information and Signature (to be completed by the provider)

I certify the information provided below is accurate. I understand the purpose of my signature on this form is to substantiate the name of the dependent care provider, the dates of service care is being provided, and the dollar amount of the services. I agree to provide the necessary receipts for documenting the participant's incurred dependent care expenses.

*Dependent(s) Name	*Start Date of Service *Must be within current plan year (mm/dd/yyyy)*	*End Date of Service *Must be within current plan year (mm/dd/yyyy)*	*Provider's Signature	*Cost Per Week

If your cost of dependent care is less than your payroll deductions or you have currently contributed more to your plan than you have incurred in expenses, you will be reimbursed on a weekly basis and should consider direct deposit for reimbursements if you are not signed up.

Signing up for free direct deposit through your online account at www.discoverybenefits.com will allow funds to be sent electronically to a checking or savings account. **Note**: No reimbursement limit applies to direct deposit.

Step 4: Participant Certification

To the best of my knowledge the provided information is complete and accurate. By submitting this, I acknowledge my child is under the age of 13, the services are eligible dependent care expenses as defined by the IRS, that I have not been previously reimbursed for these expenses, and that I will not seek reimbursement from any other source. I understand that Discovery Benefits, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441 which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Discovery Benefits. I understand that Discovery Benefits may require me to submit any additional documentation, receipts and an updated request form at any time. I should retain a copy of all submitted documentation in the event of an IRS audit.

By submitting this form I certify the above.

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www.DiscoveryBenefits.com
866-451-3399 • 866-451-3245
PO Box 2926 • Fargo, ND 58108-2926
customerservice@discoverybenefits.com

Out-of-Pocket Reimbursement Request Form

This form is not for Discovery Benefits Debit Card claims.

Completion Guide

Claims can also be submitted by logging in to your account at **www.discoverybenefits.com**. This form is for reimbursement of any out-of-pocket expenses where your Discovery Benefits debit card was not used. Documentation to substantiate purchases made with your Discovery Benefits debit card must be uploaded via your online account or submitted with a copy of a Receipt Reminder.

Step 1: Participant Information

- Complete the required fields (*).
- Changes to your profile can be made by logging in to your account at **www.discoverybenefits.com**.
- Please write legibly. Missing information may delay the processing of your claim.

Step 2a: Medical Reimbursement Information —

You may submit one form per receipt or lump all receipts together and only submit one form. Submitting one receipt per form is the preferred method.

- **Plan type:** Enter the three- or four-letter code (located below the claim table) to identify the account from which you are requesting reimbursement.
- **Date of service(s):** Provide the date or range of dates the expense was incurred, including the year.
- **Merchant name:** Provide the name of the merchant or facility where the expense was incurred. If filing a lump sum claim that includes multiple merchants, please write "Multiple" in this box.
- **Person receiving the product or service:** Provide your name or the name of the tax dependent for which the service was provided or the product was purchased. If filing a lump sum claim for multiple people, please write "Multiple" in this box.
- **Description of services:** Provide a brief description of the service.
- **Amount requested for reimbursement:** Provide the total amount requested.

Step 2b: Dependent Care Reimbursement Information —

Having your dependent care provider sign this form is the preferred method to file for reimbursement. If you want to file a claim online, you may have your provider sign this form and upload this form to the claim.

- **Plan type:** DCA.
- **Date range of services, including the year:** Provide the date or range of dates the expenses were incurred including the year.
- **Name of provider:** Provide the name of the dependent care provider or facility.
- **Provider's signature:** Provide the dependent care provider's signature.
- **Amount requested for reimbursement:** Provide the total amount requested.

Step 3: Participant Certification

Submit the completed form with supporting documentation to Discovery Benefits.

Mail: PO Box 2926; Fargo, ND 58108-2926

Fax: 1-866-451-3245

Documentation Requirements

Documentation for eligible medical expenses, required by the IRS, includes a third-party receipt containing the following information:

- Date service was received or purchase made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)
- Name of the merchant/provider

Verification of dependent care expenses is required by the IRS. The dependent care provider's signature on this form is the preferred method. We also accept documentation from the provider. The provider documentation must include the following information:

- Dates of service (that have been incurred)
- Description of service
- Dollar amount charged for incurred services
- Name of the provider

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid dependent care/eligible expenses where services have not yet occurred

When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, have the provider write "co-payment" on the receipt and sign it.

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www.DiscoveryBenefits.com
866-451-3399 • 866-451-3245
PO Box 2926 • Fargo, ND 58108-2926
customerservice@discoverybenefits.com

Out-of-Pocket Reimbursement Request Form, continued

This form is not for Discovery Benefits Debit Card claims.

Claims can also be submitted by logging in to your account at **www.discoverybenefits.com**. This form is for reimbursement of any out-of-pocket expenses where your Discovery Benefits debit card was not used. Documentation to substantiate purchases made with your Discovery Benefits debit card must be uploaded via your online account or submitted with a copy of a Receipt Reminder.

*Required Fields

Step 1: Participant Information

*Participant Name (First, MI, Last)

*Social Security Number

*Employer Name (Do not abbreviate)

Employee ID

Updates or changes to your information can be made by logging into your account at **www.discoverybenefits.com**.

Step 2a: Medical Reimbursement Information —

You may submit one form per receipt or lump all receipts together and only submit one form. Submitting one receipt per form is the preferred method.

*Plan Type	*Date of Service	*Merchant Name	*Person receiving the product or service	Description of the services	*Amount requested for reimbursement

***Plan Types:** **MSA**—Medical Flexible Spending Account (Medical FSA); **LMSA**—Limited Medical Flexible Spending Account (Limited Medical FSA); **EMSA**—Employer Funded Medical Spending Account; **RMSA**—Retiree Medical Savings/Spending Account; **PRA**—Premium Reimbursement Arrangement; **HRA**—Health Reimbursement Arrangement

Step 2b: Dependent Care Reimbursement Information —

Having your dependent care provider sign this form is the preferred method to file for reimbursement. If you want to file a claim online, you may have your provider sign this form and upload this form to the claim.

*Plan Type	*Date range of services, including year	*Name of provider	*Provider's signature	*Amount requested for reimbursement
DCA				

Step 3: Participant Certification

To the best of my knowledge, the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses as defined by the IRS and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement from any other source. I understand that Discovery Benefits, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. If submitting expenses for my Dependent Care Account, I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Discovery Benefits. By submitting this form I certify the above.

I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

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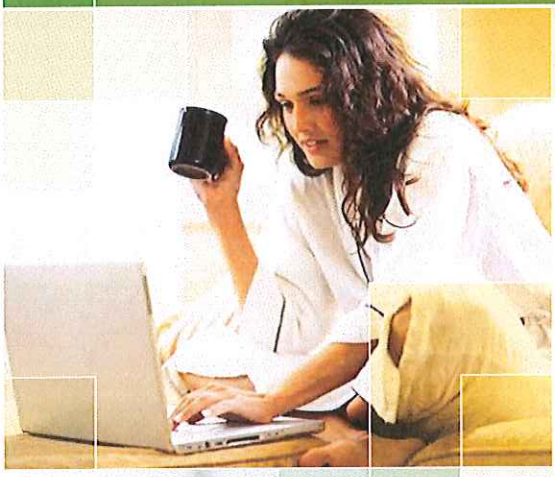
MEDICAL MUTUAL®

My Health Plan: Information and Tools You'll Love to Use



My Health Plan is your secure, personalized member website designed to help you keep track of all of your healthcare information.

With My Health Plan, you can:

- Check on claims and benefit information
- Review Explanation of Benefits (EOB) statements
- Search the largest network of healthcare providers and facilities in Ohio
- Access personalized wellness resources to help you live healthier
- Get discounts on exercise equipment, fitness club memberships and other health-related products and services
- Watch interactive videos to help you make important healthcare decisions
- Choose how you would like to receive communications
- View your member identification (ID) card and email or fax it to your doctor or pharmacy.

Spend Less on Healthcare with My Care Compare

When you're logged into My Health Plan, you have access to My Care Compare, our cost comparison tool. Look up cost estimates for medical services like lab work, X-rays, MRIs and therapy. Refine your search based on location, quality, alternative treatment options and patient satisfaction.

Even if you already have a doctor, you can use My Care Compare to see if your costs will change based on where you receive care.

Go Mobile

The MedMutual mobile app lets you access your health plan when you're on the go. Use your iPhone® or Android™ as a shortcut to the information and tools you use most frequently. Download the app for free from iTunes or Google Play to have access to your health plan anywhere you need it.

Download the app today. Search for MedMutual in the iTunes® AppStore or GooglePlay.™

Available on the App Store

GET IT ON Google play

MedMutual.com

Find a Provider

Searching for doctors and medical facilities is easier than ever with our Provider Search tool, available on the homepage of MedMutual.com.

Choose Your Search Criteria

This versatile tool, which replaced the Provider Lookup feature, allows you to search by what matters most to you. Narrow your search by:

- Name
- Specialty
- Gender
- Language spoken
- Hospital affiliation
- Specific practice
- Awards and recognition

Compare Your Options

Evaluate up to four providers using a side-by-side comparison to help you make the best possible decision for you.

Know Your Costs

The Provider Search tool is integrated with the new Treatment Cost Estimator to help you make cost-effective choices. Find out approximately how much certain services will cost you by choosing participating providers.

Log In to *My Health Plan* for Advanced Features

By logging in to *My Health Plan*, the website can automatically fill in the search fields with your personal and network information for even quicker searches.

Make the Most of Your Health

Maximize Your Benefits and Save Money

Your health insurer should give you tools and resources to help you make the best health choices for you and your family. We do just that. Medical Mutual products and services help you achieve your best possible health and improve your quality of life at every stage.

As a member, you and your family have access to many programs, discounts, money-saving tools and resources—all designed with you in mind. Take advantage of these options to help manage your health, make healthcare decisions, and save time and money. Register for our secure member site, My Health Plan, by visiting Member.MedMutual.com.

- **Stay in network**
  Use doctors, hospitals and other healthcare providers and facilities covered by your Medical Mutual plan.
- **Talk with your doctor or use a lower-cost facility**
  Choose an urgent care facility or convenience clinic instead of an emergency room for everyday injuries and illnesses.
- **Know what's covered**
  Before you have a service or procedure, review your Certificate of Coverage or speak to one of our Customer Care Specialists to make sure it is covered under your plan.
- **Take care of yourself**
  Your plan's preventive benefits may cover well visits and some screenings and immunizations. Remember, preventing a disease is less of a burden than treating a disease—both financially and emotionally.
- **Register on My Health Plan**
  To get 24/7 access to time- and money-savings tools, programs and discounts, register for My Health Plan at Member.MedMutual.com. All you need to get started is your member identification number, date of birth and email address.

My Health Plan Dashboard

Your My Health Plan homepage dashboard gives you an overview of your benefits, including the total billed amount, the discount applied, what Medical Mutual paid and your financial responsibility. The dashboard also includes deductible and claim information for your plan year.

Claims & Balances

Use the Claims & Balances tab to view your claims and check the balances of your Flexible Spending Account (FSA) or Health Reimbursement Account (HRA).

- Reference your Explanation of Benefits to see your claims information.
- Sort claims by date of service, dependent name and more.
- Export your information to an Excel file, PDF or CSV file.
- See detailed information about your deductibles and coinsurance.

Benefits & Coverage

Discover the benefits of your health insurance and what is covered by your plan under the Benefits & Coverage tab.

- View your plan benefits, including your Summary of Benefits and Coverage (SBC).
- See an overview of your coverage, maximums, coinsurance and more for medical, pharmacy, dental and vision.
- Order member identification (ID) cards and print temporary copies.

Resources & Tools

We want you to get the most out of your health plan. Use the Resources & Tools tab to explore the resources available to Medical Mutual members.

Resources

In this section, use the Health Resource Center to increase your health knowledge through interactive tools and quizzes, Virtual Health Guides, a searchable health encyclopedia, a symptom checker and health decision tools. You will also find a glossary, forms, the Member FAQ guide, Health Savings Account (HSA) information and how to download our mobile app.

Tools

Use our Find a Provider tool to locate doctors, urgent care or hospitals in our network. Search what matters to you—location, specialty or gender.

Our Treatment Cost Estimator helps you get an idea of how much certain medical services will cost. Estimates are available for a variety of procedures and treatments, including office visits, lab tests, scans and X-rays, and preventive screenings.

On-the-Go Access

The MedMutual mobile app keeps up with your on-the-go lifestyle and is with you wherever you are. Download the app through iTunes or Google Play. From the app you can access:

- Your member identification (ID) card that you can share with your healthcare providers by email or fax.
- Find a Provider search tool to find a doctor, hospital or urgent care facility covered by your health plan, as well as get directions.

Healthy Living

Take advantage of a variety of wellness programs under the Healthy Living tab to help you understand your health, identify risk factors for disease and make positive changes to help you live healthy.

Disease Management and Maternity Programs

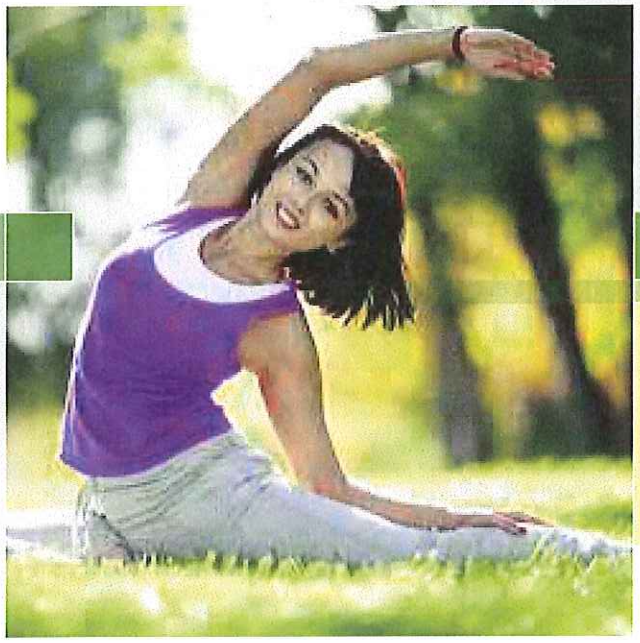
Whether you live with a chronic condition or just found out you're pregnant, having a coach to guide you can help. The Disease Management and Maternity Programs support you by helping you learn more about your condition and giving you plans designed for your individual needs. Your doctor and healthcare team will continue to treat you, while a health coach empowers you to manage your condition.

Our programs, available at no additional cost, help members who are pregnant or diagnosed with one or more of the following conditions:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Chronic pain conditions
- Coronary artery disease
- Depression
- Diabetes
- Heart failure

Weight Watchers Reimbursement

Let Medical Mutual reimburse you for your participation in Weight Watchers. Our program offers up to $150 in reimbursement fees per calendar year for members age 10 and older who participate in an At Work or Community Meeting series. (Dependents ages 10 to 16 must meet Weight Watchers' specific program requirements to participate.) For additional information or to enroll in the Weight Watchers Reimbursement Program, visit My Health Plan or call (866) 204-2878.



Go Paperless

Going paperless allows you to keep and store your healthcare information in a safe, convenient location using our online member site. Choose to go paperless and receive your Explanation of Benefits (EOB) statements, Summary of Benefits and Coverage (SBC) and our Healthy Outlooks newsletter electronically. All alerts will be sent to the email address you use to register for My Health Plan.

QuitLine Program

Our program helps tobacco users give up the habit for good by providing one-on-one coaching, a personalized quit plan, educational materials and a supply of nicotine replacement therapy, all at no out-of-pocket cost. To enroll in the QuitLine Program or for additional information, visit My Health Plan or call (866) 204-2878.

Fitness

Save money and get active with a membership discount at Curves,® or find a discounted gym membership through our national parter, GlobalFit.®

Learn

Explore a variety of useful articles on key health topics, including Healthy Outlooks, our member newsletter that speaks to health issues, health plan education and our health and wellness services.

Shop

Discover a variety of member-only discounts, which include baby products, fitness club fees, hearing aids, drugstore items and other healthy products. Vendors include:

- AmericanFitness.net
- Beltone
- Drugstore.com
- Safe Beginnings
- The Chef's Garden®
- YOGAaccessories.com

My Profile

Health Assessment

Completing this assessment can help you understand your overall health and identify your risk for certain chronic diseases. The Health Assessment is located on the homepage after you log into My Health Plan. Based on your results, you may receive educational brochures on wellness topics or be referred to the Disease Management Program for advice and coaching to improve your health.

Health History

This tool allows you to review and search your confidential, interactive, electronic medical history. Examples of what you can view include information for you and your dependents about current and past medications, medical services and providers visited.

Healthcare Reform

You've probably heard about healthcare reform, and you may have wondered what it is and how it affects you. Like any sweeping law, it can be complicated. We're here to help you understand healthcare reform by breaking it down into the parts that may impact you. Visit MedMutual.com/Reform.

MEDICAL MUTUAL®

CAROLINA CARE PLAN | CONSUMERS LIFE

Estimate Your Costs

Estimate Your Costs

It's important that you not only receive the highest quality care available, but also understand the costs associated with it. Make cost-effective decisions with the help of our Treatment Cost Estimator, available on *My Health Plan.*

Choose a Treatment

Picking a treatment is easy. You can browse specific treatments by:

- Service type (such as a lab test)
- Affected body part
- Using an A-Z list

Select a Provider

Integrated with our Treatment Cost Estimator, the Provider Search tool makes finding the right provider easier than ever. You can search for providers by:

- Location
- Specialty
- Doctor name
- Facility name

Compare Your Options

Choose up to four providers and evaluate their costs using a side-by-side comparison.

Know Your Costs

Knowing an estimate of how much you owe before an appointment provides you with important information to make the best possible healthcare decisions. Estimates factor in how much your insurance will cover to determine your out-of-pocket costs.

To get started, just visit MedMutual.com and log on to *My Health Plan*.

MEDICAL MUTUAL®

Preventive Care Services

A GUIDE FOR EMPLOYERS AND MEMBERS

An ounce of prevention is worth a pound of cure. Getting preventive care is one of the most important steps our members can take to manage their health. Routine preventive care can identify and address risk factors before they lead to illness. When illness is prevented, it helps reduce healthcare costs. Members should work with their healthcare providers, who can help them follow these guidelines and address their specific health concerns.

The screenings and immunizations listed in this summary include services required by healthcare reform (the Patient Protection and Affordable Care Act).

For plan years beginning on or after September 23, 2010, non-grandfathered health plans[1] must cover these routine immunizations and other services that are recommended by the United States Preventive Services Task Force A or B, and by other organizations such as Bright Futures, endorsed by the American Academy of Pediatrics.

If these services are performed by a network provider, members cannot be charged a copayment, coinsurance or deductible. Out-of-network charges may apply if the services are performed by a non-network provider.

If you have questions about these recommended screenings and immunizations, please contact your Medical Mutual representative or broker. He or she can also give you more details about the recommended frequency of these services. You can also call our Customer Care Center at the number on your identification card for more information.

Child Preventive Care[2]

Preventive Physical Exams and Screening Tests

- Behavioral counseling to prevent skin cancer
- Behavioral counseling to promote a healthy diet
- Blood pressure screening
- Cholesterol and lipid level screening
- Dental cavities prevention (including application of fluoride varnish to all primary teeth)
- Depression screening
- Developmental and behavioral assessments
- Hearing screening for newborns
- Iron deficiency anemia screening and iron supplementation
- Lead exposure screening
- Newborn gonorrhea prophylaxis
- Newborn screenings, including sickle cell anemia
- Screening and behavioral counseling related to tobacco and drug use
- Screening and counseling for obesity
- Screening and counseling for sexually transmitted infections
- Screenings for heritable diseases in newborns
- Tuberculosis screening
- Vision screening

Immunizations (Vaccines)

- Diphtheria, Tetanus, Pertussis (DTaP, Tdap)
- Haemophilus influenza type B (Hib)
- Hepatitis A (HepA) and Hepatitis B (HepB)
- Human Papillomavirus (HPV)
- Influenza (flu shot) (IIV, LAIV)
- Measles, Mumps, Rubella (MMR)
- Meningococcal (MCV)
- Pneumococcal (pneumonia) (PCV, PPSV)
- Polio (IPV)
- Rotavirus (RV)
- Varicella (chicken pox) (VAR)

Prescription Drugs[3]

- Fluoride (age 0 to 6 years)
- Iron (age 0 to 12 months)

Please Note
This is a summary of the Affordable Care Act Preventive Care requirements and is not intended to be an exhaustive list. This list is subject to change upon issuance of additional regulations or guidance. The preventive care services on the back of this flier are for your information only. They are not intended to be, and should not substitute for, professional medical advice, diagnosis or treatment from your treating medical professional. Decisions about care need to be individualized and should be made in concert with treating medical professionals. The information provided does not establish or imply coverage for any particular treatment or service. Any recommended treatment or services will be determined based on your eligibility and coverage under the specific terms and conditions of your benefit plan.

Adult Preventive Care[2]

Preventive Physical Exams and Screening Tests

- Abdominal aortic aneurysm screening (males age 65 to 75)
- Blood pressure screening
- Cholesterol and lipid level screening
- Colorectal cancer screening including fecal occult blood test, flexible sigmoidoscopy or colonoscopy (age 50 to 76)
- Depression screening
- Diabetes screening
- Hepatitis B screening if at high risk for infections
- Hepatitis C screening if at high risk (or one-time screening for adults born 1945 to 1965)
- HIV screening
- Screening and counseling for sexually transmitted infections
- Screening for lung cancer (current and former smokers ages 55 to 80)

Counseling and Education Interventions

- Behavioral counseling to prevent skin cancer
- Behavioral counseling to promote a healthy diet
- Counseling related to aspirin use for the prevention of cardiovascular disease
- Prevention of falls in older adults
- Screening and behavioral counseling to reduce alcohol abuse
- Screening and behavioral counseling related to tobacco use
- Screening and nutritional counseling for obesity (up to four visits; additional visits must be approved)

Immunizations (Vaccines)

- Hepatitis A (HepA) and Hepatitis B (HepB)
- Herpes Zoster (shingles) (HZV)
- Human Papillomavirus (HPV)
- Influenza (flu shot) (IIV, LAIV)
- Measles, Mumps, Rubella (MMR)
- Meningococcal (MCV, MPSV)
- Pneumococcal (pneumonia) (PCV, PPSV)
- Tetanus, Diphtheria, Pertussis (Td, Tdap)

Prescription Drugs[3]

- Aspirin (males age 45 to 79, females age 55 to 79; pregnant females at risk for preeclampsia)
- Colonoscopy preparations (age 50 to 75)
- Folic acid (females only)
- Medication to reduce risk of primary breast cancer in women
- Smoking cessation aids
- Vitamin D (age 65 and older)
- Women's contraceptives

Women's Services

- Breast and ovarian cancer susceptibility screening, counseling and testing (including BRCA testing)
- Breast cancer screening (mammogram)
- Breast feeding counseling and rental of breast pumps and supplies up to the purchase price
- Bone density test to screen for osteoporosis (one every 24 months for age 50 and older)
- Cervical cancer screening (Pap test)
- Chlamydia screening
- Discussion of chemoprevention with women at high risk for breast cancer
- FDA-approved contraception methods and counseling for women, including sterilization
- HPV DNA testing
- Lactation classes (up to 20 visits)
- Pregnancy screenings (including hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, gonorrhea, Chlamydia, iron deficiency anemia, alcohol misuse, tobacco use, HIV, gestational diabetes)
- Prenatal services
- Primary care intervention to promote breastfeeding
- Screening and counseling for interpersonal and domestic violence
- Well woman visits (up to three visits)

Footnotes

1. If you do not know your health plan's grandfathered status, contact our Customer Care Center at the number on your identification card.
2. Some exams, screening tests and immunizations may be subject to age restrictions. Refer to USPreventiveServicesTaskForce.org for details.
3. To receive 100 percent coverage for these medications (i.e., no out-of-pocket cost), members must get a prescription from their healthcare provider and present it at the pharmacy, even if the medication is available over the counter without a prescription.

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MEDICAL MUTUAL®

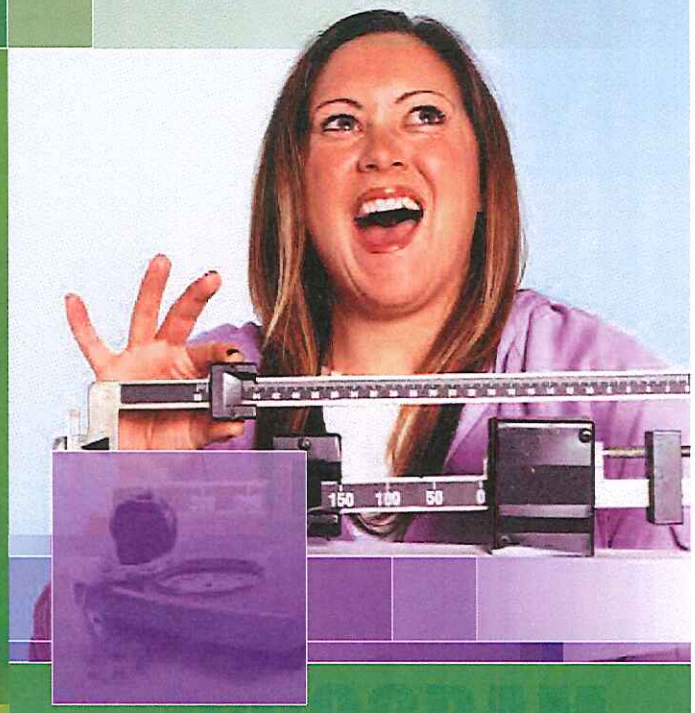
Weight Watchers

Steps to Good Health

Tips for success:

- Drink water instead of sugary or caffeinated drinks.
- Try to get at least 20-30 minutes of moderate intensity activity each day.
- If you're just starting an exercise program, start slowly. Check with your healthcare provider to make sure you're healthy enough for exercise.
- Set realistic, measurable goals and reward yourself when you meet them.
- Practice portion control and aim for a minimum of five servings of fruits and vegetables each day.

To get started toward being a slimmer, healthier and happier you, call (866) 204-2878 to attend in your community.



Weight Watchers

MEDICAL MUTUAL®
2060 East Ninth Street
Cleveland, Ohio 44115-1355

MedMutual.com

Reach Your Goals

Get Rewarded for Living Healthier

To help you reach your health goals, Medical Mutual® partners with Weight Watchers, the world's leading provider of weight management services.

Achieving a healthy weight can help reduce your risk of developing health problems like heart disease, diabetes and certain types of cancer.[1] Take an important first step toward your personal weight loss or maintenance goals by making a plan.

If you need more motivation, we'll reimburse up to $150 off your enrollment fees each year for attending and completing a Weight Watchers series.

Weight Watchers Series Options

Enroll

- Community Meeting Series: Call (866) 204-2878 to purchase weekly vouchers or Monthly Pass and find local meetings.
- At Work Meeting Series: Ask your employer if At Work Meetings are available or call (800) 828-9675 for information about how to set up meetings at your workplace. Minimum enrollment is required. Available in participating areas in the U.S.

Attend

- Community Vouchers or At Work Meetings: Attend the minimum number of meetings in a series.
- Monthly Pass: Only miss one meeting of a three-month series or two meetings of a four-month series.
- Program details are available on our member website, My Health Plan. Log in at Member.MedMutual.com and click Healthy Living then Weight Watchers.

Submit

- Meet the program requirements and submit the required Reimbursement Form and proof of purchase within 90 days of completing a series. Medical Mutual will reimburse you $50 or $75 depending on the series purchased.

Program Information

- To download and print a Reimbursement Form and review additional information or official rules, please log into Member.MedMutual.com. Click Healthy Living then Weight Watchers.
- Reimbursement amount is based on the meeting series purchased and attendance. The maximum reimbursement per calendar year is $150, regardless of when a meeting series starts or ends. Partial reimbursement will not be given.

These recommendations are informational only. They do not take the place of professional medical advice, diagnosis or treatment. Eligibility and coverage depend on your specific benefit plan. This brochure is considered marketing material and provides information about purchasing or using the service or product. We have no financial ownership or incentive arrangement for the use of this product(s) or service(s). Programs are subject to change without notice.

1. Retrieved from: Guh et al. The incident of co-morbidities related to obesity and overweight; A systematic review and meta-analysis. BMC Public Health 2009; 9:88.

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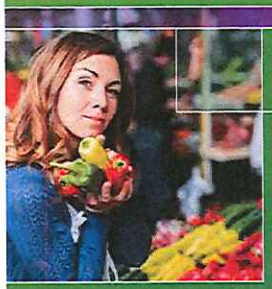


Lifestyle Coaching

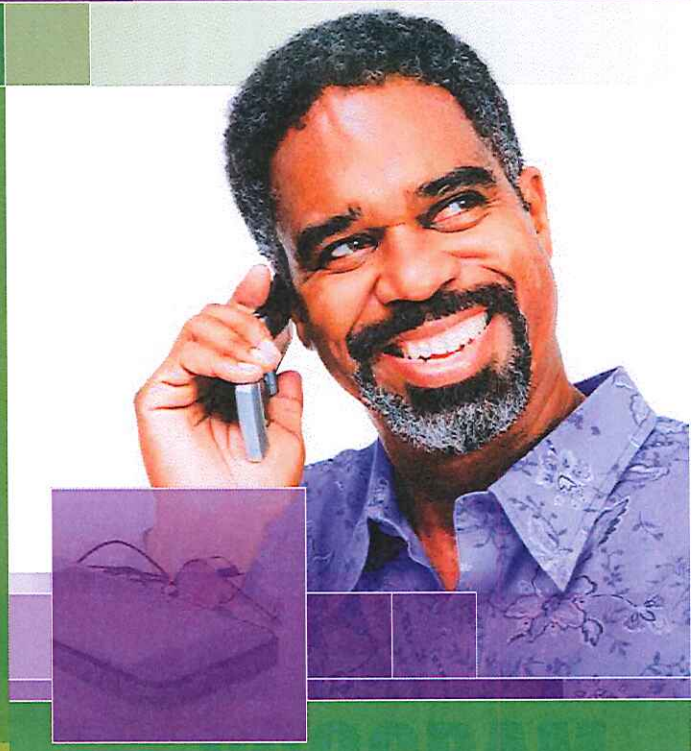
Learn to Live Well

Reaching your health goals is easier with a lifestyle coach to guide you. You can learn how to:

- Set realistic goals and make plans to meet them
- Make simple changes to your lifestyle that can lead to long-lasting results
- Develop a plan to reduce your stress and feel better
- Be more active by doing things you enjoy
- Quit using tobacco by overcoming common withdrawal symptoms, cravings and stress

All programs will give you access to:

- Online resources, interactive tools and trackers
- Coaches to help you develop skills to make healthier choices and lifestyle changes on your own
- Support to overcome barriers that could keep you from reaching your goal



Lifestyle Coaching

There is no out-of-pocket cost to participate in this voluntary program. Plus, you will get a $25 gift card after completing a program.

MEDICAL MUTUAL®
2060 East Ninth Street
Cleveland, Ohio 44115-1355

MedMutual.com

Reach Your Health Goals

Get Inspired and Create Good Habits

We can help you reach your health goals. Lifestyle Coaching is a six-month program for members who want to take action and meet a personal health goal.

Programs include:

- Reach a Healthy Weight (Lose or Maintain)
- Live Tobacco Free
- Be More Active
- Improve Your Diet
- Feel Less Stress

A certified lifestyle coach will work with you to help you set goals just for you. Those goals will fit your lifestyle and schedule.

Get Personal Support

Enroll Online

- Log into My Health Plan at MedMutual.com/member.
- Click Healthy Living, then Lifestyle Coaching.
- Complete and submit the online enrollment form.

Enroll by Phone

- Call (800) 258-3175 and choose option 4. Ask questions about the Lifestyle Coaching Program and enroll.

Enrollment Rules

- You can enroll in the Lifestyle Coaching Program once every 12 months. For example, you enroll in the program on July 1, 2015, and complete a six-month program. You cannot enroll in the program again until July 1, 2016.
- You and your covered dependents can join a program.
- All participants must be age 18 or older.
- You cannot participate in the Lifestyle Coaching Program if you are currently enrolled in our Disease Management Program. You can participate in Lifestyle Coaching if you are also enrolled in our Maternity Program.
- Once you enroll, you must talk with your coach at least once a month to stay in the program.

Talk to Your Coach

Once you join a program, you can contact your lifestyle coach by email or phone. You choose which option works best for you.

Email

You can email your coach at any time. He or she will answer your email within 24 hours (Monday through Friday) or 48 hours (Saturday or Sunday). Your personal coach will give you his or her contact information.

Phone

Lifestyle coaches are available by phone:
Monday through Friday: 8 a.m. to 9 p.m.
Saturday: 9 a.m. to 6 p.m.

Bilingual language services and TTY communication assistance for the hearing impaired are available.

Your coach will give you the motivation and information you need to meet your goals. As part of the program, you will get a personal action plan and ongoing support.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

MEDICAL MUTUAL®
CAROLINA CARE PLAN | CONSUMERS LIFE

CARRIER

PICA ☐☐☐ PICA ☐☐☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. ____ 3. ____ 2. ____ 4. ____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ / 29. AMOUNT PAID $ / 30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

SC37 R7/11

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.


DELTA DENTAL®
Welcome!
Delta Dental of Ohio
(800) 524-0149 • www.deltadentaloh.com

Welcome to Delta Dental. We are pleased to provide your dental benefits coverage and we look forward to serving you.

Delta Dental provides the advantages of two of the nation's largest networks of participating dentists—our Delta Dental PPO℠ network and our Delta Dental Premier® network.

This packet includes general information about what you can expect as a Delta Dental member. It also contains resources to help you understand coverage and learn how to use your benefits. (Please see your Summary of Dental Plan Benefits to review your specific plan details.) In addition, our website (www.deltadentaloh.com) is an online resource for locating participating dentists, accessing your plan details, managing your account and finding oral health information.

If you have questions about your new dental program, please feel free to call our Customer Service department at (800) 524-0149. Our automated inquiry system is available 24/7 and can answer most questions. Customer Service representatives are available for more complicated questions Monday through Friday from 8:30 a.m. to 8 p.m. Eastern Time.

Definitions

Certificate	A standard booklet provided by Delta Dental to subscribers explaining their dental benefit coverage.
Copayment	As provided by your plan, the percentage of the charge, if any, that you will have to pay for covered services.
Covered Services	The unique benefits selected in your plan detailed in the Summary of Dental Plan Benefits and Certificate.
Summary of Dental Plan Benefits	A description of the specific provisions of your group dental plan.
Deductible	Amount a person and/or family must pay toward Covered Services before Delta Dental begins paying for services.
Maximum Payment	The maximum dollar amount Delta Dental will pay in any benefit year or lifetime for covered dental services.
Delta Dental PPO Dentist Fee Schedule	The maximum amount allowed per procedure for services rendered by a Delta Dental PPO dentist as determined by that dentist's local Delta Dental plan.
Maximum Approved Fee	A system used by Delta Dental to determine the approved fee for a procedure rendered by a Delta Dental Premier dentist.
Nonparticipating Dentist Fee	The maximum fee allowed per procedure for services rendered by a nonparticipating dentist.
Balance Billing	The difference between the submitted fee and the approved fee that can be charged to the patient by a nonparticipating dentist. Delta Dental participating dentists do not balance bill.
Predetermination	A written estimate of benefits that may be available under your plan for your proposed dental treatment.
Submitted Amount or Submitted Fee	The fee a dentist bills to Delta Dental for a specific treatment.

This booklet only includes a sample summary of definitions.
Please refer to your Certificate for full details.

Benefits of Having Delta Dental Coverage

Need an example of the benefits of having dental benefits? Mr. Smith has a spouse and two children. Everyone in the family gets two cleanings, two oral exams, X-rays, and typically requires a few other services in a year.

	Without dental benefits coverage	With Delta Dental coverage *(services from a Delta Dental PPO dentist)*	Mr. Smith's plan covers[1]
Exam and cleaning (8)	$900	$0	100%
Bitewing X-rays (4)	$220	$0	100%
Fillings (2)	$300	$36.80	80%
Crown	$890	$380.50	50%
Out-of-pocket costs	$2,310	$417.30	–
TOTAL SAVINGS	**$0**	**$1,892.70**	**–**

** Estimations only. Savings will vary on plan design, provider participation, and office location.*
[1] Percentages applied to Delta Dental PPO Fee Schedule.

You may even see savings on procedures not covered under your dental plan if you visit a Delta Dental participating dentist. Most non-covered services are still subject to approved fees contracted between the dentist and Delta Dental, so the savings are passed on to you, the patient.

Dental coverage is about more than just about saving money. Oral health is an essential part of overall health. Delta Dental uses scientific evidence to enhance plan designs in ways that improve health and save money.

If you have one of the conditions listed here, ask your dentist how you can better manage your oral health to prevent infection and improve your condition. In some cases, Delta Dental covers additional cleanings for individuals that have one of these conditions:

- Diabetes and periodontal (gum) disease
- Pregnancy and periodontal (gum) disease
- Certain heart conditions that put you at high or moderate risk for infective endocarditis
- Kidney failure or are undergoing dialysis
- Suppressed immune system due to chemotherapy and/or radiation treatment, HIV-positive status, organ transplant, and/or stem cell (bone marrow) transplant.

Payment Examples

Once you start using your dental benefits, you will receive an Explanation of Benefits (EOB) statement showing the amount the plan paid and the amount you owe the provider, if any. Below are two examples of how the plan works and how receiving services from a Delta Dental PPO or Delta Dental Premier dentist can help you save money.

It is important that you review your benefit summary to see what your plan's benefit levels are as **these are only examples and actual payments will vary**.

Diagnostic & Preventive (Cleaning)

Submitted Amount*	**$100**
Delta Dental PPO Dentist Fee Schedule**	**$70**
Delta Dental Premier Maximum Approved Fee**	**$90**
Nonparticipating Dentist Fee	**$87**

What happens if you go to a:	**Delta Dental PPO dentist**	**Delta Dental Premier dentist**	**Nonparticipating dentist**
Benefit level	**100%**	**100%**	**100%**
Plan pays	**$70**	**$90**	**$87**
Member pays	**$0**	**$0**	**$13**

Basic Service (Root Canal)

Submitted Amount*	**$625**
Delta Dental PPO Dentist Fee Schedule**	**$450**
Delta Dental Premier Maximum Approved Fee**	**$600**
Nonparticipating Dentist Fee	**$550**

What happens if you go to a:	**Delta Dental PPO dentist**	**Delta Dental Premier dentist**	**Nonparticipating dentist**
Benefit level	**80%**	**50%**	**50%**
Plan pays	**$360**	**$300**	**$275**
Member pays	**$90**	**$300**	**$350**

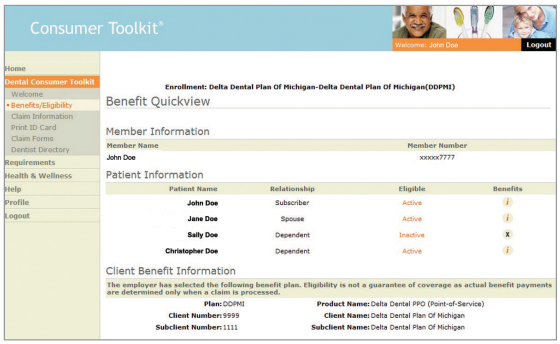
* Amount a dentist charges for the procedure.
** Amount a Delta Dental participating dentist accepts as payment in full.

Consumer Toolkit®—Access Your Benefits Information 24/7

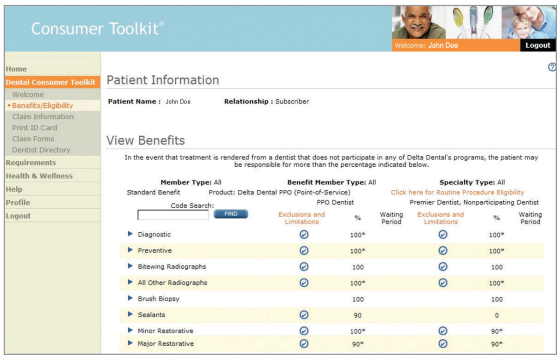
Stay current on your dental benefits with Delta Dental's easy-to-use Consumer Toolkit. This secure online tool is designed to give you 24/7 access to important information regarding your dental benefits, including:

- Eligibility information
- Current benefits information (such as how much of your yearly benefit has been used to date, how much is still available to use, levels of coverage for specific dental services, etc.)
- Specific claims information, including what has been approved and when it was paid

Eligibility



Up-to-date benefit information



The site also allows you to elect to receive your Explanation of Benefits (EOB) statements electronically, print claim forms and identification cards, and browse oral health information.

All users must first register to gain access to the Consumer Toolkit. Privacy of your online benefit information is assured through highly secure encryption technology.

To start taking advantage of this innovative tool, follow these simple steps:

1. Visit www.deltadentaloh.com/consumertoolkit.
2. a) If you have already registered, click the "Log In Now" button.

   b) If you are new to the Consumer Toolkit, click the "New User" button to register.

   - NOTE: You will need the subscriber's (the person whose name is on the benefit package) member ID. The member ID is an assigned number unique to the subscriber. In most cases, the member ID is the same as the subscriber's Social Security number.
3. Complete required fields and follow the on-screen instructions.
4. Select your own username and password to access the site.

Help topics can be found by selecting "Help" or clicking the ⓘ at any time within the Toolkit. If you need further assistance, contact Toolkit support at (866) 356-0301.

Frequently Asked Questions About Delta Dental Coverage

What is required for enrollment in Delta Dental?

Your benefits administrator will provide you with information about how to enroll.

What are my benefits?

You can find this information in your Summary of Dental Plan Benefits and your Certificate or by logging in to Consumer Toolkit.

Do I need to tell my dentist my coverage has changed?

Yes. At your first dental visit after coverage becomes effective, you should tell your dentist that you have Delta Dental of Ohio coverage. A standard reference card will be provided to you with this information included.

Do I need an ID card to receive care?

No. It is not necessary to present a personalized ID card to receive treatment. Your dental office will use your Social Security number (or alternate ID) to verify eligibility and benefits and to submit claims. If you prefer a personalized ID card, you may print one using our online Consumer Toolkit.

How can I find out if my dentist participates with Delta Dental or find a participating dentist?

To find a participating dentist, use the link on our homepage at www.deltadentaloh.com or log in to Consumer Toolkit. You can also call your dentist's office and ask if he or she participates with Delta Dental PPO or Delta Dental Premier.

Do I have to go to a participating dentist?

No. You may visit any licensed dentist; however, you may pay more money out of pocket at a nonparticipating provider. You'll be responsible for paying the nonparticipating dentist whatever he or she charges at the time of service. You will receive a payment from Delta Dental based on the dentist's submitted fee or Delta Dental's nonparticipating dentist fee, whichever is less. You also may have to submit your own claims if you choose a nonparticipating dentist.

How can I contact Delta Dental's Customer Service?

Customer Service can be reached at (800) 524-0149. Our automated inquiry system is available 24/7 and can answer most questions quickly. Representatives are available to assist with more complicated questions Monday through Friday from 8:30 a.m. to 8 p.m. Eastern Time. To submit a written inquiry, please send to: Delta Dental, PO Box 9089, Farmington Hills, MI 48333-9089. Please include your name, group name and number and the subscriber's member ID number when writing.

How do I submit a claim?

Delta Dental participating dentists will fill out and file claim forms for you. If you choose to visit a nonparticipating dentist, you may be required to file your own claim forms. Forms can be downloaded at www.deltadentaloh.com. Send completed forms to: Delta Dental, PO Box 9085, Farmington Hills, MI 48333-9085.

Where should claims be sent for services rendered prior to my Delta Dental effective date?

Claims for dental services rendered prior to the plan's effective date must be submitted to your previous dental administrator to receive reimbursement.

What if I'm in the middle of treatment when my new coverage becomes active?

Delta Dental will cover services completed on or after your effective date.

If my plan incudes orthodontia coverage, how will orthodontic claims be processed?

Dentists are required to submit an orthodontic treatment plan. A percentage of the total fee will be paid when orthodontic treatment begins. Payments will be based on the type of treatment or until the lifetime orthodontic maximum is reached.

If orthodontic treatment is in progress, Delta Dental will calculate payments based on the dentist's original claim form. The remaining liability for the claim will be recalculated based on the months left in the treatment plan. Payments will be made for the remaining payment months or until the lifetime orthodontic maximum is reached.

DELTA DENTAL®

How Delta Dental pays for orthodontic services

Proper tooth alignment is important not only for a beautiful smile, but also for function. When teeth are aligned, it's easier to chew and talk. And it's also important to correct and guide tooth and jaw development as a child grows, in order to ensure a healthy and functioning smile for adulthood.

Orthodontic services, often referred to as "ortho", are services, treatment, and procedures used to correct malposed or misaligned teeth. These services can include braces, retainers, and other orthodontic appliances. Your coverage level for orthodontic services depends on the plan chosen by your employer/ organization. Orthodontic services are a Class IV benefit, usually payable for eligible people up to age 19, and limited to the lifetime maximum per person as specified in your Summary of Dental Plan Benefits.

Do I need a referral to visit an orthodontist?

No referral is necessary if you go to an orthodontist. Both general dentists and orthodontists provide orthodontic treatment. You are free to visit the dentist of your choice. You can find a participating Delta Dental orthodontist on our Web sites at:

- Michigan: www.deltadentalmi.com
- Ohio: www.deltadentaloh.com
- Indiana: www.deltadentalin.com

Or by calling our Customer Service department at (800) 524-0149. Or by registering and logging onto Delta Dental's Consumer Toolkit® from our Web sites.

How will orthodontic services be paid?

Delta Dental requires your dentist to submit an orthodontic treatment plan to us. When orthodontic treatment starts, we will pay a percentage of the initial fee. We will continue to make quarterly payments until the treatment ends or the lifetime orthodontic maximum is reached.

What if treatment has already begun under a different carrier?

For treatment that began prior to eligibility with Delta Dental, we will make payments only for the months of treatment while eligibility is active with Delta Dental. We will calculate our payments based on the original claim form from the provider. We subtract the initial/banding fee from the total fee (as this was incurred prior to eligibility with Delta Dental) and divide by the number of months of treatment. We will then pay for the remaining months of treatment until treatment is finished or the lifetime maximum is reached. If a group has the orthodontic maximums carried over from a prior carrier, Delta Dental will pay for only the remainder of the lifetime orthodontic maximum.

How can I find out what's covered under my plan?

To find out what's covered under the dental plan chosen by your employer:

- Refer to your Summary of Dental Plan Benefits and your Dental Care Certificate
- Register and log onto Delta Dental's Consumer Toolkit from our Web sites
- Call Delta Dental's Customer Service department at (800) 524-0149

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1K cc

It's easy to register for an account on vsp.com.

Just follow these steps:

1. Visit **vsp.com**
2. Click on REGISTER at the top of the page
3. Enter the member's SSN or Member ID Number
4. Enter the member's first and last name
5. Enter the member's date of birth
6. Click CONTINUE
7. Follow the steps to create a user name and password

Once you register, you can review your benefit information, access personalized eligibility and plan coverage details, and print a Member Vision Card.

Register Today!

GROUP VOLUNTARY TERM LIFE CERTIFICATE SUMMARY

This summary describes the terms and conditions of the Policy. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate, available from the Policyholder. The capitalization of a term not normally capitalized according to standard punctuation rules indicates a word or phrase that is a defined term in the Certificate. A person is not necessarily entitled to insurance because he or she received this summary. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Policy. This summary was published on January 20, 2016.

POLICY INFORMATION

Policyholder: Granville Exempted Village Schools
Policy Effective Date: January 1, 2016
Policy Number: GVTL-AY6L
Class(es): All Eligible Employees
Policy Anniversary: January 1
Group Number: G000AY6L

ELIGIBILITY

You (the Employee) must be performing the normal duties of Your regular job for the Policyholder on a regular and continuous basis 15 or more hours each week to be eligible for insurance.

Your eligible Dependents must be able to perform normal activities and not be confined (at home, in a hospital, or in any other care facility) to be eligible for insurance.

WHEN INSURANCE BEGINS

An eligible Employee will become insured on the first day of the month that coincides with or follows the day the Employee becomes eligible, subject to certain conditions (as described in the Exceptions to When Insurance Begins provision in the Certificate).

An eligible Dependent will become insured on the latest of the day the Employee becomes insured, the Employee acquires the eligible Dependent, or the Employee submits a Written Request to enroll the Dependent for insurance (if required), subject to certain conditions (as described in the Exceptions to When Insurance Begins provision in the Certificate).

Additional eligibility conditions apply as described in the Certificate.

BENEFIT AMOUNT(S)

Insurance for You (The Employee)

You may elect to be insured for an amount of life insurance from $10,000 to $300,000, in increments of $10,000. In no event shall Your amount of life insurance exceed 10 times Your Annual Earnings, rounded to the next higher multiple of $10,000.

Provided You have elected some amount of life insurance, Your amount of accidental death and dismemberment (AD&D) insurance is equal to Your amount of life insurance.

Your Guarantee Issue Amount is 10 times Your Annual Earnings or $150,000, whichever is less. If You have questions regarding the amount of Your insurance, You may contact the Policyholder.

Insurance for Your Dependent(s)

You may elect to have Your Spouse insured for an amount of life insurance from $10,000 to $20,000, in increments of $10,000, provided the amount elected does not exceed 100% of Your amount of life insurance.

Provided You have elected some amount of life insurance for Your Spouse, Your Spouse's amount of accidental death and dismemberment (AD&D) insurance is equal to Your Spouse's amount of life insurance.

You may elect to have Your eligible Dependent child(ren) insured for an amount of life insurance equal to $10,000, provided the amount elected does not exceed 100% of Your amount of life insurance. Each eligible Dependent child must have the same amount of insurance.

Provided You have elected some amount of life insurance for Your Dependent child(ren), the amount of accidental death and dismemberment (AD&D) insurance for Your Dependent child(ren) is equal to the amount of life insurance for Your Dependent child(ren).

The Guarantee Issue Amount for Your Spouse is 100% of Your elected amount of life insurance or $20,000, whichever is less. The Guarantee Issue Amount for Your Dependent child(ren) is 100% of Your elected amount of life insurance or $10,000, whichever is less. If You have questions regarding the amount of insurance for Your Dependent(s), You may contact the Policyholder.

Benefit Reduction(s)

As You grow older, the amount of life and AD&D insurance for You and Your Spouse will be reduced according to the following schedule:

At the Age of:	The Original Amount of Insurance Will Reduce to:
70	67%
75	50%

FEATURE(S)

Annual Increase Option

You may submit a Written Request to increase the amount of insurance once a year, provided the new amount of insurance does not exceed the maximum benefit amount shown in the Schedule. You may increase Your amount of insurance by up to $10,000, in increments as shown in the Schedule, subject to certain conditions.

Living Benefits

In the event You incur a Terminal Condition while insured under the Policy, You, Your Spouse or Your legal representative may submit a Written Request for an advance payment of part of Your life insurance death benefit. The maximum amount of Living Benefits available is 75% of the amount of life insurance for You in effect at the time of the request or $225,000, whichever is less.

Additional Accidental Death and Dismemberment (AD&D) Benefit(s)

In addition to basic AD&D benefits, You are protected by the following benefit(s):

- Paralysis
- Airbag
- Seat Belt
- Childcare
- Child Education
- Spouse Education

Continuation of Insurance for Layoff or Leave, Injury or Sickness, or Partial Disability

You may be able to continue insurance for You and Your Dependent(s) from the day You cease to be Actively Working, subject to certain conditions.

Continuation of Insurance for Total Disability with Waiver of Premium

You may be able to continue insurance for You from the day You cease to be Actively Working due to Your Total Disability, subject to certain conditions.

Portability

In the event Your insurance under the Policy ends, You have the right to continue receiving group life and accidental death and dismemberment insurance for You and/or Your Dependent(s), subject to certain conditions.

Conversion

If group life insurance ends or the benefit reduces, You or any of Your Dependent(s) may apply for an individual policy of life insurance, subject to certain conditions.

EXCLUSION(S)

We will not pay benefits for a death which results from suicide, while sane or insane, within two years from the date insurance begins (under the Policy or any Prior Plan). Instead, We will refund the total of the premiums paid for insurance under the Policy.

If death results from suicide, while sane or insane, within two years from the effective date of any increase in the amount of insurance under the Policy, benefits in the amount of the increase will not be paid. Instead, We will refund the total of the premiums paid under the Policy for said increase in insurance.

Several exclusions apply to the accidental death and dismemberment (AD&D) benefits as described in the Certificate.

Portability vs Conversion

Granville Exempted Village Schools Group ID: G000AY6L

If your group coverage ends or reduces, you may be eligible to continue ("port") your employer sponsored life/accidental death & dismemberment insurance or convert your life insurance policy to an individual whole life insurance policy in order to maintain coverage.

The grid below outlines the differences between Portability and Conversion to help you determine the best option for you. If you have any questions regarding the Portability or Conversion process, please contact your Benefits Administrator or take advantage of the toll-free number provided by Mutual of Omaha Insurance Company. You can reach a service representative by calling (877) 466-8367, Monday through Friday 9:00 a.m. to 5:00 p.m. (Eastern Standard Time).

	Portability	Conversion
Coverage Continues as	Group Term Life Insurance	Individual Whole Life Insurance
Eligibility	Employee and/or spouse are under 70 when group coverage ends	Group life coverage terminates or is reduced for any reason
Children	Eligible as long as employee and/or spouse has ported coverage	Group life coverage terminates or is reduced for any reason
Election Period	Request form must be received within 31 days of employer sponsored insurance ending	Application must be received within 31 days of employer sponsored insurance ending/reducing
Medical Information	None required	None required
Rates	Based on amount of insurance and age	Based on amount of insurance, gender and age
Billing Options	Quarterly, semiannually, annually	Semiannually, annually
Cash Value	No (Term Insurance)	Yes (Permanent Insurance)
Termination	Age 70 for employee and/or spouse Limiting age for children 21/25	Death
Living Benefit	Included	Not included
Minimum	Employee: $10,000 Spouse: $5,000 Dependents: $2,000	$5,000
Maximum	Lesser of prior coverage under group plan or $500,000 for employee or $250,000 for spouse	Amount of prior coverage under group plan

Conversion Process

If your group coverage ends or reduces, you have the opportunity to convert your employer sponsored life insurance policy, or voluntary life insurance you have elected, to an individual whole life policy. You may convert an amount up to your previous coverage level without medical underwriting.

Follow these steps to successfully convert your life insurance:

1. Obtain a Group Life Conversion Form from your employer or at mutualofomaha.com/customer-service
2. Ensure your employer completes the section "Information to be Completed by the Personnel Office"
3. Complete remaining sections of the application form
4. Attach check or money order for the premium payment (see application to determine amount)
5. Send completed form and premium payment within **31 days** of group insurance ending/reducing to the address on the application
6. Receive notification from us once your request has been processed

For questions regarding eligible insurance amounts, please contact your Benefits Administrator.

Other questions about the conversion process should be directed to Mutual of Omaha at (800) 826-8054.

MUGC9429

Life Conversion Coverage

Life Goes on with Group Conversion

Your group life insurance has been valuable protection for you and your family. Now that it will be terminated, you may wish to convert this important coverage to an individual policy. This information has been prepared to help you take advantage of your right to continue your protection.

About Life Conversion Coverage

Life Conversion Coverage is individual permanent life insurance issued without evidence of insurability.

Life Conversion Coverage can be obtained when your life insurance under the group policy ends. Your group certificate will describe when conversion coverage is available to you, and will show the amount of coverage you can convert.

Conversion coverage will be issued without evidence of good health, provided:
(a) you complete the attached application,
(b) you enclose a check or money order for the first premium payment and
(c) these items are forwarded to us within 31 days after your group insurance ends.

Your conversion policy will be effective on the 31st day after your group insurance ends. During this 31-day period, you remain covered under the continued coverage provision of your group certificate.

You may apply for an amount that is not more than the amount of your current group insurance coverage (this is your maximum). You may elect coverage in $1,000 increments up to your maximum.

The individual policy is Whole Life Express Insurance, which provides a level benefit throughout your lifetime. Premiums for this coverage are payable while living until the policy anniversary following age 95.

Premium rates are shown in the table that follows. If premium payments are discontinued, you may:
(a) receive any existing cash value or
(b) use the cash value to purchase extended term insurance or a reduced amount of paid-up life insurance.

For additional information or premium rates on conversion coverage, please write or call us at:

United of Omaha Life Insurance Company

Attn: 4th Floor, Group Conversion
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Phone: 1-800-826-8054

To Apply for Life Conversion Coverage

In order to apply for life conversion coverage, you must do the following:

1) Complete the Life Conversion Application that follows. Use black or blue ink, or a typewriter. Write clearly and do not erase – any corrections should be crossed out and initialed by you. Answer each question fully – do not use dashes or ditto marks.

2) Make sure the section entitled "Information to be Completed by the Personnel Office" is completed by the employer or administrator of the group policy.

3) Attach your check or money order payable to United of Omaha Life Insurance Company for the first annual or semiannual premium payment.

4) Send your premium payment and completed application to the above address within 31 days after your group insurance ends.

Privacy Notice: *When United of Omaha Life Insurance Company evaluates an application for life conversion coverage, only the information on the application is reviewed. This information, and other information we may later collect to administer coverage, may sometimes be disclosed without your express authorization. We have a procedure which allows you to review and amend any information we collect about you – other than information relating to a claim, lawsuit or criminal proceeding. If you would like to know more about our information practices, please write us at the address shown above.*

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Calculating The Premium

The premium amounts in the table below are per $1,000 of coverage. Calculate your annual and/or semiannual premium in the calculation worksheet, following the steps and example below.

To calculate annual and semiannual premium:

1) Divide your desired death benefit amount by 1,000.
2) Locate your age group and gender on the table below to identify the premium rate per thousand.
3) Multiply #1 by #2 above.
4) Add $36 for the annual policy fee to obtain the **annual premium** for the coverage.
5) Multiply the annual premium by .52 to obtain the **semiannual premium** for the coverage.

Issue Age	Male	Female
0-4	$6.80	$6.10
5-9	$7.70	$6.90
10-14	$8.80	$7.80
15-19	$10.00	$9.00
20-24	$17.00	$12.50
25-29	$21.00	$15.00
30-34	$25.00	$17.50
35-39	$30.00	$20.50
40-44	$35.00	$24.00
45-49	$41.00	$30.00
50-54	$46.00	$33.00
55-59	$58.00	$40.00
60-64	$80.00	$51.00
65-69	$111.00	$72.00
70-74	$154.00	$108.00
75-79	$196.00	$149.00
80-84	$238.00	$198.00
85	$304.00	$255.00

Example (Assumes a 50-year-old male with current group life coverage of $20,000.)

20	x	$46.00	=	$920.00	+	$36	=	$956.00
Desired coverage amount/$1,000		Premium rate per thousand		Premium for coverage		Annual policy fee		**Total annual premium**

$956.00	x .52	=	$497.12
Total annual premium			**Total semiannual premium**

Calculation Worksheet

_____	x	_____	=	_____	+	$36	=	$ _____
Desired coverage amount/$1,000		Premium rate per thousand		Premium for coverage		Annual policy fee		**Total annual premium**

_____	x .52	=	_____
Total annual premium			**Total semiannual premium**

Conversion Application

This application must be completed and mailed within 31 days after your group insurance ends. Mail the conversion to: United of Omaha Life Insurance Company, Attn: Individual Underwriting Services, Mutual of Omaha Plaza, Omaha, Nebraska 68175.

Life Insurance Section

1 Applicant's Name (First, Middle, Last)

_____

2 Social Security Number

_____

3 Male ☐ Female ☐

4 Age _____ **5** Date of Birth _____ _____ _____
Mo. Day Yr.

6 Residence (Number, Street, City, State, ZIP)

_____

_____

7 Home Phone Number (_____)_____

8 Amount of Insurance $_____
(Show amount in thousands, not greater than the amount you are entitled to convert.)

9 Mode of Premium Payments
☐ Annually ☐ Semiannually

10 Amount Paid with Application

$ _____

11 Beneficiary (Give full name and relationship to applicant)

Primary _____

Contingent _____

12 Have you or any person proposed for insurance been offered cash, or any other consideration for obtaining this policy? ☐ Yes ☐ No

13 Are you or any proposed insured planning to enter into a finance arrangement to pay any premium payments due under this policy? ☐ Yes ☐ No

If "Yes" to questions 12 or 13, please explain: _____

_____

Payment will be shared equally by all primary beneficiaries who survive you; if none, it will be shared equally by all contingent beneficiaries who survive you. Unless otherwise stated, you have the right to change the beneficiary.

Group Information Section

1 Group Policyholder _____ Group Policy No._____

2 I have been insured under the above Group Policy as: ☐ An employee or member ☐ A dependent

3 I became insured under the Group Policy: _____ Month _____ Day _____ Year

4 My group insurance terminated: _____ Month _____ Day _____ Year

5 Was termination due to disability? ☐ Yes ☐ No
(If "Yes," give date and cause of disability.) _____

Life Agreements Section

I am applying to United of Omaha for the life conversion coverage shown above. I agree United will not be under any obligation or liability under this application unless:

(1) I have the right to convert the insurance shown above.
(2) The application is made within 31 days after my group insurance ends.

Date _____ , _____ Signed at _____

_____ _____
Witness Applicant's Signature

Whole Life Express Policy Form 6879L-0202, or state equivalent. In OK, 6918L-0202. In OR, 6949L-0202. In TX, 6920L-0202.
135L-0682_OH_1012

Information to be completed by the personnel office

Group Policyholder _____

Policy No. _____ Phone (_____) _____

Address (Number, Street, City, State, ZIP) _____

Applicant's Name _____

Certificate No. _____

1 The Applicant was insured under the above Group Policy as: ☐ An employee or member ☐ A dependent

2 For what amount of coverage was the Applicant insured? $ _____

3 What is the Applicant's date of birth? _____ Month _____ Day _____ Year

4 When did the Applicant become insured under the Group Policy? _____ Month _____ Day _____ Year

5 The Applicant's coverage was: ☐ terminated on _____ Month _____ Day _____ Year

☐ reduced by $ _____ on _____ Month _____ Day _____ Year

Because of _____

_____

Completed by _____ Signature (Employer or Administrator)

Title _____ Date _____ , _____

Portability Process

If your group coverage ends or reduces, you may have the opportunity to continue ("port") your employer sponsored life/accidental death and dismemberment insurance policy or voluntary life/accidental death and dismemberment coverage you elected for an affordable group rate. These rates are not the same as what you paid on a payroll deduction basis. However, you may port an amount up to your previous coverage level without medical underwriting.

Follow these steps to successfully port your life insurance:

1. Obtain a Standard Term Life Portability Request Form from your employer or at mutualofomaha.com/customer-service
2. Ensure your employer completes Section 1: Group Information and Date of Hire/Association
3. Complete remaining sections of the application form
4. Attach check or money order for the premium payment (see application form to determine amount)
5. Send completed form and premium payment within **31 days** of group insurance ending or reducing to the address on the application
6. Receive notification from us once your request has been processed

For questions regarding eligible insurance amounts, please contact your Benefits Administrator:

Other questions about the conversion process should be directed to us at (877) 466-8367.

MUGC9428

A Guide for Successfully Completing the Mutual of Omaha Term Life Portability Request Form

Mutual of Omaha appreciates the opportunity to provide you with valuable life insurance protection for yourself and/or your loved ones. So that we can effectively process your request for life insurance under the Term Life Portability Plan, we rely on the information you provide on this form.

This guide provides information and instruction to help you successfully complete and submit the form. Please consult your employer/benefits administrator if you need assistance with information for the form.

About the Form

The Term Life Enhanced Portability Form is a request for insurance under Mutual of Omaha's Term Life Portability Plan. Insurance under this plan is available to employees/members (hereafter referred to as "members") and/or eligible dependents when insurance under a Mutual of Omaha group term life insurance plan (voluntary and/or basic) offered by an employer/group ceases.

A completed and signed form with initial premium payment MUST be mailed to Mutual of Omaha within 31 days after insurance has ceased under the group plan for your request to be considered.

All sections of the form are to be completed. Make sure you provide all required information and answer all questions completely and accurately. If information is missing or is illegible (unreadable), the processing of the form will be delayed. Please contact the employer/ benefits administrator to determine or confirm information as needed.

Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.

Section 1: Employer/Group Information

Provide the name and ID number for the employer/group. The number will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to the employer/group. The original date of hire or date of association for the member must also be provided.

Section 2: Applicant Information

Please provide all required applicant information. If the Member is eligible to port insurance, the member must be the applicant and elect insurance for dependents to be eligible. If the member is not eligible to port insurance, the spouse (in the event of divorce or the employee's death, for example) can be the applicant and is eligible to port term life insurance for her/himself and dependents.

The applicant must be age 70* or less to be eligible for insurance. Insurance under the portability plan terminates at age 70.*

To ensure any additional correspondence regarding your request occurs as quickly as possible, check the box to consent to receive future correspondence via email.

Section 3: Dependent Information

To be eligible to port term life insurance, dependents must have been insured under the group plan on the day preceding the day coverage ceased under the plan.

Section 3: Dependent Information (Continued)

If the member is eligible to port insurance, the member must elect insurance for dependents to be eligible.

In addition, a spouse must be age 70* or less and children age 26 or less to be eligible for insurance. Spouse insurance under the portability plan terminates at age 70,* and child insurance terminates at age 26.

If the applicant is a spouse, do not provide spouse information in this section.

Section 4: Current Term Life Insurance Amount(s) Eligible for Portability

For the applicant and eligible dependents, provide the term life insurance amount(s) that were both:

- In-force at the time coverage ceased under the group plan; and
- Eligible for portability† (the contract for coverage contained a portability provision).

These are the maximum amount(s) of coverage that can be requested under the portability plan.

†You may have had group life insurance under a Voluntary Term Life Insurance plan, a Basic Life Insurance plan, or both, from the group. Any plan must include a portability provision for the insurance available to you under the plan to be portable. It may be possible that the insurance you had under a Voluntary Term Life Insurance plan is portable, but the insurance you had under a Basic Life Insurance plan is not, for example. Please consult the contract for each plan or the employer/benefits administrator to determine if portability is available.

Section 5: Monthly Rates Per $1,000 of Insurance

These are the monthly rates per $1,000 of insurance that apply under the Term Life Portability Plan.

The member and spouse rates are age banded, which means that the premium for member and spouse insurance is assessed according to age – as the member or spouse age and advances to the next age band, premiums for insurance will increase accordingly. The initial premium payment is based on the current age of the member or spouse. The child rate does not vary by age.

If the term life insurance offered by the group included an accidental death & dismemberment (AD&D) insurance rider, you are also eligible to port AD&D insurance in an amount equal to the amount of life insurance ported, if you so choose. This rate is the same for member, spouse and child(ren) and does not vary by age.

The rates presented in Section 5 are used in Section 6 to determine premium for insurance under the portability plan.

SECTION 6: PORTABILITY INSURANCE ELECTION & INITIAL PREMIUM PAYMENT CALCULATION

To complete insurance election and initial premium payment calculation, the type of insurance requested must be indicated, then premium amounts must be calculated for each individual for whom ported insurance is being requested, and a billing mode must be selected.

First, select the type of insurance requested, either "Life Insurance Only" or "Life and AD&D Insurance." If the term life insurance offered by the group included an accidental death & dismemberment (AD&D) insurance rider, you are also eligible to port AD&D insurance in an amount equal to the amount of life insurance ported, if you so choose.

Next, do the following to complete this section:

(1) Provide the first name of each individual for whom ported insurance is being requested.

(2) Provide the Insurance Amount each individual is requesting (rounded up to the nearest $1,000), subject to the following:

- The Insurance Amount for each individual must be less than or equal to the amount of insurance the individual had when insurance ceased under the group plan, not to exceed $500,000. The maximum amounts are equivalent to the Current Insurance Amounts indicated in Section 4.
- The Insurance Amount for the employee must be $10,000 or more. The Insurance Amount for spouse must be $5,000 or more, and for child(ren), $2,000 or more.
- If the applicant is an employee, dependent spouse and child(ren) insurance amounts must be less than or equal to 50% of the insurance amount applied for by the member.
- Insurance Amount(s) must be in increments of $5,000 for the member and/or spouse. (Example: $10,000 and $25,000 are acceptable insurance amounts, but $12,000 and $27,000 are not.) The Insurance Amount for child(ren) must be in $1,000 increments.

(3) Calculate the Coverage Factor for each individual, by dividing your Insurance Amount (2) by 1,000. (Example: $25,000 / 1,000 = 25; 25 is the Coverage Factor.)

(4) Insert the appropriate monthly rate per $1,000 of insurance for each individual, for the current age for member and/or spouse. Rates are provided in Section 5. If you are requesting both life and AD&D insurance, you must add the AD&D monthly rate per $1,000 ($0.060) to the life monthly rate per $1,000 to obtain the appropriate monthly rate per $1,000. (Example: The appropriate monthly rate per $1,000 for a 34 year old applicant requesting life and AD&D coverage is $0.165 ($0.105 for Life plus $0.060 for AD&D).)

(5) Calculate the Monthly Premium for each individual, by multiplying the Coverage Factor (3) by the Monthly Rate (4).

(6) Calculate the Total Monthly Premium, by adding together all of the amounts in the Monthly Premium (5) column.

(7) Select a billing frequency. To pay premium every 3 months (quarterly), insert a "3" into column (7). To pay premium twice a year (semi-annually), insert a "6" into column (7). To pay premium annually, insert a "12" into column (7).

(8) Calculate the Premium Subtotal, by multiplying the Total Monthly Premium (6) by the Billing Frequency (7).

(9) Calculate the Initial Premium Payment, by adding the $5.00 Billing Fee to the Premium Subtotal (8).

SECTION 7: BENEFICIARY FOR DEATH BENEFITS

You must designate a beneficiary for any life insurance proceeds in the event of your death. You (the applicant) are the beneficiary for any dependent life insurance.

If you wish to designate additional beneficiaries (beyond what space allows for on the form), please attach an additional sheet of paper to the form that includes the required information.

SECTION 8: ACKNOWLEDGEMENT AND SIGNATURE

Read the statements in this section. If you understand and agree to the statements, sign and date the form to complete the form. Your signature binds you to the statements in this section, and allows the form to be processed by Mutual of Omaha.

SECTION 9: INSTRUCTIONS

Follow these instructions to ensure your request is properly submitted and received by Mutual of Omaha. Be sure to include the Group ID Number on any payment, and mail the request form and the payment to Mutual of Omaha as soon as possible after your coverage ends under the group plan.

Remember, to be considered for coverage under the Term Life Portability Plan, your request must be received within 31 days of the date coverage under the group plan ended.

*The ages referenced in Sections 2 and 3 represent Attained Age, which is the age of any individual as of the policy anniversary date of October 1 of a given year. For example, lets say you are 69 years old on October 1, 2009. Your Attained Age for the policy year (October 1, 2009 - September 30, 2010) is 69, even if your 70th birthday is in November. In this example, you are eligible for coverage under this plan until September 30, 2010.

Term Life Portability Request Form

Premium Services

Underwritten by: United of Omaha Life Insurance Company

Please refer to "A Guide for Successfully Completing the Term Life Portability Request Form" when completing this form. Please consult the employer/benefits administrator if you need assistance with information for the form.

Section 1: Group Information and Date of Hire/Association (Please print clearly. Required fields are marked with an asterisk (*).)

Group/Employer Name*	Group ID Number*	Date of Hire/Association (MM/DD/YYYY)*
	G000 __ __ __ __	

Section 2: Applicant Information (Please print clearly. Required fields are marked with an asterisk (*).)

Last Name*	First Name*	MI

Street Address*	Email Address

City*	State*	ZIP Code*	Telephone*

Birth Date (MM/DD/YYYY)*†	Social Security Number*	Gender*
		☐ Female ☐ Male

†*The applicant must be the Attained Age of 70 or less to be eligible for insurance.*

Consent to Email Correspondence

☐ Check this box if you consent to receiving future correspondence regarding this request via email.

Applicant Type*	Individuals for Whom Ported Insurance is Being Requested* (†Applies to employee/member applicants)
☐ Employee/Member ☐ Spouse	☐ Myself ☐ Myself & Spouse† ☐ Myself, Spouse & Child(ren)† ☐ Myself & Child(ren)

Reason for Request*

If you are an employee/member applicant, indicate why you are requesting insurance, and provide the date (MM/DD/YYYY) as requested:

☐ Status Change/Reduction in Hours Date of Change: _____ ☐ Employment/Association Terminated Date of Termination: _____ ☐ Plan Terminated by Group/Employer Date of Termination: _____ ☐ Employee/Member Retirement Date of Retirement: _____

If you are a spouse applicant, please indicate why you are requesting insurance, and provide the date (MM/DD/YYYY) as requested:

☐ Divorce; Date of Divorce: _____ ☐ Death of Employee/Member; Date of Death: _____ ☐ Ineligible Due to Employee/Member Age; Date of Ineligibility: _____ ☐ Ineligible Due to Employee/Member Active Military Status; Date of Ineligibility: _____

Section 3: Dependent Information (Please print clearly. All fields are required for any dependents requesting insurance.)

Dependent Type	Last Name	First Name	MI	Date of Birth† (MM/DD/YYYY)	Gender
☐ Spouse ☐ Child					☐ Female ☐ Male
Child					☐ Female ☐ Male
Child					☐ Female ☐ Male
Child					☐ Female ☐ Male
Child					☐ Female ☐ Male
Child					☐ Female ☐ Male

†*A spouse must be the Attained Age of 70 or less and children must be the Attained Age of 26 or less to be eligible for insurance.*

Section 4: Current Term Life Insurance Amount(s) Eligible for Portability (Please print clearly.)

	Applicant*	Spouse (If applicable)	Child(ren) (If applicable)
Eligible Insurance Amount	$	$	$

Section 5: Monthly Rates Per $1,000 of Insurance

	Employee/Member and Spouse Rates										Child Rate
Age	0 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	All Ages
Life Rate	$0.100	$0.100	$0.105	$0.149	$0.227	$0.408	$0.735	$1.300	$1.978	$3.733	$0.120
AD&D Rate	$0.060 (applies to Employee/Member, Spouse and Child for all ages)										

†*The ages referenced in Sections 2 and 3 represent Attained Age, which is the age of any individual as of the policy anniversary date of October 1 of a given year. For example, lets say you are 69 years old on October 1, 2009. Your Attained Age for the policy year (October 1, 2009 - September 30, 2010) is 69, even if your 70th birthday is in November. In this example, you are eligible for insurance under this plan until September 30, 2010.*

Section 6: Portability Insurance Election & Initial Premium Payment Calculation

Type of Insurance Requested

☐ Life Insurance Only ☐ Life and AD&D Insurance *(This option can only be selected if an AD&D rider was available under the group plan)*

Initial Premium Payment Calculation

	(1) First Name	(2) Insurance Amount	(3) Coverage Factor (2) / 1,000	(4) Monthly Rate Life + AD&D if applicable	(5) Monthly Premium (3) X (4)	(6) Total Monthly Premium Sum of column (5) amounts	(7) Billing Frequency	(8) Premium Subtotal (6) X (7)
Applicant								
Spouse								
Child								
Child						$ _____	_____	$ _____
Child								
Child								
Child								

Billing Fee	+ $5.00
(9) Initial Premium Payment	$ _____

Section 7: Beneficiary For Death Benefits

Important Note: AZ, CA, ID, LA, NV, NM, TX, WA and WI are community property states. If you live in a community property state and you designate someone other than your spouse as a beneficiary, state law requires that your spouse consent to such designation. If you do not obtain your spouse's consent to the foregoing designation(s), then such designation(s) may not be effective.

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

Primary Beneficiary Designation

Last Name	First Name	Relationship to Applicant	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Applicant	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Section 8: Acknowledgement and Signature

I understand that I may request insurance under the portability plan subject to the following:

- I understand that this insurance is subject to the rules of the policy governing the portability plan.
- I understand that the individuals covered under this plan must satisfy the plan's requirements to be eligible for benefits and that payment of premium does not ensure eligibility for insurance. In the event that any premium is collected after eligibility for portability insurance ceases, I understand that the unearned premium will be refunded in accordance with the terms of the policy governing the portability plan.
- This request for insurance must be received by Mutual of Omaha within 31 days of the date that insurance ceased under the group plan.
- My request is subject to review and acceptance by Mutual of Omaha.
- Premium amounts may increase if any of the individuals insured under the plan enter a higher premium age category, or if portability plan experience requires a change for all individuals insured under the plan.

By signing below, I acknowledge that I understand and agree to the above statements.

SIGNATURE OF APPLICANT _____ **DATE** _____/_____/_____

Section 9: Instructions

1) Mail this completed and signed form with the Initial Premium Payment to Mutual of Omaha as soon as possible after insurance has ceased under the group plan. The form and payment must be received by Mutual of Omaha within 31 days of the date insurance under the group plan ended.

2) Make the check or money order for the Initial Premium Payment payable to United of Omaha Life Insurance Company. Be sure to include the Group ID Number (from Section 1) on the payment.

3) Submit this form and payment to:
Mutual of Omaha
Policyowner Services
PO BOX 2147
Omaha NE 68103-2147

If you have any questions regarding this form, please contact the employer/benefits administrator, or contact Mutual of Omaha toll-free at (877) 466-8367.

Important information regarding your disability benefit programs

STRS Ohio offers 3 different programs: **Defined Benefit**, **Defined Contribution** and **Combined**. Depending on the program you participate in, you may, or may not have access to disability income protection. Often referred to as "**paycheck insurance"**, Short-Term and Long-Term disability coverage can provide a weekly or monthly **income replacement** if you are unable to work due to a covered injury or illness. It is important that you review your STRS benefits as well as your Mutual of Omaha benefits to determine the best level of **income protection** for you and your family.

It is important to understand that you may be able to receive benefits under both the Mutual of Omaha disability plan and STRS, but the Mutual of Omaha plan will offset with any benefits received under the STRS program. If you are not currently insured under STRS, you should strongly consider Mutual of Omaha disability benefits to fill the gap in eligibility or coverage.

STRS Defined Benefit Plan*

Depending on your membership date in STRS, you have access to either the disability allowance program or the disability retirement program.

Disability Allowance: Existing members on June 30, 2013 must have at least 5.00 years of qualifying service credit to be eligible. New members on July 1, 2013 must have at least 10.00 years of service to be eligible. Your benefit can be between 45% and 60% of your Final Average Salary, depending on years of service.

Disability Retirement: Members earning service credit before July 1, 2013 must have at least 5.00 years of qualifying service credit to be eligible. You must be younger than 60 years old when the disability application is filed. Your benefit can be between 30% and 75% of your Final Average Salary, depending on years of service.

Example 1: Your membership started on July 20, 2013. You will not be eligible for STRS disability benefits until you have 10.00 qualifying service credits. You are not covered by any disability program unless you purchase Mutual of Omaha disability coverage. Please review your Mutual of Omaha disability benefit options carefully.

Example 2: Your membership started on July 1, 2007. You have 8 qualifying credits. You are eligible for STRS disability. The STRS calculation can be found online, and will be between 30% and 75% of your Final Average Salary, depending on which program you qualify for and your years of service.

If you became totally disabled and could not perform your occupation, the maximum Mutual of Omaha benefit is 60% of salary. Mutual of Omaha would offset with any STRS benefits, providing the difference up to 60% income replacement ratio. Any benefits received from Mutual of Omaha would be tax-free.

STRS Defined Contribution Plan*

If you are participating in this plan, there are no disability benefits available under STRS. **You may be eligible to enroll for disability benefits through Mutual of Omaha. If you are participating in the Defined Contribution Plan, you should strongly consider Mutual of Omaha Short- and Long-Term Disability benefits.**

Example: You are not eligible for any disability benefits under STRS. If you would like to review disability plans (paycheck insurance) which can pay you up to 60% of your current income (tax-free), you are strongly encouraged to review the Mutual of Omaha Short- and Long-Term Disability benefit options carefully.

STRS Combined Plan*

Eligibility for *Existing members on June 30, 2013:* You must have at least 5.00 years of qualifying service credit on account with STRS to be eligible for disability coverage.

Eligibility for *New members on or after July 1, 2013:* You must have at least 10.00 years of qualifying service credit on account with STRS to be eligible for disability coverage.

If you feel you qualify per the eligibility criteria above, your monthly benefit available under STRS can be between 45% and 60% of your Final Average Salary, depending on years of service.

Example 1: Your membership started on July 20, 2013. You will not be eligible for STRS disability benefits until you have 10.00 qualifying service credits. You are not covered by any disability program unless you purchase Mutual of Omaha disability coverage. Please review your Mutual of Omaha disability benefit options carefully.

Example 2: Your membership started on July 1, 2007. You have 8 qualifying credits. You are eligible for STRS disability. The STRS calculation would be (2.2% x 8 = 17.6%). The minimum benefit is 45%, so your benefit would be 45% of your Final Average Salary.

If you became totally disabled and could not perform your occupation, the maximum Mutual of Omaha benefit is 60% of salary. Mutual of Omaha would offset with the 45% received through STRS. Any benefits received from Mutual of Omaha would be tax-free. If you were purchasing Mutual of Omaha coverage, you can expect to receive a combined 60% replacement ratio between both benefits.

* Please see the STRS website or your membership documents to verify exact benefits and eligibility criteria for your specific situation. The above is meant to be a guide, helping you interpret your various benefits and options under both plans.

GROUP VOLUNTARY LONG-TERM DISABILITY CERTIFICATE SUMMARY

This summary describes some of the terms and conditions of the Policy. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate, available from the Policyholder. A person is not necessarily entitled to insurance because he or she received this summary. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Policy. This summary was published on December 10, 2015.

POLICY INFORMATION

Policyholder:	Granville Exempted Village Schools
Policy Effective Date:	January 1, 2016
Policy Anniversary:	January 1
Policy Number:	GUPR-AY6L
Group Number:	G000AY6L
Classification:	All Eligible Employees Electing the 5 Year Benefit Duration
Minimum Work Hours Required:	15 hours per week
Eligibility Present Waiting Period:	None
Eligibility Future Waiting Period:	None
When Insurance Begins:	the first day of the month that coincides with or follows the day the Employee becomes eligible. Additional eligibility conditions apply as described in the Certificate.
Elimination Period:	The later of: a) 90 calendar days; or b) the date Your short-term Disability ends.

BENEFITS

Monthly Benefit Percentage:	60%
Maximum Monthly Benefit:	$5,000
Minimum Monthly Benefit:	$100
Maximum Benefit Period:	**Age at Disability** — **Maximum Benefit Period** Under 65..... 5 years; 65 through 68..... to age 70; 69 and over..... 1 year.
Own Occupation Definition:	2 years
Survivor Benefit:	3 months
Vocational Rehabilitation Benefit:	5%

LIMITATIONS/EXCLUSIONS

Alcohol/Drug Abuse/Substance Abuse Limitation:	24 months
Mental Disorder Limitation:	24 months
Pre-existing Condition Exclusion:	12/12

GROUP VOLUNTARY LONG-TERM DISABILITY CERTIFICATE SUMMARY

This summary describes some of the terms and conditions of the Policy. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate, available from the Policyholder. A person is not necessarily entitled to insurance because he or she received this summary. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Policy. This summary was published on December 10, 2015.

POLICY INFORMATION

Policyholder:	Granville Exempted Village Schools
Policy Effective Date:	January 1, 2016
Policy Anniversary:	January 1
Policy Number:	GUPR-AY6L
Group Number:	G000AY6L
Classification:	All Eligible Employees Electing the SSNRA Duration
Minimum Work Hours Required:	15 hours per week
Eligibility Present Waiting Period:	None
Eligibility Future Waiting Period:	None
When Insurance Begins:	the first day of the month that coincides with or follows the day the Employee becomes eligible. Additional eligibility conditions apply as described in the Certificate.
Elimination Period:	The later of: a) 90 calendar days; or b) the date Your short-term Disability ends.

BENEFITS

Monthly Benefit Percentage:	60%
Maximum Monthly Benefit:	$5,000
Minimum Monthly Benefit:	$100
Maximum Benefit Period:	**Age at Disability** — **Maximum Benefit Period** 61 or less..... to age 65, Your SSNRA, or 3 years and 6 months, whichever is longest; 62..... Your SSNRA, or 3 years and 6 months, whichever is longer; 63..... Your SSNRA, or 3 years, whichever is longer; 64..... Your SSNRA, or 2 years and 6 months, whichever is longer; 65..... 2 years; 66..... 1 year and 9 months; 67..... 1 year and 6 months; 68..... 1 year and 3 months; 69 or older..... 1 year.
Own Occupation Definition:	2 years
Survivor Benefit:	3 months
Vocational Rehabilitation Benefit:	5%

LIMITATIONS/EXCLUSIONS

Alcohol/Drug Abuse/Substance Abuse Limitation:	24 months
Mental Disorder Limitation:	24 months
Pre-existing Condition Exclusion:	12/12

GROUP VOLUNTARY SHORT-TERM DISABILITY CERTIFICATE SUMMARY

This summary describes some of the terms and conditions of the Policy. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate, available from the Policyholder. A person is not necessarily entitled to insurance because he or she received this summary. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Policy. This summary was published on January 20, 2016.

POLICY INFORMATION

Policyholder:	Granville Exempted Village Schools
Policy Effective Date:	January 1, 2016
Policy Anniversary:	January 1
Policy Number:	GUC-AY6L
Group Number:	G000AY6L
Classification:	All Eligible Employees With Fewer Than 80 Days of Banked Sick Leave
Minimum Work Hours Required:	15 hours per week
Eligibility Present Waiting Period:	None
Eligibility Future Waiting Period:	None
When Insurance Begins:	the first day of the month that coincides with or follows the day the Employee becomes eligible. Additional eligibility conditions apply as described in the Certificate.
Elimination Period:	
Injury:	The Elimination Period is the later of: a) 14 calendar days; or b) After the exhaustion of Your accumulated salary continuance, sick leave or severance pay.
Sickness:	The Elimination Period is the later of: a) 14 calendar days; or b) After the exhaustion of Your accumulated salary continuance, sick leave or severance pay.

BENEFITS

Weekly Benefit Percentage:	60%
Maximum Weekly Benefit:	$1,250
Minimum Weekly Benefit:	$25
Maximum Benefit Period:	13 weeks
Vocational Rehabilitation Benefit:	5%

EXCLUSION

Pre-existing Condition Exclusion:	3/12

Answers when you have questions.
Guidance when you need support.℠

FMLASource®

Claim Filing if you are facing one of the following:

Birth of a child

Care for an injured service member

Adoption or foster care

Short-term disability claim

Care for a child, spouse or parent with serious health conditions

FMLASource® provides employees with quick access to experts who will answer questions, review guidelines and provide information regarding a job protected medical or family leave of absence. Please contact FMLASource for information and forms required for your leave.

FMLA or Short-term Disability Claims:

Call: 877.365.2666

TDD: **800.697.0353**

Fax: **877.309.0218**

Online: **fmlasource.com**

FMLASource® Inc. is a ComPsych® company.

A Guide for Successfully Completing the Group Short-Term Disability Claim Form

Mutual of Omaha appreciates the opportunity to provide you with valuable income protection. We rely on the information you provide on this form to effectively determine if you qualify for group short-term disability benefits.

This guide provides information and instruction to help you successfully complete and submit the claim form. Please consult your employer/benefits administrator if you need assistance in providing information for the form.

Important Tips for Paper Copy Submission

- Prior to submission, make sure you have provided all required information and answered all questions completely and accurately. If information is missing or cannot be read, the processing of your form will be delayed.
- The following guidelines provide valuable information to help you successfully complete the form.
- Please make a copy of the completed form for your records before submitting it to Mutual of Omaha/United of Omaha.

Section 1: Employee Statement

This section is to be completed by the Employee. Dates should include the month, date and year. In order to be considered complete, the form must be signed by you.

- Group ID Number for your Employer will consist of eight characters, beginning with "G000" and followed by four additional letters or numbers specific to your Employer.
- Job Title is the title of your position held with the Employer.
- The Hours Worked per Week is the number of hours you worked per week for the Employer.
- Height should be provided in feet and inches.
- Weight should be provided in pounds.
- Dominant Hand indicates whether you are primarily right- or left-handed.
- Date of Disability is the first day you were absent from work because of the disabling condition.
- Date First Treated is the date you first sought medical care because of the disabling condition.
- Other Income means money you are currently receiving or have applied to receive from any source in addition to your claim for disability benefits with Mutual of Omaha/ United of Omaha.

Authorization to Disclose Personal Information & Authorization to Disclose Health Information to my Employer

Both authorizations are to be completed by the Employee. Dates should include the month, date and year. In order to be considered complete, the form must be signed by you or your legal representative.

- By signing the authorization, you are applying for short-term disability benefits with Mutual of Omaha/United of Omaha and are agreeing to allow disclosure of personal information to the necessary parties for the purpose of claim processing.
- If the name associated with any of your medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption.

Guidelines for Section 2: Employer's Statement

This section is to be completed by the Employer. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the Employer.

- Group ID Number consists of eight characters, beginning with "G000" and followed by four additional letters or numbers.
- Date Covered Under This Plan indicates the date in which the Employee's coverage became effective.
- If the Employee is eligible for salary continuation/sick leave, this does not include Mutual of Omaha/United of Omaha short-term disability benefits, paid time off or vacation compensation.

Guidelines for Section 3: Attending Physician's Statement

This section is to be completed by the Attending Physician. Dates should include the month, date and year. In order to be considered complete, the form must be signed by the Attending Physician.

Required Fraud Warnings

Before completing the claim form, please read the Required Fraud Warnings listed on the following page.

Short-Term Disability Claim Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Group Insurance Claims Management
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001
Phone 800-877-5176 Fax 402-997-1865 Email newdisabilityclaim@mutualofomaha.com

Section 1 – Employee Statement (Answer all questions to avoid delay)

Current Employer's Name	Group ID Number	Job Title	Hours Worked per Week

Name

Address	City	State	ZIP

(Area Code) Home Telephone Number	(Area Code) Cellular Telephone Number	Social Security Number

Email Address

Date of Birth	Height	Weight	Dominant Hand: ☐ Right ☐ Left	☐ Male ☐ Female	☐ Single ☐ Married	☐ Widowed ☐ Divorced

Date of Disability (1st Day Absent)	Date First Treated	Estimated Return to Work Date

Nature of illness and when symptoms first appeared, or describe how and where accident occurred.

Was the disability work related? ☐ Yes ☐ No Have you filed a Workers' Compensation claim? ☐ Yes ☐ No

Was disability related to a motor vehicle accident or is another third party liable? ☐ Yes ☐ No

Physician's Name

Other income you have filed for, are receiving, or are eligible for:

	Amount	Date Claim Filed	Date Benefits Began
Workers' Compensation	$ _____	_____	_____
State Disability	$ _____	_____	_____
Other	$ _____	_____	_____

Overpayment Notice: Should you become overpaid at anytime during the duration of this claim we, Mutual of Omaha Insurance Company (Mutual) or United of Omaha Life Insurance Company (United), will request reimbursement of the overpaid amount. This amount is equal to the net benefit you received and any Federal Income Tax paid on your behalf for any time prior to current tax year. Your signature on the claim form authorizes Mutual or United to recover any overpaid Medicare and/or Social Security Tax that was paid on your behalf and certifies you will not attempt to recover a refund or credit of the Medicare and/or Social Security Tax with any Form W-2C that is furnished to you based on recoveries received.

Important Notice: If you have group life insurance through your employer, please contact your benefits administrator as soon as possible to determine what options are available to you to continue your life insurance. Some options require action within 31 days of the date you stop working/insurance ends for life insurance to continue.

If your coverage is written in California, North Carolina or Michigan and includes Survivor Benefits, please check your policy to determine if you can elect a survivor benefit beneficiary. If so, you may obtain a Beneficiary Designation form on the Internet or from your employer.

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

Employee's Signature: _____ **Date:**_____

Authorization to Disclose Personal Information

1. I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy benefit manager, other medical care facility, health maintenance organization, insurer, employer, consumer reporting agency and any other provider of medical or dental services to release records containing the personal information of:

   Claimant/Patient Name: _____
   (Last) (First) (Middle)

   Date of Birth: _____/_____/_____

2. Personal information includes medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information.

3. You may release information to:

   Group Disability Management Services
   Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
   3300 Mutual of Omaha Plaza
   Omaha, NE 68175-0001

   Or

   Fax 402-997-1865

   Or

   Email newdisabilityclaim@mutualofomaha.com

4. I understand that the personal information that is disclosed will be used by Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to evaluate my claim for disability benefit plan reimbursement and that if I refuse to sign this authorization my claim for benefits may not be paid.

5. I understand that if the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the personal information may be redisclosed without the protection of the federal privacy regulations.

6. This authorization will expire 24 contiguous months after the date signed.

7. I understand that I may revoke this authorization at any time by providing a written request to Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company at the address above. If I revoke this authorization, it will not affect any use or disclosure of personal information that occurred prior to the receipt of my revocation.

8. I understand that I am entitled to receive a copy of this authorization and that a copy is as valid as the original.

RETAIN A SIGNED COPY FOR YOUR RECORDS

Name(s) used for records (if different than the name below): _____

_____

_____ _____
Signature of Claimant Date

If Applicable: I am the legal representative of the claimant and I am authorized to grant permission on behalf of the claimant.

Printed Name of Legal Representative:_____

Signature of Legal Representative: _____

Type of Legal Representative: _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Authorization to Disclose Health Information to My Employer

I authorize Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to disclose health information about me to my employer, and to my employer's broker. I understand that this information will be used by my employer, and its broker, to monitor and manage the disability benefits program provided under my Group disability policy. I also understand that my employer and its broker will use the information solely for the purposes of auditing disability benefits paid, providing claims assistance, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

The health information which may be disclosed pursuant to this authorization includes such items as medical history, mental and physical condition, prescription drug records and alcohol or drug use.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

This authorization will remain in effect for 24 contiguous months from the date I sign it. I understand that I may revoke this authorization at any time. If I would like to revoke this authorization, I should send my revocation request to:

ATTN: Group Disability Management Services
Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001

Or
Fax 402-997-1865

Or
Email newdisabilityclaim@mutualofomaha.com

I also understand that any revocation of this authorization will not affect any use or disclosure of health information that occurred prior to receipt of my revocation.

I understand that I am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

_____

(Printed Name and Address)

_____ _____

Signature Date

or

If Applicable: I am the legal representative of the person whose financial and health information is to be disclosed, but I am authorized to grant permission on behalf of that person.

Printed Name of Legal Representative: _____

Signature of Legal Representative:_____

Type of Legal Representative: _____

Date: _____

RETAIN A SIGNED COPY FOR YOUR RECORDS

FAX (402) 997-1865 **Email newdisabilityclaim@mutualofomaha.com** **Form must be completed in full at no expense to Mutual of Omaha**

Section 2 – Employer's Statement (Answer all questions to avoid delay)

Company Name	Group ID Number	Master Policy Number

Class No. or Description	Division/Location No. or Description

Address	City	State	ZIP

Email Address

Employee's Name	Employee's Phone Number

Employee Address	Employee City	Employee State	Employee ZIP

Weekly earnings as defined by the Plan: _____
(Please note: Benefits will be calculated based on premium received.)
Salary Effective Date: _____

Number of weekly hours worked: _____

Was disability caused by employment? ☐ Yes ☐ No Has workers' compensation claim been filed? ☐ Yes ☐ No

Does the Employee contribute toward the premium? ☐ Yes ☐ No

If yes, what percent is paid by the Employee? _____% Is it Pre-tax or Post-tax? _____

Employee's payroll classification ☐ Exempt ☐ Non-Exempt ☐ Salaried ☐ Hourly ☐ Union ☐ Non-Union ☐ Other

How was the Employee paid? _____

Is the Employee continuing to receive compensation or pay since their last day of work? ☐ Yes ☐ No

If yes, what is the weekly amount of the type of compensation being received and the period payable?

Amount _____ Salary Continuation Start _____ End _____ Amount _____ Vacation Start _____ End _____

Amount _____ Sick Leave Start _____ End _____ Amount _____ PTO Start _____ End _____

Amount _____ Severance Start _____ End _____ Amount _____ Other Start _____ End _____

If other is marked, please describe _____

Date of Hire:	Date Covered Under This Plan:

Does Mutual of Omaha cover the Employee for group long-term disability? ☐ Yes ☐ No

Does United of Omaha Life Insurance Company cover the Employee for group life? ☐ Yes ☐ No If so, please complete the following.

Name of Employee's beneficiary according to your records:_____ Relationship to Employee:_____

Important Notice: For Employees age 60 or over, refer to the policy provisions regarding group life continuation and conversion rights.

Does Mutual of Omaha cover the employee under an additional short-term disability policy? ☐ Yes _____ (policy number) ☐ No

Please contact Employee's direct supervisor and then circle the strength demand below which best describes the Employee's job:

Circle One

S – Sedentary	10 lbs. Maximum lifting, occasional lift/carry of small articles. Some occasional walking or standing may be required.
L – Light	20 lbs. Maximum lifting with frequent lift/carry up to 10 lbs. A job is light if less lifting is involved but significant walking/standing is done or if done mostly sitting but requires push/pull on arm or leg controls.
M – Medium	50 lbs. Maximum lifting with frequent lift/carry up to 25 lbs.
H – Heavy	100 lbs. Maximum lifting with frequent lift/carry up to 50 lbs.
V – Very Heavy	Over 100 lbs. Lifting with frequent lift/carry over 50 lbs.

Employee's Job Title	Last Day at Work

What was the Employee's employment status on the first day absent?

Description of major job duties – Please attach job description	Has the Employee returned to work? ☐ Yes ☐ No a) If yes, when? b) If not, what is the estimated return to work date?

Can the Employee's job be modified? ☐ Yes ☐ No

Signature of Person Completing Claim Form	Title of Person Completing Claim Form

Date Signed	(Area Code) Phone Number	(Area Code) Fax Number	Email Address

Please notify us if the Employee returns to work after the submission of this form.

FAX (402) 997-1865 **Email newdisabilityclaim@mutualofomaha.com** **Form must be completed in full at no expense to Mutual of Omaha**

Section 3 – Attending Physician's Statement (Answer all questions to avoid delay)

Employer Name		Group ID Number
Name of Patient (Last, First, MI) – Please Print	Date of Birth	Employee's Phone Number

Employee Address	Employee City	Employee State	Employee ZIP

Diagnoses	ICD-9 Code(s)
Symptoms	Date symptom first appeared

Initial date of treatment:	Last date of treatment:	Next date of treatment/office visit:

Is disability due to: ☐ Accident/Injury ☐ Sickness

Is the disability work related? ☐ Yes ☐ No

If applicable, list the surgical procedure(s) – Describe fully and provide dates if any.

If disability is due to Pregnancy, please provide the information below:

Date of Last Monthly Period	Expected Date of Delivery	Expected Type of Delivery ☐ Vaginal ☐ Cesarean Section

Actual Date of Delivery	Actual Type of Delivery ☐ Vaginal ☐ Cesarean Section

If any of the following questions are answered "Yes," then please provide the information to the right of that question.

Was the patient treated in an Emergency Room? ☐ Yes ☐ No	Date treated	Name of Hospital	Name of Physician
Did another physician treat or will be treating the patient? ☐ Yes ☐ No	Date treated	Physician's Name and Address	
Was the patient hospital confined? ☐ Yes ☐ No	Date Confined In Hospital: From_____ To_____	Name of Hospital	
Did patient have outpatient surgery in a hospital or ambulatory surgical center? ☐ Yes ☐ No	Date of Surgery	Name of Facility	

Functional Limitations – Abilities

Indicate frequency per day the listed activity can be performed.

(n = never, o = occasional, f = frequent, c = constant)

Lifting	**Carrying**
_____1-5 lbs.	_____1-5 lbs.
_____6-10 lbs.	_____6-10 lbs.
_____11-25 lbs.	_____11-25 lbs.
_____26-50 lbs.	_____26-50 lbs.
_____51-100 lbs.	_____51-100 lbs.
_____Over 100 lbs.	_____Over 100 lbs.

Indicate longest single time duration each activity can be performed.

_____ Sitting	_____ Kneeling		_____ R: Finger Dexterity
_____ Total time on feet			_____ L: Finger Dexterity
_____ Standing	_____ Inside		_____ R: Below Shoulder
_____ Walking			_____ L: Below Shoulder
_____ Bending	_____ Outside		_____ R: Above Shoulders
_____ Squatting	_____ Working with Others		_____ L: Above Shoulders
_____ Stooping	_____ Other (explain)_____		

Reaching

Please notify us if the Employee returns to work after the submission of this form.

FAX (402) 997-1865 **Email newdisabilityclaim@mutualofomaha.com** **Form must be completed in full at no expense to Mutual of Omaha**

Mental Limitations – Abilities

Please check off the appropriate response of the person's ability to adapt to these specific job situations at this time.

	Unlimited	Somewhat Limited	Markedly Limited	Unable to Perform
Follow work rules	☐	☐	☐	☐
Perform repetitive, or short cycle work	☐	☐	☐	☐
Perform at a constant pace	☐	☐	☐	☐
Maintain attention and concentration	☐	☐	☐	☐
Perform a variety of duties	☐	☐	☐	☐
Understand, remember and carry out complex job instructions	☐	☐	☐	☐
Attain set limits and standards	☐	☐	☐	☐
Relate to co-workers	☐	☐	☐	☐
Interact with supervisors	☐	☐	☐	☐
Interact with the public/customers	☐	☐	☐	☐
Use judgment and make decisions	☐	☐	☐	☐
Direct, control or plan activities of others	☐	☐	☐	☐
Influence people in their opinions, attitudes and judgments	☐	☐	☐	☐
Expressing personal feelings	☐	☐	☐	☐
Work alone or apart in physical isolation from others	☐	☐	☐	☐

What functions of the person's own/usual occupation is the person unable to perform? (Please provide rationale here, if not already provided.)

What functional restrictions have been placed on this person?

The patient has been continuously disabled (unable to work) from _____ to _____

Is the patient able to work with job modifications? ☐ Yes ☐ No

The patient should be able to work ☐ Full-time ☐ Part-time on _____ or a specific date is unavailable, in
☐ 1 month ☐ 1-3 months ☐ 3-6 months ☐ Other (please specify)

Remarks and/or treatment plan

Name of the Attending Physician – Please Print	Specialty/Degree(s)	Tax Identification Number
Address (No., Street, City, State, ZIP)	(Area Code) Telephone Number	(Area Code) Fax Number

If necessary, whom can we contact at the attending physician's office for additional information?

Name: (Area Code) Telephone Number:

Signature of Attending Physician Date

Please notify us if the Employee returns to work after the submission of this form.

Group Claim Fraud Statements

The following fraud language is attached to, and made part of this claim form. Please read and do not remove these pages from this claim form.

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

** **Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

** **Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

** **Arkansas and 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.

** **California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

** **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.

** **Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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

** **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.

** **Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

** **Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

** **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 insurance act, which is a crime.

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

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

** **Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

** **New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment of insurance fraud, as provided in RSA 638:20.

** **New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

** **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 APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

** **Ohio:** 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 is guilty of insurance fraud.

** **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.

** **Pennsylvania:** 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.

** **Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

** **Rhode Island:** 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.

** **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.

** **Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

** **If you live in a state other than mentioned above, the following statement applies to you:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information is related to a claim by the claimant.

A Guide for Successfully Completing the Group Long-Term Disability Claim Form

Mutual of Omaha appreciates the opportunity to provide you with valuable income protection. We rely on the information you provide on this form to effectively determine if you qualify for group long-term disability benefits.

This guide provides information and instruction to help you successfully complete and submit the claim form. Please consult your employer/benefits administrator if you need assistance in providing information for the form.

Important Tips for Paper Copy Submission

- Prior to submission, make sure all required information is provided and all questions have been answered completely and accurately. If information is missing or is illegible (unreadable), the processing of your form will be delayed.
- Refer to the guidelines for each section below, which provide valuable information to help you successfully complete the form.
- Make a copy of the completed form for your records before submitting it to Mutual of Omaha/United of Omaha.

Guidelines for Section 1: Employee's Statement

This section is to be completed by the Employee. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About You

- The Group Policy Number will have eight characters, beginning with "G000" followed by four additional letters or numbers specific to your employer.
- Provide weight in pounds, and height in feet and inches.
- Your Occupation/Job Title is the title of your position held with the employer.
- Indicate any other Mutual of Omaha/United of Omaha plans in which you are currently insured.

C. Information About Your Disabling Condition

- The Date First Treated is the date you first sought out medical care because of the disabling condition.

D. Information About Work

- The Last Day Worked is the day before you were first absent from work because of the disabling condition.

E. Information About Care and Treatment

- Provide the name, specialty, phone and address for each doctor or hospital that treated you for the disabling condition.

F. Information About Other Income Benefits

- Other Income means money you are currently receiving or have applied to receive from any source in addition to your claim for disability benefits with Mutual of Omaha/ United of Omaha.
- Check all sources of other income that apply.

G. Information For Tax Withholding

- If your claim is paid, indicate whether or not you would like Mutual of Omaha to withhold income tax from your benefit payment, and if so, how much. Minimum is **$88** per month.

H. Signature

- Your signature is required.

Education, Training and Work Experience

- This form is to be completed by the employee. Please make sure all questions have been answered completely and accurately. If information is missing or is illegible (unreadable), the processing of your form will be delayed.
- Vocational rehabilitation services include, but are not limited to (a) job modification; (b) job placement; (c) retraining; and (d) other activities reasonably necessary to help you return to work.

Authorization to Disclose Personal Information

This authorization is to be completed by the employee.

- Please read this section in its entirety. By signing the authorization, you are applying for long-term disability benefits with Mutual of Omaha/United of Omaha, and are agreeing to allow disclosure of personal information to the necessary parties for purposes of claim processing.
- If the name associated with any of your medical records differs from the name provided on the form, provide any alternate names. This might occur in the event of a name change due to marriage or adoption, for example.
- IMPORTANT: To be complete, the form must be signed by you.

Guidelines for Section 2: Employer's Statement

This section is to be completed by the employer. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About the Employer

- The Group Policy Number will have eight characters, beginning with "G000" followed by four additional letters or numbers.

B. Information About the Employee

- The Date Employee Became Insured Under This Plan indicates the date in which the employee's coverage became effective.
- The Date Employee Became Insured Under Prior Plan indicates the date in which the employee's coverage was in effect under a plan prior to the Mutual of Omaha plan.
- The No. of Hours Employee Regularly Works is the number of hours the employee is typically at work per day/per week for the employer.

C. Information For Tax Withholding

- If this section is not completed, Mutual of Omaha will assume that premium paid by the employee is with pre-tax dollars.
- If this is not true, indicate otherwise and provide the percentage amount.

E. Information For Life Waiver

- Date Life Insurance Terminated means the first day the coverage is no longer in force.
- If applicable, the Paid To Date for group life insurance is the date on which the next premium is due.

F. Information About Your Pension Plan

- This section is not applicable if the disabling condition is maternity.

H. Information About Employee's Salary

- Indicate the method in which the employee is paid.
- If hourly, also indicate the hourly rate in which the employee is paid.
- Please attach supporting payroll documentation.

Guidelines for Section 3: Job Analysis

This section is to be completed by the employer. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

A. Information About the Employee's Job

- Occasionally means the employee does this activity up to 33 percent of the time.
- Frequently means the employee does the activity 34 percent to 66 percent of the time.
- Continuously means the employee does the activity 67 percent to 100 percent of the time.

B. Physical Aspects of the Job

- Check all the activities that apply to the employee's job.
- Indicate the frequency with which the employee performs the activity using the guidelines in Section A. Information About the Employee's Job.

Guidelines for Section 4: Signature and Attachments

- Attach a copy of the employee's job description to the claim application.
- Attach any additional documentation that may be helpful when reviewing the application, including further explanation of any question(s) on the application.
- Your signature is required.

Guidelines for Section 5: Physician's Statement

This section is to be completed by the attending physician. Please answer all questions in order to avoid possible delays. All dates should indicate the month, date and year.

Required Fraud Warnings

Before completing the claim form, please read the Required Fraud Warnings listed on the following page.

Required Fraud Warnings (State specific warnings apply to the resident of such state)

- **Fraud Warning:** 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.
- **Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
- **Arkansas/Kentucky/Louisiana/Maine/New Mexico/Ohio/Tennessee:** Any person who, with intent to defraud or knowing that he/she 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.
- **California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- **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.
- **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 benefits if false information materially related to a claim was provided by the applicant.
- **Kansas:** 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 as determined by a court of law.
- **Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
- **New York:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- **Oregon:** 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 may be a crime and may subject such person to criminal and civil penalties.
- **Puerto Rico:** Any person who furnishes information verbally or in writing, or offers any testimony on improper or illegal actions which, due to their nature constitute fraudulent acts in the insurance business, knowing that the facts are false shall incur a felony and, upon conviction, shall be punished by a fine of not less than five thousand (5,000) dollars, nor more than ten thousand (10,000) dollars for each violation or by imprisonment for a fixed term of three (3) years, or both penalties. Should aggravating circumstances be present, the fixed penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.
- **Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **Vermont:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.
- **Virgin Islands:** 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 penalties.
- **Virginia:** 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 may have violated state law.

Long-Term Disability Claim Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Group Insurance Claims Management
Mutual of Omaha Plaza
Omaha, NE 68175-0001
Phone 800-877-5176 Fax 402-997-1865 Email newdisabilityclaim@mutualofomaha.com

Section 1 – Employee's Statement (Answer all questions to avoid delay.)

A. Information About You

Last Name	First Name	Middle Initial	Group Policy Number

Address	City	State/Province	ZIP

Telephone ( )	Email Address	Social Security Number

Date of Birth	Height	Weight	☐ Male ☐ Female	☐ Right Handed ☐ Left Handed	☐ Single ☐ Married	☐ Widowed ☐ Divorced

Name of Your Employer (include Division/Location, if applicable)	Your Occupation/Job Title

Under what other Mutual of Omaha/United of Omaha policies are you currently covered?

Important Notice: If you have group life insurance through your employer, please contact your benefits administrator as soon as possible to determine what options are available to you to continue your life insurance. Some options require action within 31 days of the date you stop working/insurance ends for life insurance to continue.

If your coverage is written in California, North Carolina or Michigan and includes Survivor Benefits, please check your policy to determine if you can elect a survivor benefit beneficiary. If so, you may obtain a Beneficiary Designation form on the Internet or from your employer.

B. Information About Your Family (Required to determine your eligibility for Social Security benefits.)

Spouse's Name	Spouse's Social Security Number	Spouse's Date of Birth	Is your spouse employed? ☐ Yes ☐ No

First and Last Name of any children under the age of 25 — Date of Birth

_____ _____

_____ _____

_____ _____

C. Information About Your Disabling Condition

1. If your disability is due to an injury, answer the following questions and then proceed to #3 below.

When did the injury occur?

Where and how did the injury occur?

What is the date you were first treated by a physician?

2. If your disability is due to a pregnancy or an illness, answer the following questions. If <u>not</u> pregnancy-related, proceed to #3 below.

What were your first symptoms?

When did you notice these symptoms?

What is the date you were first treated by a physician?

3. If your disability is due to an injury or an illness, but not pregnancy, answer the following questions.

Why are you unable to work?

Before you stopped working, did your condition require you to change your job or the way you did your job? ☐ Yes ☐ No If **Yes**, please explain below.

Is your condition related to your occupation? ☐ Yes ☐ No If **Yes**, please explain below.

Have you filed, or do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No

D. Information About Work

What is the date of your last day worked before the disability?	On your last day worked, did you work a full day? ☐ Yes ☐ No If **No**, please explain.
What is the date you were first unable to work?	Have you returned to work? ☐ Yes, Part-Time ☐ Yes, Full-Time ☐ No What date did you return to work?

If you haven't yet returned to work, do you expect to? ☐ Yes, Part-Time ☐ Yes, Full-Time ☐ No
What date do you expect to be able to return to work?

Are you currently self-employed or working for another employer? ☐ Yes ☐ No If **Yes**, provide details.

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E. Information About Care and Treatment (If additional space is needed, please provide details on a separate page.)

Doctor who **first** provided medical attention to you for your current disability.	Doctor's Specialty	Telephone ( ) Fax ( )
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____

List all other physicians and/or hospitals you have visited for this condition below.

Doctor's Name	Doctor's Specialty	Telephone ( ) Fax ( )
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____
Doctor's Name	Doctor's Specialty	Telephone ( ) Fax ( )
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____
Name of Hospital	Department of Treatment	Telephone ( ) Fax ( )
Hospital's Address		Date(s) you were treated at the hospital From _____ To _____

Have you ever had the same or a similar condition in the past? ☐ Yes ☐ No If **Yes**, provide the following information concerning past treatments.

Doctor's Name	Doctor's Specialty	Telephone ( ) Fax ( )
Doctor's Address		Date(s) you were seen by this doctor From _____ To _____
Name of Hospital	Department of Treatment	Telephone ( ) Fax ( )
Hospital's Address		Date(s) you were treated at the hospital From _____ To _____

F. Information About Other Income Benefits (Check all benefits you are receiving or are eligible to receive.)

Source of Income	Amount	Weekly/ Monthly	Date claim was filed	Date payments began	Date payments ended
Social Security Retirement					
Social Security Disability					
Canadian Pension Plan					
Workers' Compensation					
State Disability					
Pension Retirement					
Pension Disability					
Short-Term Disability					
Unemployment					
No-Fault Insurance					
Other (include Individual or Group benefits)					

G. Information For Tax Withholding

If your request for benefits is approved, should Mutual of Omaha/United of Omaha withhold income taxes from your benefit checks? ☐ Yes ☐ No

If yes, how much should be withheld from each check (the minimum is **$88.00** per month). $_____.00

Overpayment Notice: Should you become overpaid at anytime during the duration of this claim we, Mutual of Omaha Insurance Company (Mutual) or United of Omaha Life Insurance Company (United), will request reimbursement of the overpaid amount. This amount is equal to the net benefit you received and any Federal Income Tax paid on your behalf for any time prior to current tax year. Your signature on the claim form authorizes Mutual or United to recover any overpaid Medicare and/or Social Security Tax that was paid on your behalf and certifies you will not attempt to recover a refund or credit of the Medicare and/or Social Security Tax with any Form W-2C that is furnished to you based on recoveries received.

H. Signature (Required for all claims.)

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.

The above statements are true and complete to the best of my knowledge and belief.

X _____ _____

Signature of Employee Date

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Education, Training and Work Experience

Name_____

Policy No. _____ Claim No. _____

Educational Background

High School Graduate ☐ Yes ☐ No If **No,** what was the last grade completed? _____ Last date attended _____

GED ☐ Yes ☐ No Field of Study ☐ General ☐ Business ☐ Vocational ☐ Other

Did you attend college? ☐ Yes ☐ No Last Date Attended _____

Name and Address of College: _____

_____

Major(s): _____

Final Status: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Undergraduate Degree ☐ Graduate School

Degree(s) earned: _____

Other formal training: _____

Certification(s):_____

Computer Skills:_____

Military Service ☐ Yes ☐ No If **Yes,** in which branch did you serve? _____

Rank:_____

Specialty: _____

What computer programs are you able to use?_____

List all languages spoken fluently:_____

Work Experience

Please fill out completely. Start with your most recent employment and list chronologically.

Dates: From _____ To _____

Employer: _____

Job Title: _____

List job duties: _____

List physical requirements of job: _____

Product/service produced: _____

Did you supervise others? ☐ Yes ☐ No

Reason for leaving? _____

Dates: From _____ To _____

Employer: _____

Job Title: _____

List job duties: _____

List physical requirements of job: _____

Product/service produced: _____

Did you supervise others? ☐ Yes ☐ No

Reason for leaving? _____

Dates: From _____ To _____

Employer: _____

Job Title: _____

List job duties: _____

List physical requirements of job: _____

Product/service produced: _____

Did you supervise others? ☐ Yes ☐ No

Reason for leaving? _____

Dates: From _____ To _____

Employer: _____

Job Title: _____

List job duties: _____

List physical requirements of job: _____

Product/service produced: _____

Did you supervise others? ☐ Yes ☐ No

Reason for leaving? _____

Dates: From _____ To _____

Employer: _____

Job Title: _____

List job duties: _____

List physical requirements of job: _____

Product/service produced: _____

Did you supervise others? ☐ Yes ☐ No

Reason for leaving? _____

Additional courses taken, hobbies and special skills. Please be specific such as computer skills either personal or professional, sales, carpentry, auto repair, etc.

_____

_____

_____

Are you currently involved in a vocational rehabilitation program? ☐ Yes ☐ No

If yes, please provide the name, address and phone # of the rehabilitation case worker _____

_____

_____

Are you interested in learning about our vocational rehabilitation program? ☐ Yes ☐ No

What is your employment goal or other work that you would be interested in doing? _____

Date: _____ **Signature:** _____

Authorization to Disclose Personal Information

1. I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy benefit manager, other medical care facility, health maintenance organization, insurer, employer, consumer reporting agency and any other provider of medical or dental services to release records containing the personal information of:

   Claimant/Patient Name: _____
   (Last) (First) (Middle)

2. Personal information includes medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information.

3. You may release information to:

   Group Disability Management Services
   Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
   Mutual of Omaha Plaza
   Omaha, NE 68175-0001
   Or
   Fax 402-997-1865
   Or
   Email SubmitGrpDisInfo@mutualofomaha.com

4. I understand that the personal information that is disclosed will be used by Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to evaluate my claim for disability benefit plan reimbursement and that if I refuse to sign this authorization my claim for benefits may not be paid.

5. I understand that if the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the personal information may be redisclosed without the protection of the federal privacy regulations.

6. This authorization will expire 24 months after the date signed.

7. I understand that I may revoke this authorization at any time by providing a written request to Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company at the address above. If I revoke this authorization, it will not affect any use or disclose of personal information that occurred prior to the receipt of my revocation.

8. I understand that I am entitled to receive a copy of this authorization and that a copy is as valid as the original.

RETAIN A SIGNED COPY FOR YOUR RECORDS

Name(s) used for records (if different than the name below): _____

_____

_____ _____
Signature of Claimant Date

If Applicable: I am the legal representative of the claimant and I am authorized to grant permission on behalf of the claimant.

Printed Name of Legal Representative:_____

Signature of Legal Representative: _____

Type of Legal Representative: _____

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

FAX (402) 997-1865 **Email newdisabilityclaim@mutualofomaha.com** **Form must be completed in full at no expense to Mutual of Omaha**

Section 2 – Employer's Statement (Answer all questions to avoid delay.)

Employee's Name	Social Security Number	Date of Birth

Employee's Address	Employee's Phone Number

A. Information About the Employer

Company's Name	Group Policy Number	Class No. or Description

Company's Address (Number, Street, City, State, ZIP)	Company's Telephone ( ) Company's Fax ( )

Name and Address of Location Where Employee Works	Location No.	Location Telephone ( ) Location Fax ( )

B. Information About Employee

Employee's Hire Date	Date Employee became insured under this plan: _____ Date Employee became insured under prior plan: _____	No. of hours Employee regularly works per day/per week? _____ # of hours per/week _____ # of hours per/day

C. Information For Tax Withholding

If this section is left blank, we will calculate FICA taxes based on the following assumption: 100% Employer contribution or any portion paid by Employee is paid with pre-tax dollars.

Does Employee contribute post-tax dollars toward the premium? ☐ Yes ☐ No If **Yes**, what percent is paid by Employee? _____% Post-Tax

D. Information About the Claim

Before Employee became fully disabled, were changes made to Employee's job responsibilities due to the disabling condition? ☐ Yes ☐ No

If yes, please describe the changes and when they were made.

Date Employee Last Worked	Did Employee work a full day? ☐ Yes ☐ No If **No**, how many hours were worked?

What was Employee's permanent job on his/her last day worked?	How long had Employee been in this job?

Why did Employee stop working?	Has Employee returned to work? ☐ Yes ☐ No If **Yes**, when?

Is Employee's condition work related? ☐ Yes ☐ No	Has a Workers' Compensation claim been filed? ☐ Yes ☐ No If **Yes**, send initial report of illness/injury and award notice.

Name of Workers' Comp Carrier	Address of Workers' Comp Carrier	Contact Person's Name & Phone No.

Name and Address of Medical Insurance Carrier	Is Employee covered under a Group Life policy with Mutual of Omaha? ☐ Yes ☐ No

E. Information For Life Waiver

Important Notice: If an Employee is age 60 or over, please refer to the policy provisions regarding group life continuation and conversion rights.

Is Employee covered under a Group Life policy with United of Omaha? ☐ Yes ☐ No If **Yes**, what is the effective date of the life insurance plan?

What is Employee's annual salary?	Amount of Life insurance as of last day worked

Master Policy Number	Class	Location

Date Life insurance terminated? If **not** terminated, what is the "paid to date"?	Name of beneficiary (per your records)? Relationship to Employee?

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F. Information About Your Pension Plan (Do not complete for maternity.)

Do you have a pension plan? ☐ Yes ☐ No | If **Yes**, what type? ☐ Defined Benefit ☐ 401(k) ☐ Other (specify) ☐ Defined Contribution ☐ Profit Sharing

Is Employee eligible for your pension plan? ☐ Yes ☐ No | If eligible, does Employee participate? ☐ Yes ☐ No
If **Yes**, when is Employee eligible for benefits under the pension plan?

If Employee is eligible but does not participate, explain why.

G. Information About Your Rehire or Return to Work Policies

Does your company have a rehire or return to work policy for disabled Employees? ☐ Yes ☐ No

Who should we contact if we identify a rehabilitation or return to work option? Name/Title:
Contact No.

H. Information About Employee's Salary (Please attach supporting payroll documentation.)

(Check all that apply) Employee ☐ is paid hourly ($ hourly rate) ☐ is salaried ☐ receives commissions ☐ receives bonuses

Will Employee file for disability benefits provided by any Employer/Employee Labor Management, State Disability or Union Welfare plan? ☐ Yes ☐ No
If **Yes**, please answer the following questions. Weekly amount? Date benefits begin? Date benefits end?

Is Employee eligible for Salary Continuation? ☐ Yes ☐ No If **Yes**, please answer the following questions.
Weekly amount? Date benefits begin? Date benefits end?

Is Employee eligible for Sick Leave? ☐ Yes ☐ No If **Yes**, please answer the following questions.
Weekly amount? Date benefits begin? Date benefits end?

Per the definition of Basic Monthly Earnings in your Policy, what are Employee's pre-disability monthly earnings?

Section 3 – Job Analysis (To be completed by the Employee's Supervisor or HR Department. Answer all questions to avoid delay.)

A. Information About Employee's Job

Job Title	Minimum education or training required?	How long will Employee's job be held open?

Does Employee perform supervisory functions? ☐ Yes ☐ No If **Yes**, how many people are supervised?

Describe Employee's job duties.

Indicate how each of the following related to Employee's job.

	Occasionally (0%-33%)	**Frequently (34%-66%)**	**Continuously (67%-100%)**
Computer use	_____	_____	_____
Relate to others	_____	_____	_____
Written and verbal communication	_____	_____	_____
Reasoning, math and language	_____	_____	_____
Make independent judgments	_____	_____	_____

Which of the following describe Employee's working environment? **Check all that apply.**

☐ Unprotected heights ☐ Changes in temperature ☐ Exposure to dust, fumes and gases
☐ Being near moving machinery ☐ Driving automotive equipment ☐ Other hazards (please explain)

Is Employee required to travel? ☐ Yes ☐ No If **Yes**, please answer the following questions.

How does Employee travel? ☐ Automobile ☐ Plane ☐ Train ☐ Other

What percent of the time does Employee travel?

Where does Employee travel?

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B. Physical Aspects of the Job

Select how each of the following relates to Employee's job.

Activity	Frequency of Occurrence: Occasionally (0%-33%)	Frequently (34%-66%)	Continuously (67%-100%)
☐ Standing			
☐ Walking			
☐ Sitting			
☐ Balancing			
☐ Stooping			
☐ Kneeling			
☐ Crouching			
☐ Crawling			
☐ Reaching/working overhead			
☐ Climbing			
☐ Number of stairs _____			
☐ Height of ladder _____			
☐ Pushing			
☐ Pulling			
☐ Lifting/Carrying			

Please indicate any activities that require lifting, carrying, pushing or pulling. In addition, specify the weight involved with this activity.

Describe Activity	Weight

Can alternating sitting and standing activity help Employee perform the job? ☐ Yes ☐ No

Does the job require use of the feet to operate foot controls? ☐ Yes ☐ No
If **Yes**, list type of equipment.

How important is good vision in the job?

List the major tasks which require the use of one or both hands.	One Hand	Both Hands

Can the job be modified to accommodate the disability either temporarily or permanently? ☐ Yes ☐ No If **Yes**, explain.

Is it possible to offer Employee assistance in doing the job (e.g., use of technology or personal assistance)? ☐ Yes ☐ No If **Yes**, explain.

Section 4 – Employer's Signature and Attachments (Please Attach Employee's job description and additional documentation.)

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

Name of person completing this form: _____

Title: _____ Email Address: _____

Telephone: ( ) _____ Fax: ( ) _____

Signature: _____ Date: _____1

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Section 5 – Physician's Statement (Answer all questions to avoid delay.)

A. General Information

Patient's Name	Employer's Name	Policy Number

Patient's Social Security Number	Height	Weight	Blood Pressure	Date of Birth

B. Complete the following for normal pregnancy, then go to Section E.

Date of the patient's last menstrual period?	Expected date of delivery?

Expected length of postpartum recovery?	First date of treatment?	Last date of treatment?

C. Complete the following for all conditions except normal pregnancy.

Primary diagnosis (including ICD-9 or DSM code)	Symptoms

What diagnostic testing has been done?	Objective Findings

Are there secondary conditions contributing to the patient's disability? ☐ Yes ☐ No
If **Yes**, what are they (include ICD-9 or DSM)?

If this is a cardiac condition, what is the functional capacity (American Heart Association)?
☐ Ejection Fraction ☐ Class 1–No Limitation ☐ Class 2–Slight Limitation ☐ Class 3–Marked Limitation ☐ Complete Limitation

If this is a psychiatric condition, what is the current GAF/WHODAS score?	In the past year, what was the patient's highest GAF/WHODAS score?

When did symptoms first appear?	Date of patient's first visit?	Date patient was first unable to work?

Date of patient's last visit?	How often do you see this patient?

Is the patient's condition work related? ☐ Yes ☐ No If **Yes**, please explain.

Has patient undergone surgery or expected to have surgery in the future? ☐ Yes ☐ No If **Yes**, answer the following.
Date of surgery: Surgical Procedure? Result:

What medication is the patient currently taking or been prescribed?

Please indicate other types and frequencies of treatment.

Has the patient been referred to a medical rehabilitation or therapy program? ☐ Yes ☐ No If **Yes**, give details.

Have you referred the patient for other types of consultations? ☐ Yes ☐ No If **Yes**, give details.

Has the patient been hospital confined? ☐ Yes ☐ No If **Yes**, please complete the following.

Name of Hospital	Address of Hospital	Dates of Confinement
		From_____ To_____

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D. Information About the Patient's Inability to Work

Briefly describe the patient's restrictions. (SHOULD NOT DO)

Briefly describe the patient's limitations. (CANNOT DO)

What is your prognosis for recovery?

Has patient achieved maximum medical improvement? ☐ Yes ☐ No If **No**, please complete the following.

How soon do yo expect fundamental changes in the patient's medical condition?

☐ 1-2 months ☐ 3-4 months ☐ 5-6 months ☐ 6 months to a year ☐ 1 year or more ☐ Never

Give details concerning expected improvement or deterioration.

What is your treatment plan for the patient's return to work or return to prior level of function?

In an eight-hour workday, the patient can: **(Circle full hourly capacity for <u>each</u> activity.)**

Sit	1	2	3	4	5	6	7	8
Stand	1	2	3	4	5	6	7	8
Walk	1	2	3	4	5	6	7	8

Are there restrictions in:	Yes	No	If **Yes**, please fully explain below.
Driving/Operating motorized equipment	☐	☐	
Lifting/Carrying	☐	☐	
Use of hands in repetitive actions	☐	☐	
Use of feet in repetitive movements	☐	☐	
Bending	☐	☐	
Squatting	☐	☐	
Crawling	☐	☐	
Climbing	☐	☐	
Reaching above shoulder level	☐	☐	
Other	☐	☐	

Please check off the appropriate response of the person's ability to adapt to these specific job situations at this time.

	Unlimited	**Somewhat Limited**	**Markedly Limited**	**Unable to Perform**
Follow work rules	☐	☐	☐	☐
Perform repetitive, or short cycle work	☐	☐	☐	☐
Perform at a constant pace	☐	☐	☐	☐
Maintain attention and concentration	☐	☐	☐	☐
Perform a variety of duties	☐	☐	☐	☐
Understand, remember and carry out complex job instructions	☐	☐	☐	☐
Attain set limits and standards	☐	☐	☐	☐
Relate to co-workers	☐	☐	☐	☐
Interact with supervisors	☐	☐	☐	☐
Interact with the public/customers	☐	☐	☐	☐
Use judgment and make decisions	☐	☐	☐	☐
Direct, control or plan activities of others	☐	☐	☐	☐
Influence people in their opinions, attitudes and judgments	☐	☐	☐	☐
Expressing personal feelings	☐	☐	☐	☐
Work alone or apart in physical isolation from others	☐	☐	☐	☐

FAX (402) 997-1865 **Email newdisabilityclaim@mutualofomaha.com** **Form must be completed in full at no expense to Mutual of Omaha**

D. Information About the Patient's Inability to Work (continued)

What functions of the person's own/usual occupation is the person unable to perform? (Please provide rationale here, if not already provided.)

What functional restrictions have been placed on this person?

When do you expect the patient to return to prior level of functioning?	Would you recommend vocational rehabilitation for this patient? ☐ Yes ☐ No

E. Required Attachments and Signature

After you have fully completed this form, please attach copies of the following materials.

- Office notes for the period of treatment received over the last two years
- Test results showing objective findings
- Hospital discharge summaries
- Consulting physician reports

Your Name	Degree
Specialty	Telephone No. ( ) Fax No. ( )

Address

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.

X _____ _____

Signature of Attending Physician (no stamp) Date

Accident Insurance

Trustmark
INSURANCE COMPANY
PERSONAL. FLEXIBLE. TRUSTED.

100 1913 - 2013 Years of Trust

Every life has a story.

You have a picture of the way you want your life to go.

Now imagine if something happens that not only changes your picture, it changes your life story.

That's when Trustmark Accident insurance can help. It can help you live your story, your way – even when unexpected accidents get in the way.

Sometimes life can take a tumble.

You do everything you can to keep your family safe, but accidents do happen. When they do, it's good to know you have help to manage the unexpected bills that come with them.

Trustmark Accident insurance is designed to cover unexpected expenses that result from all kinds of accidents, even sports-related and household ones.[1] It provides cash benefits to cover things your health insurance doesn't, such as:

- Deductibles
- Co-payments
- Transportation and lodging costs
- Everyday bills and more

What's more, your benefits come directly to you without any restrictions on how you can use them. You can't predict when unexpected accidents will happen, but you can help protect your family from the expenses accidents bring with them.

Trustmark Accident insurance provides a financial cushion to help you take care of bills, so you can take care of each other. It's that simple.

Why do you need it?

Take a moment, now, to think about life as you know it. Then ask yourself this: If you were suddenly injured in an accident, how would you manage the expenses of life during your recovery?

- How often are children injured in accidents?
- How much would a trip to the emergency room cost you?
- Would you want to ensure you and your family get the best care available?

[1]Please consult your policy/group certificate for exclusions, limitations and policy details.

Think About It

About 42.2 million visits to hospital emergency rooms in the United States were injury related.[2]

[2] National Center for Health Statistics, February 2011

Accident Insurance Provides 24-hour Coverage[3] with benefits for:

Hospital Admission
Hospital Confinement[4]
Hospital Intensive Care Unit[4]
Emergency Room Treatment

- **Initial Care Benefits:** Physician visit, ambulance, emergency room treatment, hospital benefits, lodging, blood, surgery, emergency dental
- **Injury Benefits:** Burn; concussion; dislocation; eye injury; fracture; herniated disc; laceration; loss of finger, toe, hand, foot, sight; tendon, ligament, rotator cuff injury; torn knee cartilage
- **Follow-up Care Benefits:** Physical therapy, appliances, prosthetic device, artificial limb, skin graft, transportation

[3]Please refer to Schedule of Benefits for benefit amounts and covered conditions for your state. [4]Hospital Confinement and ICU Benefits cannot be paid at the same time. Benefit amount payable may vary by state.

Benefits you'll appreciate

- Benefits paid directly to you without any restrictions on how you can use them.
- Benefits are paid to you regardless of any other coverage you have.
- **Guaranteed Issue –** There are no medical questions you'll have to answer, but your spouse or domestic partner must answer a disability question.
- **Guaranteed Renewable –** Renewable as long as premiums are paid.
- **Level Premiums and Benefits –** Rates don't increase and benefits don't decrease because of age.
- **Family Coverage –** Apply for your spouse, children, and dependent grandchildren.
- **Portability –** Take your coverage with you and pay the same premium. It's yours to keep even if you change jobs or retire.
- **Convenient Payroll Deduction –** No bills to watch for. No checks to mail. A direct bill option is available when you change jobs or retire.

It's your story. Help protect it with Accident insurance.

Trustmark
Voluntary Benefit Solutions
PERSONAL. FLEXIBLE. TRUSTED.

Underwritten by Trustmark Insurance Company
Rated A- (EXCELLENT) A.M. Best[1]
400 Field Drive • Lake Forest, IL 60045
trustmarksolutions.com

THIS IS A LIMITED POLICY

This brochure provides a brief description of benefits and is not a contract. Plan availability and/or coverage, benefits, definitions, exclusions and limitations may vary by state. See Plan A-607, HS-12000, WB607 and other optional riders for your state for exact terms and provisions. This is an Accident only policy/group certificate with limited benefits and does not pay benefits for diseases, sickness or for loss from sickness. This is not a Worker's Compensation Policy nor a Medicare policy. Benefits are supplemental and not intended to cover all medical expenses. In MA, this health plan alone does not meet Minimum Creditable Coverage standards and will not satisfy the individual mandate that you have health insurance. In WY, this policy/group certificate does not contain comprehensive adult wellness benefits as defined by state law.

[1] An A.M. Best rating is an independent opinion of an insurer's financial strength and ability to meet its ongoing insurance policy and contract obligations. Trustmark is rated A- (4th out of 16 possible ratings ranging from A++ to Suspended).

P485-1283 (12-12) 24

Schedule of Benefits[1]

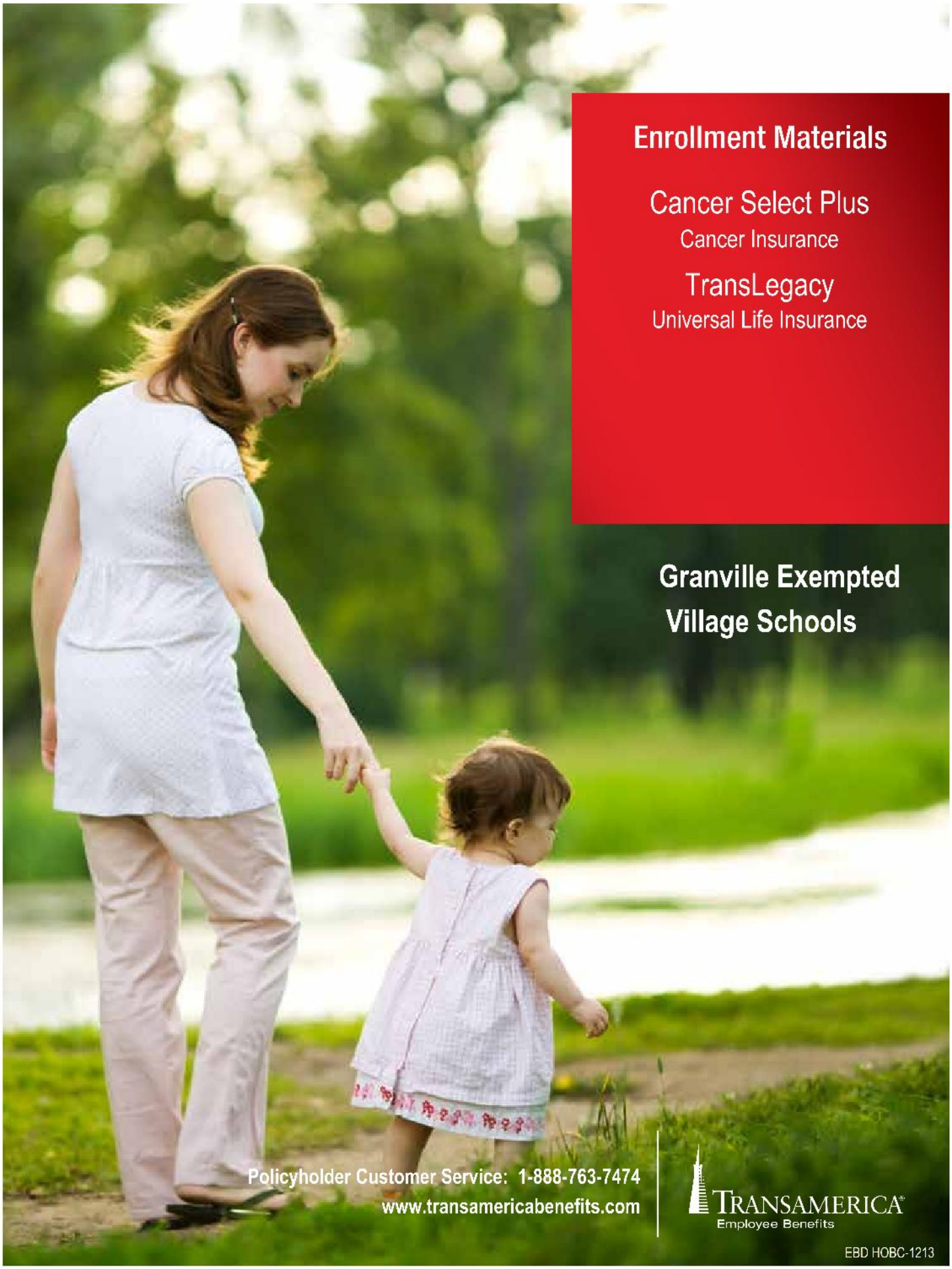
Accident Insurance Provides 24-Hour Coverage

Benefit	Amount
Initial Care	
Hospital Benefits	
Admission Benefit (per admission)	$2,000
Confinement Benefit (per day up to 365 days)	$400
ICU Benefit (per day up to 15 days)	$600
Emergency Room Treatment	$200
Ambulance	
Ground	$200
Air	$1,000
Initial Doctor's Office Visit	$100
Lodging (per night up to 30 days per accident)	$100
Surgery Benefit	
Open, abdominal, thoracic	$2,000
Exploratory	$200
Blood, Plasma and Platelets	$600
Emergency Dental Benefit	
Extraction	$100
Crown	$300
Follow-Up Care	
Accident Follow-Up Treatment	$100
Physical Therapy	
Up to six visits per person per accident	$50
Appliance	$200
Transportation	
100+ miles, up to three trips	$475
Prosthetic Device or Artificial Limb	
More than one	$2,000
One	$1,000
Skin Grafts	25% of applicable burn benefit
Accidental Death	
Employee	$50,000
Spouse[2]	$20,000
Child	$10,000
Accidental Death – Common Carrier	
Employee	$100,000
Spouse[2]	$40,000
Child	$20,000
Catastrophic Accident	
Employee	$100,000
Spouse[2]	$50,000
Child	$50,000

Benefit	Amount
Injuries	
Fractures	
Open reduction	up to $10,000
Closed reduction	up to $5,000
Chips	25% of applicable closed reduction
Dislocations	
Open reduction	up to $8,000
Closed reduction	up to $4,000
Laceration	up to $800
Burns	
Flat amount for:	
Third-degree 35 or more sq. in.	$15,000
Third-degree 9-34 sq. in.	$2,250
Second-degree for 36% or more of body	$1,125
Concussion	$200
Eye Injury	
Requires surgery or removal of foreign body	$400
Herniated Disc	$800
Loss of Finger, Toe, Hand, Foot or Sight	
Loss of both hands, feet, sight of both eyes or any combination of two or more losses	$15,000
Loss of one hand, foot or sight of one eye	$7,500
Loss of two or more fingers, toes or any combination of two or more losses	$1,500
Loss of one finger or one toe	$750
Tendon/Ligament/Rotator Cuff Injury	
Repair of more than one	$1,200
Repair of one	$800
Exploratory surgery without repair	$200
Torn Knee Cartilage	$1,000
Exploratory surgery	$200
Health Screening Benefit	
One per person per year Routine health screening tests	$100

Type of Coverage	Weekly Rate (52 per year)
Employee	$4.40
Employee and Spouse[2]	$6.71
Employee and Child(ren)	$8.15
Family	$10.47

[1]Benefits are payable only as the result of a covered accident. Benefits may vary by state and additional benefits may be available in some states. Most benefits are paid once per person per covered accident unless otherwise noted. [2]In some states, spouse, domestic partner or civil union partner.


Enrollment Materials
Cancer Select Plus
Cancer Insurance
TransLegacy
Universal Life Insurance
Granville Exempted Village Schools
Policyholder Customer Service: 1-888-763-7474
www.transamericabenefits.com
TRANSAMERICA
Employee Benefits
EBD HOBC-1213

TRANSAMERICA EMPLOYEE BENEFITS

CLAIMS-EXPRESS

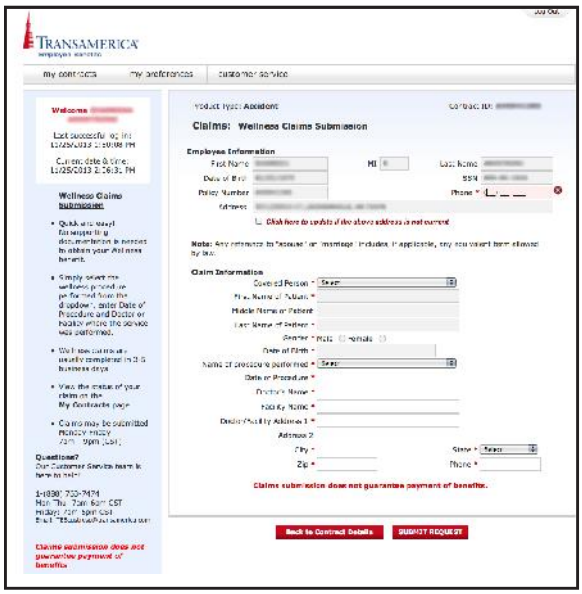
File Claims Quick and Easy

File TransConnect, Short-Term Disability and Cancer, Critical Illness and Accident Wellness Claims online.

Transamerica's claim filing process is a snap! Customers can submit claims online, phone or fax for **TransConnect** and **Short-Term Disability** benefits along with **wellness claims for cancer, critical illness** and **accident benefits**.

How to File Claims Online

Customers **register at www.tebcs.com** then complete the online form and upload documentation to support their requests. Following submission, customers may view the status, review the submitted claim form and documentation. Once the claim is processed, the Explanation of Benefits (EOB) statement will be available online as well.



How to File a Claim by Phone or Fax

Contact the Transamerica Claims Customer Service Department at (800) 251-7254 and press 2 or fax directly to the Claims Department at (866) 586-6528. The following information must be provided:

+ Insured's name/ policy number
+ Covered person's name, date of birth and relationship to insured
+ Doctor and facility name, address and phone number
+ Name of test/procedure
+ Date of test/procedure
+ (Fax only) Provider's billing statement, which includes the test/procedure and the date it was performed

File Claims for Other Products

Claims for other products may be completed by downloading the respective claim form at **www.tebcs.com**. Once the proper documentation is received, the claim will be processed.

QUESTIONS ABOUT CLAIMS

Call the Claims Customer Service Department at (800) 251-7254 and press 2.

TRANSAMERICA®
Employee Benefits

EBD HOWL-1113

CancerSelect® Plus Cancer only Indemnity Insurance is underwritten by ***Transamerica Life Insurance Company,*** *Cedar Rapids, Iowa.*

In the US, men have slightly less than a 1 in 2 lifetime risk of developing cancer, while the risk for women is a little more than 1 in 3.[1] Anyone can develop cancer, but can you help protect yourself and your family from the out-of-pocket costs associated with cancer treatment?

- Wellness Benefits
- Hospital Benefits
- Surgery Benefits
- Radiation and Chemotherapy Benefits
- Cancer Maintenance Therapy Benefits

Good medical coverage helps, but is it enough?

While some individuals diagnosed with cancer have meaningful and adequate health insurance to cover most of the cost of treatment, an increasing number of privately insured workers face the prospect of crippling out-of-pocket costs, according to updated information from the National Cancer Institute. Those rising health care costs often leave both uninsured and individuals with insurance without the coverage they need – especially the 11 million Americans with cancer.[2]

If you or one of your family members were to be diagnosed with cancer, would you want to face those chances? Now there's a way you can add more benefits for you and your family.

If cancer is the disease you worry about most, you're not alone.

The financial costs of cancer care can be a burden to people diagnosed with cancer, their families, and society as a whole. National cancer care expenditures have been steadily increasing in the United States. Costs also are likely to increase as new, more advanced treatments are adopted as standards of care.[3] With this supplemental benefit your employer is making available, you'll not only have more resources to cope with any future diagnosis of cancer, but you'll also have wellness benefits to help you detect cancer early when it's most treatable.

Guaranteed issue. No health questions or physical exams are required

1 American Cancer Society. Cancer Facts & Figures 2012. Atlanta: American Cancer Society; 2012.

2 National Cancer Institute. Cancer Query System: Cancer Prevalence Database. http://srab.cancer.gov/prevalence/canques.html.2012.

3 National Cancer Institute. "Cancer Costs Projected to Reach at Least $158 Billion in 2020." Jan. 12, 2011. http://www.nih.gov/news/health/jan2011/nci-12.htm.

TRANSAMERICA®
Employee Benefits

Policy form series CPCAN200 and CCCAN200. Forms may vary, coverage available where approved. This is a brief summary of CancerSelect Plus Group Cancer-only Insurance. Limitations and Exclusions apply. Please refer to the policy, certificate and riders for complete details.

25916551
CCP01C-1112

This insurance pays you directly and is not reduced by other insurance.

While typical health insurance pays your doctor or hospital, this supplemental insurance pays you directly unless you assign benefits. Some benefits pay by the day or treatment, while others reimburse you for expenses you incur. Either way, it can be a source of financial support just when you and your family need it most!

You can cover only yourself or add your eligible spouse and children.

If you are 18 years old or more, you can purchase this valuable supplemental benefit. You can also choose to cover your eligible family members, including your spouse age 18 or older and your children from birth through age 25.

Valuable benefits for your life.

Review the attached benefits and costs for the insurance policy your employer has designed for your consideration. It's a long list of benefits, but they're all important. As you read through the list of all the ways this supplemental coverage pays, think about how you could possibly cover all these costs on your own. Fighting cancer can be challenging both financially and emotionally, and the more resources you have, the better prepared you and your family will be.

Hospital Benefits	Plan 1 - 2.00 Units	Policy Pays
Hospital Confinement	$200	per day of covered confinement
Extended Benefits	$400	per day; begins on day 91 of continuous confinement; in lieu of all other benefits (except surgery and anesthesia)
Attending Physician	$40	per day while hospital confined; one visit per 24-hour period
Inpatient Drugs and Medicines	$30	per day while hospital confined
Private Duty Nurse	$200	per day while hospital confined; must be authorized by the attending physician; cannot be hospital staff or a family member
Ambulance	$200	for service by a licensed ambulance service for transportation to a hospital; admittance required
Extended Care Facility	$200	per day; up to the number of days for the prior hospital stay; admittance must be within 14 days of hospital discharge
Government or Charity Hospital	$200	per day of covered confinement; in lieu of all other benefits
Hospice Care	$200	per day of hospice care; 100-day lifetime maximum; not payable while hospital confined
Surgery Benefits	**Plan 1 - 3.00 Units**	**Policy Pays**
Surgery — Inpatient	$3,000	maximum benefit; actual benefit is determined by the surgery schedule in the contract; for multiple procedures in same incision only the highest benefit is paid; for multiple procedures in separate incisions will pay highest benefit and then 50% for each lesser procedure
Surgery — Outpatient	$4,500	
Anesthesia	25%	of covered surgery benefit
Prosthesis	$1,500	maximum benefit; pays actual charges per device requiring implantation
Hair Prosthesis	$150	maximum benefit; pays actual charges for wig to cover hair loss from cancer treatment

Reconstructive Surgery	Breast Cancer – simple or total mastectomy	$360	for reconstructive surgery within 2 years of the initial cancer removal; excludes skin cancer and malignant melanoma; benefit not payable if paid under any other provision of the policy
	Breast Cancer – radical mastectomy	$510	
	Cancers of the male or female genitalia	$510	
	Cancer of the head, neck, or oral cancers	$750	
Second Surgical Opinion		$300	when surgery is prescribed; excludes skin cancer
Ambulatory Surgical Center		$450	maximum per day; pays actual charges for outpatient surgery at an ambulatory surgical center
Skin Cancer	One removal	$225	for removal of skin cancer (skin cancer does not include malignant melanoma or mycosis fungoides)
	Per additional removal	$105	
Radiation and Chemotherapy Benefits		**Plan 1 - 2.00 Units**	**Policy Pays**
Radiation and Chemotherapy		$10,000	maximum benefit per 12-month period; pays actual charges
Associated Radiation & Chemo Expenses		$500	maximum benefit per 12-month period; pays actual charges for treatment consultations and planning, adjunctive therapy, radiation management, chemotherapy administration, physical exams, checkups, and laboratory or diagnostic tests; transportation and lodging are not included as associated expenses
Blood, Plasma, Blood Components, Bone Marrow and Stem Cell Transplant		$10,000	maximum benefit per 12-month period; pays actual charges
Associated Blood & Plasma Expenses		$500	maximum benefit per 12-month period; pays actual charges for administration of blood, plasma and blood components, transfusions, processing and procurement, or cross-matching, treatment consultations and planning, physical exams, checkups, and laboratory or diagnostic tests; transportation and lodging are not included as associated expenses

New or Experimental Treatment	$10,000	maximum benefit per 12-month period; pays actual charges for drugs or chemical substances approved by the FDA for experimental use on humans or surgery or therapy endorsed by either the NCI or ACS for experimental studies received in the US or its territories
Wellness & Non-Medical Benefits	**Plan 1 - 2.00 Units**	**Policy Pays**
Annual Cancer Screening	$100	per calendar year for cancer screening tests: • mammogram • pap smear • flexible sigmoidoscopy • prostate-specific antigen test • chest x-ray • hemocult stool specimen • ultrasound • CEA • CA125 • biopsy • thermography • colonoscopy • serum protein electrophoresis • bone marrow testing • blood screening
Magnetic Resonance Imaging (MRI) Scan	$100	per calendar year for MRI scan used as diagnostic tool for breast cancer
Non-Local Transportation	Included	round-trip charges or private vehicle allowance, up to 750 miles at $0.40 per mile, when required non-local hospital confinement is more than 50 miles from residence for a covered person and an adult immediate family member during confinement; payable once per confinement
Family Member Lodging	$100	per day (maximum 50 days per 12 month period) for lodging expenses for an adult immediate family member when non-local hospital confinement is required
Outpatient Lodging	$100	per day (maximum 50 days per 12 month period) for lodging expenses for a covered person to receive radiation or chemotherapy on an outpatient basis if not available locally
Physical Therapy & Speech Therapy	$50	per treatment; limit one treatment per day
At-Home Nursing	$100	per day, up to the number of days of the prior hospital stay when admitted within 14 days of hospital discharge

Waiver of Premium	Included	waives premium for total disability due to cancer after 60 consecutive days of total disability; total disability must begin prior to the covered person's 70th birthday
Cancer Maintenance Therapy Benefit	**Plan 1 - 1.00 Units**	**Policy Pays**
• Cancer Suppressive Therapy • Hematological Drugs • Anti-Nausea Drugs • Motility Agents	$1,000	maximum benefit per 12-month period; pays actual charges
First Occurrence Rider (Rider Form Series CROCC100, 200 or 300)	**Plan 1 - 3.00 Units**	**Policy Pays**
Initial Diagnosis Benefit	$3,000	pays a one-time, lump-sum benefit when a covered person is initially diagnosed with cancer (except skin cancer), based on a microscopic examination of fixed tissue or preparations from the hemic system. Clinical diagnosis is accepted under certain conditions.
Specified Illness and Disease Rider (Rider Form Series CRSPD200)	**Plan 1 - 1.00 Units**	**Policy Pays**
Provides benefits for losses that are the direct result of a covered specified illness or disease.		
Hospital Confinement	$100	per day of covered confinement
Extended Benefits	$200	per day; begins on day 91 of continuous confinement; in lieu of all other benefits (except surgery and anesthesia)
Attending Physician	$20	per day while hospital confined; one visit per 24-hour period
Inpatient Drugs and Medicines	$15	per day while hospital confined
Private Duty Nurse	$100	per day while hospital confined; must be authorized by the attending physician; cannot be hospital staff or a family member
Ambulance	$100	for service by a licensed ambulance service for transportation to a hospital; admittance required
Extended Care Facility	$100	per day; up to the number of days for the prior hospital stay; admittance must be within 14 days of hospital discharge
Government or Charity Hospital	$100	per day of covered confinement; in lieu of all other benefits
Hospice Care	$100	per day of hospice care; 100-day lifetime maximum; not payable while hospital confined

Surgery	$1,000	per surgery; pays the lesser of the amount shown or an amount determined by multiplying the work relative value unit obtained from the Medicare Physician Fee Schedule by $25
Outpatient Surgery	$1,500	per surgery; pays 150% of the surgery benefit
Anesthesia	25%	per surgery; pays the selected percentage of the surgery benefit
Second Surgical Opinion	$100	for a second opinion when the first opinion prescribes surgery as treatment
Ambulatory Surgical Center	$150	maximum per day; pays charges for surgery performed at an ambulatory surgical center or hospital as an outpatient; paid in addition to the outpatient surgery benefit

Covered Specified Illnesses and Diseases include:				
Adrenal Hypofunction (Addison's Disease)	Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	Botulism	Brucellosis	Budd-Chiari Syndrome
Cerebral Palsy	Cholera	Cystic Fibrosis	Diphtheria	Encephalitis
Hansen's Disease	Hepatitis (Chronic B or Chronic C with liver failure or hepatoma)	Histoplasmosis	Huntington's Chorea	Legionnaires' Disease
Lupus	Lyme Disease	Mad Cow Disease	Malaria	Meningitis
Muscular Dystrophy	Myasthenia Gravis	Necrotizing Fascitis	Osteomyelitis	Poliomyelitis
Primary Biliary Cirrhosis	Primary Sclerosing Cholangitis (Walter Payton's Liver Disease)	Q Fever	Rabies	Reye's Syndrome
Rheumatic Fever	Rocky Mountain Spotted Fever	Scarlet Fever	Scleroderma	Sickle Cell Anemia
Tay-Sachs Disease	Tetanus	Thallasemia	Toxic Epidermal Necrolysis	Toxic Shock Syndrome
Trichinosis	Tuberculosis	Tularemia	Typhoid Fever	Whooping Cough (Pertussis)

Actual charges means the amount actually paid by or on behalf of the insured and accepted by the provider as payment in full for services provided.

PRODUCT DETAILS

Semi-Monthly Premium	Individual	Single Parent Family	Family
Plan 1	$12.27	$14.02	$22.20

Issue State: Ohio
Rate generation date: August 20, 2014

LIMITATIONS AND EXCLUSIONS

We provide benefits only for cancer as defined herein, which is positively diagnosed while coverage is in force. It does not provide benefits for any other illness or disease.

- We may reduce or deny a claim or void coverage for loss incurred by a covered person:
  - During the first 2 years from the effective date of such coverage for any misstatements in the application which would have materially affected our acceptance of the risk;
  - At any time for fraudulent misstatements in the application.
- We will only pay for loss as a direct result of cancer. Proof of positive diagnosis must be submitted to us for each new claim. We will not pay for any other disease or incapacity that has been caused, complicated, worsened or affected by, or as a result of cancer, except as specifically covered under the contract.
- If a covered hospital confinement is due to more than one covered condition, benefits will be payable as though the confinement or expense were due to one condition. If a hospital confinement or expense is also due to a disease or condition that is not covered, benefits will be payable only for the part of the hospital confinement or expense due to the covered disease or condition.
- Under no condition will we pay any benefits for losses or medical expenses incurred prior to the effective date.

Pre-Existing Condition Limitation - No benefits are provided during the first 12 months for pre-existing conditions for which the covered person has been diagnosed, treated, or for which the covered person has incurred expense or has taken medication within 12 months prior to the effective date of such person's coverage. Pre-existing condition also includes a condition that manifests itself in a way that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment.

Total Disability means the inability to perform all of the material and substantial duties of the employee's regular occupation. Total Disability will be considered to exist when under the regular care and attendance of a physician for the necessary treatment of cancer. After the first two years of Total Disability, the employee will continue to be considered Totally Disabled if unable to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience. On or after age 65, Total Disability will mean that a physician has certified that the employee is unable to perform two or more Activities of Daily Living (continence, transferring, dressing, toileting, eating and bathing) without direct personal assistance as a result of cancer.

12-Month Benefit Period - The initial 12-Month Benefit Period is the 12-month period beginning on the date of positive diagnosis. Subsequent 12-Month Benefit Periods begin on the same month and day as the immediately preceding 12-Month Benefit Period; however, if the covered person incurs no covered loss during the 3 months after the end of any 12-Month Benefit Period, the next 12-Month Benefit Period will begin on the next date a covered loss is incurred. Benefit Periods are determined separately for each covered person.

First Occurrence Rider

Benefits are not payable:
- For cancer diagnosed prior to the Effective Date of this Rider;
- For any other illness or disease other than internal Cancer;
- For Skin Cancer or any Cancer excluded from coverage by name or specific description.

Specified Illness and Disease Rider

This Rider provides benefits for the Initial Positively Diagnosed Specified Illness or Disease defined in this Rider on or after the Effective Date of this Rider. It does not provide benefits for any other illness or disease.

We will only pay for loss as a direct result of a Specified Illness or Disease. Proof of Positive Diagnosis must be submitted with each new claim. We will not pay for any disease or incapacity that has been caused, complicated, worsened, or affected by, or as a result of a Specified Illness or Disease or its treatment.

Benefits under "Waiver of Premium" of the Contract do not apply to this Rider for Total Disability due to a Specified Illness or Disease.

Termination of Insurance

Employee coverage will terminate on the earliest of:

- The date of the employee's death;
- The date on which the employee ceases to be eligible for coverage;
- The last date for which premium payment has been made to us;
- The last date on which employment terminates;
- The date the group master policy terminates; or
- The date the employee sends us a written notice to cancel coverage.

Dependent coverage will terminate on the earliest of:

- The date the employee's coverage terminates;
- The last date for which premium payment has been made to us;
- The date the dependent no longer meets the definition of dependent;
- The date the group master policy is modified so as to exclude dependent coverage; or
- The date the employee sends us a written notice to cancel dependent coverage.

We will have the right to terminate the coverage of any covered person who submits a fraudulent claim under the policy.

Portability Option

If an employee loses eligibility for this insurance for any reason other than nonpayment of premiums, coverage can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue coverage.

Termination of the Group Master Policy

The policyholder may end the policy on any premium due date by submitting a 60-day advance written notice. A group will not be continued if it drops below the minimum required participation. The group master policy will be terminated and coverage of all remaining insureds will end, subject to the Portability Option.

Other Insurance with Us

An individual can only have one cancer policy or certificate with us. If a person already has cancer insurance with us, such person is not eligible to apply for this coverage.

TransLegacy℠ universal life insurance

*Underwritten by **Transamerica Life Insurance Company,** Cedar Rapids, Iowa.*

4% guaranteed interest rate and powerful coverage for your eligible family members.

Now without a medical exam you can buy universal life insurance coverage and build cash value with a guaranteed 4% interest rate. You can protect yourself and eligible members of your family, all with the convenience of payroll deduction.

Do you have enough life insurance, coverage for a terminal illness, and protections that help in the event of a layoff?

Half of all American households say they need more life insurance—more than ever before.[1] Now's your chance to join families across the country who are taking action.

You can choose the amount of coverage you need between $25,000 and $100,000. None of us likes to think about these things, but it's important that you can also tap into your life insurance death benefit early if you're ever diagnosed with a terminal illness. That benefit could really help you and your family during a difficult time. If you're ever laid off from your full-time job, there's also protection to keep paying for your policy for as long as six-months.[4] You'll be able to keep your coverage and take it with you if you ever leave the company.

You can cover yourself, your spouse, and your eligible dependent children and grandchildren.

There are two ways to choose enough benefit for your family. In addition to your own coverage, you can buy a universal life policy for your spouse and each eligible child and grandchild. Or you could choose term life insurance protection attached to your policy or your spouse's that will add extra coverage.

Guaranteed issue up to $100,000 - no health questions or physical exams are required

- Coverage up to $100,000
- No Physicals or Blood work[2]
- Dependent Coverage Available
- Guaranteed 4% Interest Rate
- Cash Values
- Convenient Payroll Deduction
- Terminal Illness Benefit[3]
- Level Death Benefit
- Layoff Provision[4]

1 LIMRA Trends in Life Insurance Ownership study, 2010
2 Acceptance based on answers to questions on your applications for coverage.
3 Not available in Massachusetts
4 Not available in Massachusetts, Maryland, Tennessee, Virginia, Vermont, or Washington.

TRANSAMERICA®
Employee Benefits

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CLG01C-0313

TransLegacy℠
universal life insurance

TransLegacy℠ Universal Life Insurance is ***underwritten by Transamerica Life Insurance Company,*** *Cedar Rapids, Iowa.*

Accelerated Death Benefit for Long-Term Care Rider

Get your money early if you ever need long-term care and an added benefit to make the money go further.

Wouldn't it be helpful to take an "advance" against your life insurance death benefit if you are ever diagnosed as being chronically ill and still know there will be life insurance left for your family? That's the purpose of your Accelerated Death Benefit for Long-Term Care Rider with Extension of Benefits Rider. Chronically ill means a licensed physician says you are unable to perform for 90 days or longer at least two activities of daily living—such as dressing, taking a shower, eating, toileting, and being able to move from one activity to another—or that you suffer severe issues with memory or being able to think.

4% of your life insurance death benefit amount is available each month

The amount of money available to you if you are ever chronically ill will be 4% of your life insurance benefit for up to 25 months, provided you are in a licensed nursing or assisted living facility. If you are receiving home health care or day care instead, it will be 2% for 50 months.

You also have the option to receive a one-time lump sum payment of 20% of your life insurance benefit instead of receiving monthly payments. Once you have chosen and received payment under this option, there will be no other amounts payable under this rider.

When benefits are paid under this provision, your life insurance death benefit, surrender charges, and your policy's accumulation value will be reduced proportionately. If you have an outstanding policy loan, your monthly loan payments will be subtracted from your benefits every month to continuing paying off your loan balance. Any remaining balance will be paid to your beneficiary in the event of your death. If you have used all of your death benefit, the policy will end.

You don't have to make monthly payments when you're chronically ill

You will not need to make monthly premium payments during the months you are receiving benefits under this provision (those amounts are waived for you). When you file a claim, there will be administrative expenses deducted from your monthly claim payments.

Accelerated death benefit provisions all work together

You may have other accelerated death benefits that allow you to access your life insurance early for critical illness or other purposes. Remember that all of these provisions work together up to a maximum 100% of your life insurance death benefit.

Be aware of how this money is taxed

When you get early life insurance benefits, you may have to pay taxes on all or part of this money, although these payments are intended to be excluded from your gross income for federal tax purposes. We may update the policy language with an amendment from time to time to meet any future tax changes or make needed tax clarifications, and if we do, you'll receive a written notice of any changes. We cannot guarantee how these payments will be treated for income tax purposes. These monthly payments could also impact your eligibility for public assistance programs. Talk with a qualified tax advisor and appropriate social services agencies to help you understand how an early payout could affect you and your family.

This rider may not cover all the costs associated with long term care incurred during the period of coverage.

This is a brief summary of Accelerated Death Benefit for Long Term Care Rider with Extension of Benefits Rider and Paid-Up Insurance offered with TransLegacy℠ Universal Life Insurance. Limitations and exclusions may apply. Be sure to read your insurance certificate for the exact definition of disability and the way this benefit is applied in your state Refer to the policy, certificate and riders for complete details.

Rider Form Series CRABLT00. Forms may vary, coverage available where product is approved.

CLG03C3(NC)-0512

TransLegacy HAV - Universal Life Insurance

With Riders: WPLF LTC TI

Non-Tobacco, Death Benefit Option: A - Level

Issue Age	$25,000 Face Amount Semi-Monthly Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	$50,000 Face Amount Semi-Monthly Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	$100,000 Face Amount Semi-Monthly Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	Issue Age
16	N/A+			9.21	6,655		17.65	14,313		16
17	N/A+			9.50	6,821		18.24	14,599		17
18	N/A+			9.81	6,997		18.86	14,942		18
19	N/A+			10.13	7,233		19.51	15,389		19
20	N/A+			10.47	7,428	18,437	20.18	15,685	36,851	20
21	N/A+			10.82	7,579		20.88	15,964		21
22	N/A+			11.39	7,810		22.02	16,402		22
23	N/A+			11.79	8,041		22.82	16,826		23
24	N/A+			12.21	8,203		23.65	17,072		24
25	N/A+			12.82	8,329	17,828	24.87	17,317	35,638	25
26	N/A+			13.30	8,476		25.85	17,592		26
27	N/A+			13.81	8,565		26.86	17,725		27
28	N/A+			14.34	8,698		27.93	17,949		28
29	N/A+			14.90	8,757		29.05	18,072		29
30	N/A+			15.68	8,850	17,092	30.59	18,229	34,209	30
31	N/A+			16.30	8,979		31.83	18,439		31
32	8.87	4,296		16.97	9,038		33.18	18,540		32
33	9.22	4,350		17.68	9,130		34.60	18,698		33
34	9.70	4,393		18.64	9,177		36.51	18,777		34
35	10.09	4,425	8,079	19.43	9,241	16,168	38.09	18,867	32,335	35
36	10.64	4,404		20.51	9,169		40.26	18,707		36
37	11.21	4,380		21.65	9,100		42.54	18,541		37
38	11.79	4,364		22.82	9,048		44.87	18,403		38
39	12.52	4,335		24.27	8,965		47.78	18,230		39
40	13.17	4,283	7,328	25.57	8,855	14,670	50.38	17,986	29,326	40
41	13.85	4,231		26.93	8,721		53.10	17,712		41
42	14.56	4,170		28.36	8,592		55.96	17,426		42
43	15.41	4,101		30.05	8,437		59.34	17,100		43
44	16.19	4,033		31.63	8,285		62.49	16,788		44
45	17.02	3,950	6,370	33.27	8,099	12,735	65.77	16,398	25,474	45
46	18.10	3,874		35.45	7,933		70.13	16,054		46
47	19.25	3,810		37.74	7,792		74.72	15,754		47
48	20.34	3,756		39.92	7,666		79.08	15,489		48
49	21.59	3,675		42.41	7,489		84.07	15,131		49
50	22.89	3,585	5,417	45.02	7,302	10,833	89.29	14,739	21,672	50
51	24.27	3,390		47.78	6,906		94.79	13,932		51
52	25.71	3,180		50.66	6,467		100.55	13,048		52
53	27.11	2,955		53.46	6,008		106.15	12,111		53
54	28.70	2,702		56.63	5,489		112.49	11,067		54
55	30.35	2,490	3,706	59.93	5,053	7,408	119.09	10,187	14,819	55
56	32.50	2,174		64.23	4,415		127.70	8,899		56
57	34.73	1,793		68.69	3,645		136.62	7,350		57
58	37.07	1,485		73.38	3,019		146.00	6,090		58
59	39.61	1,146		78.47	2,335		156.17	4,711		59
60	42.19	784	1,418	83.63	1,602	2,837	166.49	3,238	5,675	60
61	44.88	386		88.99	799		177.22	1,625		61
62	47.69	11		94.61	40		188.45	100		62
63	50.73	0		100.70	0		200.65	0		63
64	53.79	0		106.82	0		212.87	0		64
65	56.99			113.23			225.69			65
66	60.77			120.77			240.78			66
67	64.72			128.67			256.58			67
68	68.87			136.98			273.19			68
69	73.25			145.73			290.69			69
70	77.86			154.96			309.16			70

\+ Face Amount is insufficient to require the minimum planned premium of $8.67 Semi-Monthly. Solve - Target Premium

* Values assume that all planned periodic premiums are paid to Age 100. Guaranteed values are based on the minimum interest rate of 4.00% and maximum fees and charges. Non-Guaranteed values are based on a current illustrated interest rate of 5.25% and current fees and charges and are not guaranteed. Values are affected by the actual interest rates credited and cost of insurance rates charged.

The Child Term Rider may be added for additional premium of $0.63 semi-monthly per $5,000. Values shown above are not valid if the Child Term Rider is added.

Issue Ages 56+ do not include the WPLF Rider.

TRANSAMERICA Employee Benefits

A detailed illustration will be provided on delivery of a contract or earlier if requested. This is a quotation, not a contract.

Underwritten by Transamerica Life Insurance Company. Home Office: Cedar Rapids, IA

August 20, 2014
Issue State: OH Ver: 7.57B(11A)07

TransLegacy HAV - Universal Life Insurance

With Riders: WPLF LTC TI

Tobacco, Death Benefit Option: A - Level

Issue Age	$25,000 Face Amount Semi-Monthly Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	$50,000 Face Amount Semi-Monthly Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	$100,000 Face Amount Semi-Monthly Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	Issue Age
16	N/A+			11.73	3,786		22.70	8,673		16
17	N/A+			12.15	4,061		23.54	9,259		17
18	N/A+			12.58	4,360		24.40	9,762		18
19	N/A+			13.20	4,771		25.64	10,515		19
20	N/A+			13.67	5,046	20,936	26.57	11,055	41,845	20
21	N/A+			14.15	5,338		27.54	11,575		21
22	N/A+			14.83	5,630		28.90	12,081		22
23	N/A+			15.36	5,967		29.97	12,730		23
24	N/A+			15.93	6,232		31.09	13,268		24
25	8.72	2,869	10,094	16.69	6,487	20,227	32.61	13,708	40,454	25
26	9.05	3,002		17.34	6,672		33.92	14,040		26
27	9.47	3,092		18.18	6,844		35.61	14,389		27
28	9.92	3,199		19.08	7,023		37.40	14,661		28
29	10.30	3,361		19.84	7,292		38.92	15,178		29
30	10.80	3,423	9,645	20.83	7,407	19,289	40.90	15,353	38,563	30
31	11.22	3,513		21.69	7,557		42.61	15,656		31
32	11.76	3,616		22.76	7,735		44.75	15,972		32
33	12.33	3,668		23.90	7,800		47.04	16,074		33
34	12.83	3,761		24.89	7,952		49.03	16,378		34
35	13.46	3,806	9,033	26.15	8,026	18,055	51.53	16,490	36,130	35
36	14.15	3,826		27.54	8,073		54.31	16,543		36
37	14.88	3,830		28.99	8,033		57.22	16,431		37
38	15.63	3,844		30.49	8,039		60.22	16,435		38
39	16.41	3,831		32.05	7,989		63.33	16,313		39
40	17.36	3,812	8,180	33.95	7,919	16,337	67.13	16,151	32,680	40
41	18.22	3,797		35.68	7,881		70.59	16,055		41
42	19.13	3,767		37.49	7,807		74.22	15,875		42
43	20.07	3,726		39.38	7,692		77.99	15,638		43
44	21.09	3,690		41.41	7,606		82.06	15,454		44
45	22.12	3,626	7,089	43.49	7,479	14,191	86.21	15,173	28,382	45
46	23.39	3,596		46.01	7,387		91.26	14,980		46
47	24.80	3,539		48.84	7,262		96.92	14,699		47
48	26.29	3,486		51.82	7,137		102.87	14,443		48
49	27.74	3,431		54.72	7,022		108.67	14,195		49
50	29.37	3,361	6,045	57.98	6,862	12,092	115.21	13,869	24,189	50
51	31.10	3,166		61.43	6,455		122.10	13,043		51
52	32.77	2,945		64.77	6,005		128.78	12,126		52
53	34.65	2,702		68.53	5,511		136.30	11,126		53
54	36.48	2,437		72.19	4,962		143.61	10,020		54
55	38.51	2,225	4,043	76.25	4,530	8,084	151.73	9,141	16,168	55
56	41.05	1,895		81.34	3,861		161.91	7,794		56
57	43.69	1,492		86.63	3,044		172.49	6,150		57
58	46.44	1,176		92.12	2,404		183.47	4,858		58
59	49.33	835		97.90	1,713		195.03	3,472		59
60	52.35	488	1,440	103.94	1,009	2,879	207.11	2,054	5,757	60
61	55.48	136		110.19	298		219.63	624		61
62	58.75	0		116.74	0		232.72	0		62
63	62.12	0		123.49	0		246.21	0		63
64	65.60	0		130.44	0		260.13	0		64
65	69.23			137.71			274.65			65
66	73.34			145.92			291.08			66
67	77.75			154.74			308.72			67
68	82.38			163.99			327.21			68
69	87.28			173.80			346.84			69
70	92.38			184.00			367.24			70

+ Face Amount is insufficient to require the minimum planned premium of $8.67 Semi-Monthly. Solve - Target Premium

* Values assume that all planned periodic premiums are paid to Age 100. Guaranteed values are based on the minimum interest rate of 4.00% and maximum fees and charges. Non-Guaranteed values are based on a current illustrated interest rate of 5.25% and current fees and charges and are not guaranteed. Values are affected by the actual interest rates credited and cost of insurance rates charged.

The Child Term Rider may be added for additional premium of $0.63 semi-monthly per $5,000. Values shown above are not valid if the Child Term Rider is added.

Issue Ages 56+ do not include the WPLF Rider.

TRANSAMERICA Employee Benefits

A detailed illustration will be provided on delivery of a contract or earlier if requested. This is a quotation, not a contract.

Underwritten by Transamerica Life Insurance Company. Home Office: Cedar Rapids, IA

August 20, 2014
Issue State: OH Ver: 7.57B(11A)07

LTC **Accelerated Death Benefit for Long Term Care Rider (Form CRABLTOH):**
Allows the owner to receive 4% of the rider face amount per month for up to 25 months if the insured is confined in a licensed nursing or assisted living facility, or 2% of the rider face amount per month for up to 50 months if the insured receives home health care or adult day care services. The benefit for this rider can only be triggered by a chronically ill diagnosis that must be certified by a licensed physician.

WPLF **Waiver of Monthly Deductions Due to Layoff Rider (Form CRULWT00):**
Protects life insurance from lapsing for up to six months if the insured (employee only) is involuntarily laid off.

TI **Accelerated Death Benefit for Terminal Illness Rider (Form CRABTI00):**
Lets the insured "tap into" life insurance in the event of a future terminal illness diagnosis and still provides a benefit for the beneficiary.

Accelerated Death Benefit for Long Term Care Rider (ADB-LTC) (Rider Form Series CRABLT00) - If included in plan, accelerates a portion of the coverage amount for each month that a covered employee or spouse is eligible for benefits (certified as being chronically ill and confined to a nursing/assisted living facility or receiving home health/adult day care for at least 4 visits per month). There is a 30-day waiting period and a 90-day elimination period that must be satisfied before benefits are payable. We will waive the monthly deductions each month that benefits are paid under this rider. This rider is not available for children.

The death benefit and other contract values will be reduced accordingly. This rider will terminate once 100% of the coverage amount has been accelerated.

Accelerated Death Benefit for Terminal Illness Rider (Rider Form Series CRABTI00) - If included in plan, accelerates a portion of the coverage amount if a covered person is first diagnosed with a terminal illness which, in the best medical judgment, will result in death within 12 months.

When exercised, an administrative fee of $100 plus 12 months advanced interest will be deducted from the benefit payment. The death benefit and other contract values will be reduced accordingly and this rider will terminate.

Child Level Term Insurance Rider (Rider Form Series CRCHIL00) - If included in plan, allows a covered employee or spouse (but not both) to cover all eligible children, age 15 days through age 25, for the selected amount of term insurance. Coverage on each child terminates on that child's 26th birthday or when the parent's coverage ends, whichever is earlier. Upon termination the child has 31 days in which to convert to an individual contract for up to 5 times the amount of coverage under this rider.

Waiver of Monthly Deductions due to Layoff Rider (Rider Form Series CRULWT00) - If included in plan, waives the monthly deductions for up to six months per year if the employee is involuntarily laid off. Benefits are limited to three layoffs per year and are based on the employee's layoff only. Layoff of a covered spouse or child does not qualify for this waiver. Premium payments must have begun prior to the covered employee's layoff. Rider is available through age 55 and terminates on the employee's 60th birthday or when the coverage is assigned to another party, whichever is earlier.

If a covered employee withdraws the cash value, tax consequences and/or surrender charges may apply.

Fluctuations in interest rates or policy charges may require the payment of additional premiums.

Individuals currently on disability or on premium waiver are not eligible for coverage.

During the first two years, the death benefit for suicide is limited to the return of premiums paid, less any loans, partial surrender amounts, and accelerated benefits paid, if any.

Accelerated Death Benefit for Long Term Care Rider

Any facility or service provider must be licensed in the covered person's state of residence, if required. Some facilities and services are not covered.

Benefits will not be paid simultaneously if the insured qualifies under this rider for confinement, home health care. In any given month the insured qualifies for both benefits, we will either pay the monthly accelerated benefit for confinement or accelerated benefit for home health care, whichever is greater.

We will not pay rider benefits for care that is received or loss incurred as a result of:
- an intentionally self-inflicted injury, or attempted suicide;
- war or any act of war, declared or undeclared, or service in the armed forces of any country;
- treatment of the insured's alcohol, drug or other chemical dependence, except if the drug dependency was sustained or acquired at the hands of a physician, or while under treatment for an injury or sickness; or
- the insured's commission of, or attempt to commit, a felony; or an injury that occurs because of the insured's involvement in an illegal activity.

We will not pay rider benefits if the confinement or service:
- is received outside the United States and its territories; or
- is provided by ineligible providers; or
- is rendered by members of the insured's immediate family; or
- are fully or partially reimbursed by a state or federal workers' compensation plan, Medicare, or any other governmental program, except Medicaid; or
- would not be charged for in the absence of insurance.

Accelerated Death Benefit for Terminal Illness Rider

We will not pay for conditions diagnosed prior to the effective date of the rider.

Termination of Insurance

Coverage, including all riders, ends on the earliest of the following dates:
- the monthly contract date following the receipt of written request for surrender.
- the maturity date.
- the date of death.
- the date the contract ends, lapses or becomes fully paid-up life insurance - subject to the grace period.
- the date a nonforfeiture option becomes effective.

Portability Option

If an employee loses eligibility for this insurance for any reason other than nonpayment of premiums, coverage can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue coverage.

Termination of the Group Master Policy

The policyholder may end the policy on any premium due date by submitting a 60-day advance written notice. A group will not be continued if it drops below the minimum required participation. The group master policy will be terminated and coverage of all remaining insureds will end, subject to the Portability Option.

| New Voluntary Benefit |

Your Employer and LifeLock Partner to Protect Your Identity

Protect your personal information and defend against attacks with 24/7, proactive identity theft protection from LifeLock.

From the doctor's office to the online store, your information is everywhere and identity theft is one of the fastest growing crimes in the nation.[1]

That's why LifeLock works around the clock to keep your personal information safer and more secure. Using advanced detection technology, our always-on service protects you from identity theft before it happens.

Over 8 million American's fell victim to identity theft last year.[2] Get constant and relentless protection. Enroll in LifeLock during your open enrollment period for just pennies a day!

LifeLock® Services:

LifeLock works 24/7 to safeguard your personal information both online and off:

- **Identity Threat Detection and Alerts**
  Alerts you whenever LifeLock detects your personal information in fraudulent applications for credit and/or services within their extensive network.**
- **Reduced Pre-Approved Credit Offers**
  LifeLock will request your name be removed from pre-approved credit card offer mailing lists.
- **Advanced Internet Threat Detection**
  Patrols black market Internet sites for the illegal selling or trading of your information.
- **Address Change Verification**
  Warns you when a detected change of address is requested in your name, helping reduce your chances of mail fraud.
- **Lost Wallet Protection**
  LifeLock will help you quickly cancel and replace lost or stolen credit cards to help stop fraudulent charges.
- **24-Hour Member Support**
- **$1 Million Total Service Guarantee****

Special Pricing for Employees:

TIER	LIFELOCK MEMBERSHIP
Employee Only	$4.25/ Semi-Monthly
Employee + Spouse	$8.50/ Semi-Monthly
Employee + Children*	$7.44/ Semi-Monthly
Employee + Family*	$11.69/ Semi-Monthly

**Employee and Children and Employee and Family Tiers:*
You may enroll up to 8 children with 4 of those children between the ages of 18 and 26.

HOW TO ENROLL:

Please enroll during Open Enrollment

You must provide for yourself and each dependent you enroll:

First and Last Name, Social Security Number
Date of Birth, Address

Your LifeLock service will begin on your benefit effective date.

1 Social Security Administration. "Identity Theft And Your Social Security Number." SSA Publication No. 05-10064. August 2009.

2 Javelin Strategy & Research. "2011 Identity Fraud Survey Report." February 2011.

**Restrictions apply. See LifeLock.com/legal/terms for details. Due to New York State law restrictions, the LifeLock Service Guarantee cannot be offered to residents of New York.

LifeLock® BENEFIT SOLUTIONS

Millions of people will have their identity stolen this year.

Don't be one of them.

Protect everything you've worked for—add LifeLock® Identity Theft Protection to your benefits package during this year's annual enrollment. Identity theft is one of the fastest growing crimes in the nation.[1] When criminals steal your identity, they can ruin your good name by:

- *Opening new lines of credit*
- *Draining your savings and retirement accounts*
- *Running up utility or healthcare bills*
- *Obtaining jobs and filing fraudulent tax returns*
- *Giving your name to police when arrested*

Fortunately, your employer has elected to make LifeLock® Identity Theft Protection a part of your benefits package and available at a special rate. LifeLock® service works to safeguard your identity, 24 hours a day, seven days a week. Using advanced detection technology, our always-on service helps protect you from identity theft before it happens.

The enrollment process is as simple as checking a box during annual enrollment. Your employer has all the information we need to start protecting your identity.

Why Add LifeLock?

Real Proactive Identity Theft Protection. LifeLock can detect and help shutdown fraud as it occurs—sometimes up to 60 days sooner than credit monitoring.

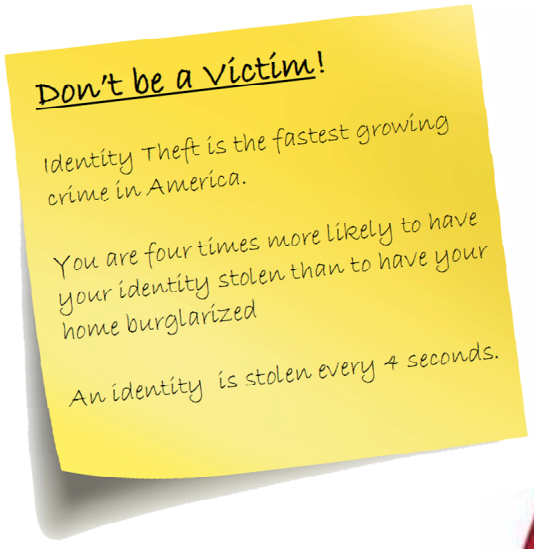
Comprehensive Safeguards. LifeLock helps stop identity thieves by protecting you online, helping protect against mail theft, helping to cancel and replace stolen credit cards, and much more.

Advanced Protection. LifeLock offers additional services, including public records monitoring, Peer-to-peer file sharing protection and credit monitoring to provide protection that's customized for your lifestyle.

24/7/365 Member Service. Identity thieves don't keep bankers' hours, so neither do we. Should you become a victim of identity theft, or just have a question, our live and domestic identity theft protection experts are ready to help.

$1 Million Total Service Guarantee.* If you become a victim of identity theft while you are a LifeLock member we will spend up to $1 million to hire experts, lawyers, investigators, consultants and whoever else it takes to help your recovery. Benefits under the Service Guarantee are being provided under a zero deductible identity theft insurance policy.**Restrictions apply. See www.LifeLock.com for details.*

Identity Theft Insurance** Identity theft insurance included with your LifeLock membership – with zero deductible – reimburses you for certain out-of-pocket expenses. ***Restrictions apply. See www.LifeLock.com for details.*



☑ **Start protecting your identity today, add LifeLock® Identity Theft Protection during enrollment.**

LifeLock® BENEFIT SOLUTIONS

Source 1: An identity was stolen on average every four seconds in 2010 based on identity fraud victim figures from: Javelin Strategy & Research. "2011 Identity Fraud Survey Report." February 2011.

Your ComPsych® GuidanceResources® Program

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. Your GuidanceResources program provides support, resources and information for personal and work-life issues. The program is company-sponsored, confidential and provided at no charge to you and your dependents. This flyer explains how GuidanceResources can help you and your family deal with everyday challenges.

Confidential Counseling

3 Session Plan

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by GuidanceConsultants℠—highly trained master's and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling (up to 3 sessions per issue per year) and other resources for:

- Stress, anxiety and depression
- Relationship/marital conflicts
- Problems with children
- Job pressures
- Grief and loss
- Substance abuse

Financial Information and Resources

Discover your best options.

Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- Getting out of debt
- Credit card or loan problems
- Tax questions
- Retirement planning
- Estate planning
- Saving for college

Legal Support and Resources

Expert info when you need it.

Talk to our attorneys by phone. If you require representation, we'll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts

Work-Life Solutions

Delegate your "to-do" list.

Our Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:

- Child and elder care
- Moving and relocation
- Making major purchases
- College planning
- Pet care
- Home repair

GuidanceResources® Online

Knowledge at your fingertips.

GuidanceResources Online is your one stop for expert information on the issues that matter most to you...relationships, work, school, children, wellness, legal, financial, free time and more.

- Timely articles, HelpSheets℠, tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Child care, elder care, attorney and financial planner searches

Free Online Will Preparation

Get peace of mind.

EstateGuidance® lets you quickly and easily write a will on your computer. Just go to www.guidanceresources.com and click on the EstateGuidance link. Follow the prompts to create and download your will at no cost. Online support and instructions for executing and filing your will are included. You can:

- Name an executor to manage your estate
- Choose a guardian for your children
- Specify your wishes for your property
- Provide funeral and burial instructions

ONEAMERICA®

OneAmerica is the marketing name for American United Life Insurance Company(R) (AUL). AUL markets ComPsych services. ComPsych Corporation is not an affiliate of AUL and is not a OneAmerica company.

Travel Assistance Services
provided by Europ Assistance USA

Emergencies can happen away from home – now there are certain services available when you travel.
When an emergency occurs, especially when traveling, you need help that is fast and simple. With a phone call to Europ Assistance USA (EA-USA), you, your spouse, domestic partner and dependent children[1] can get access to the programs and services offered by EA-USA.

The travel assistance services are being offered to covered persons under American United Life Insurance Company®'s (AUL) group life insurance contracts under a program provided by EA-USA. EA-USA provides access to worldwide 24-hour medical and transportation services to covered persons who are traveling, business or personal, 100 or more miles away from home during a covered trip.[2] EA-USA can also provide Pre-Trip Assistance services to help prepare and plan for a covered person's trip.

The program and services provided by EA-USA are being offered to covered persons under most AUL group life insurance policyholders at no additional premium cost to the covered policyholder.[3]

Covered persons have access to numerous travel assistance services offered by EA-USA and these services are further outlined in EA-USA's brochure.[4] (Refer to the EA-USA brochure located at www.europassistance-usa.com for a complete listing of services.)

Should a covered person desire to utilize the travel assistance services of EA-USA, the covered person will first need to do the following:

1. Call an EA-USA representative at the dedicated toll-free line at **1-866-294-2469**.
2. Provide contact name and phone number of the covered policyholder.
3. Allow EA-USA to verify the covered person's eligibility.

For more information on the services offered under EA-USA's Travel Assistance program, an EA-USA representative can be contacted at **1-866-294-2469** or online at www.europassistance-usa.com.[5]

Please see back of document for footnotes.

1. *The definition of a spouse, domestic partner and children will be the definition found in AUL's group life insurance contract, form number(s) G-150, G-212, G-303, G-2400 (Trust and Direct), G-2410, G-2411, G-2412, G-2413, G-2414, G-2415, G-2416, G-2417, G-2500, G-2502, G-2525, G-2526, G-2510, G-2511, G-2535, G-2536.*

2. *EA-USA offers and administers the program and services in most countries. However, conditions and events such as force majeure, war, natural disasters or political instability may occur or exist that render assistance services difficult or impossible in some areas. Therefore, availability of services cannot always be guaranteed or offered. A "covered trip" is defined as a business or pleasure trip of not more than 90 days in length.*

3. *A "covered person" is an individual, who receives coverage under a covered policyholder's AUL group life insurance contract and the individual's spouse, domestic partner and children. A covered person does not include an individual who has been approved for continuation of insurance or portability benefits, an individual insured under AUL's 2+ Protector contract or an individual insured under AUL's Voluntary Universal Life insurance contract. The program and services are not offered or available to individuals who are not covered persons and may be terminated or discontinued at any time.*

4. *Eligibility must always first be verified by EA-USA through the covered policyholder's designated contact.*

5. *All services must be arranged by EA-USA who is wholly responsible for provision and administration of the program. In all cases, the service and payments must be arranged, authorized, verified and approved in advance by EA-USA. AUL should not be contacted to discuss, arrange or schedule services.*

? Did you know?

+ Europ Assistance had over 62 million telephone calls in 2007 (two calls per second) and 12.5 million assistance cases (one case every two seconds).

++ In 2006, we performed our 150,000,000th assistance case.

Why Europ Assistance?

What is Europ Assistance USA?

We are the US office of Europ Assistance, the company that created the concept of Travel Assistance 45 years ago. Travel Assistance helps you if you are faced with an emergency when traveling. With a local network providing support in virtually all countries in the world, EA is here to assist you 24 hours a day.

In a life-threatening situation, should I call local authorities or Europ Assistance USA?

In the event of a life-threatening emergency, please first call the local emergency authorities to receive immediate assistance, and then contact Europ Assistance USA.

I have medical insurance. Why do I need travel assistance as well?

EA has the resources to help you medically and financially in case of a travel emergency. Even the best health insurance companies do not have an out of area network comparable to EA. EA's network is both domestic and international. EA monitors your medical condition to make sure you receive proper care. EA can help you find an appropriate medical facility or transport you to one if necessary. On the financial side, even if your medical insurance provides complete overseas coverage, you will most likely have to pay up front for medical services. EA can in many cases provide the necessary guarantee of payment, saving you from having to pay expenses out of pocket.

Contact Us

Europ Assistance USA is here to help you 24 hours a day in the event of an emergency.

When you call, please be ready to provide:
**The name of your employer
**A phone number where we may reach you

US/Canada: 1 866 294 2469

From other locations call collect:

+1 240 330 1509

Email OPS@europassistance-usa.com

E-Services: www.europassistance-usa.com

Username: AUL

Password: travel411

4330 East-West Highway, Suite 1000 - Bethesda, MD 20814 - USA
www.europassistance-usa.com

G-21373

Your Travel Assistance Program

Your guide to safe travel

Emergencies happen, but help is now only a phone call away.

Europ Assistance USA (EA) provides 24 hour services that can help you access emergency assistance when you are traveling 100 or more miles away from home. Europ Assistance USA is there when a crisis strikes to help you obtain the care and attention you need.

Over 850,000 multilingual service professionals stand ready to assist you in 200 countries and territories worldwide.

Key Services:

Medical Search and Referral
EA will assist you in finding physicians, dentists, and medical facilities.

Medical Monitoring
During the course of a medical emergency, professional case managers, including physicians and nurses, will monitor your case to determine whether the care is appropriate or if evacuation/repatriation is required.

Emergency Evacuation/Medically Necessary Repatriation
In the event of a medical emergency, when a physician designated by EA determines that it is medically necessary for you to be transported under medical supervision to the nearest hospital or treatment facility or be returned to your place of residence for treatment, EA will arrange, and arrange payment for the transport under proper medical supervision.

Dependent Children Assistance
If any dependent children under the age of 18 traveling with you are left unattended because you are hospitalized, EA will arrange, and arrange payment for their economy class transportation home. Should transportation with an attendant be necessary, EA will arrange for a qualified escort to accompany the children.

Visit by Family Member/Friend
If you are traveling alone and must be or are likely to be hospitalized for seven consecutive days, EA will arrange, and arrange payment for round-trip transportation for one member of your immediate family, or one friend designated by you, from his or her home to the place where you are hospitalized.

Repatriation of Remains
In the event of your death while traveling, EA will arrange, and arrange payment for all necessary government authorization, including a container appropriate for transportation and for the return of the remains to place of residence for burial.

Traveling Companion Assistance
If a travel companion loses previously-made travel arrangements due to your medical emergency, EA will arrange for your traveling companion's return home.

Replacement of Medication and Eyeglasses
EA will arrange to fill a prescription that has been lost, stolen or requires a refill, subject to local law, whenever possible. EA will also arrange for shipment of replacement eyeglasses. Costs for shipping of medication or eyeglasses, or a prescription refill, etc. are your responsibility.

Vehicle Return
EA will arrange, and arrange payment for the return of the vehicle left unattended to your domicile or place of rental if you become physically unable to operate any non-commercial vehicle (i.e., auto, motorhome, rental car, etc.) as a result of a medical emergency. The vehicle must be in good driving condition and capable of being driven on the highway in compliance with local laws. You will not be reimbursed for services provided to you at no cost.

Emergency Travel Arrangements
If appropriate, EA will make new travel arrangements or change airline, hotel, and car rental reservations.

Emergency Cash
EA will advance up to $500 after satisfactory guarantee of reimbursement from you. Any fees associated with the transfer or delivery of funds are your responsibility.

Locating Lost or Stolen Items
EA will assist in locating and replacing lost or stolen luggage, documents, and personal possessions.

Legal Assistance/Bail
EA will locate an attorney and advance bail bond, where permitted by law, with satisfactory guarantee of reimbursement from you. (You pay attorney fees).

Interpretation/Translation
EA will assist with telephone interpretation in all major languages or will refer you to an interpretation or translation service for written documents.

Pre-Trip Information
EA offers a wide range of informational services before you leave home, including: Visa, Passport, Inoculation and Immunization Requirements, Cultural Information, Temperature, Weather Conditions, Embassy and Consulate Referrals, Foreign Exchange Rates, and Travel Advisories

Who is eligible for these services?
Individuals who receive coverage under American United Life Insurance Company®'s product offerings and their spouses, domestic partners and children are eligible for these services once coverage has been verified. Pre-trip informational services are available at any time. All other services take effect when you are on a trip 100 miles or more from home lasting 90 days or less.

How is coverage verified?
EA does not receive names of individual covered members. When you call, EA will verify eligibility through your employer's designated contact person. There may be circumstances in which EA reasonably believes that a sick or injured person is a Covered Member, but cannot verify participation through the employer's designated contact person. If your employer does not inform EA of eligibility status within 24 hours from EA's initial verification inquiry and you claim to be a covered member, then EA shall have the right, but not the obligation, to consider you a Covered Member. Before providing any services deemed appropriate by EA, EA will request payment from you or from a member of your family or friend.

Who is responsible to pay for these services?
After your coverage has been verified, EA will arrange, and arrange payment for the following subject to the policy limits and guidelines:
- Emergency Evacuation: $150,000 Combined Single Limit (CSL)
- Medically Necessary Repatriation: Included in CSL
- Repatriation of Remains: Up to $15,000

If traveling alone:
- Visit of Family Member or Friend: Up to $5,000
- Return of Dependent Children under Age 18: Up to $5,000
- Return of Vehicle: Up to $2,500

If EA is unable to verify your coverage, you must provide proper guarantee of payment prior to EA incurring third party expenses.

Conditions and Exclusions:
All transportation related services, coverages and payments must be arranged and pre-approved by EA. EA shall not provide services enumerated if the coverage is sought as a result of: suicide or attempted suicide; intentionally self-inflicted injuries; participation in any war, invasion, acts of foreign enemies, hostilities between nations (whether declared or not) or civil war, rebellion, revolution, and insurrection, military or usurped power; participation in any military maneuver or training exercise; traveling against the advice of a Physician; traveling for the purpose of obtaining medical treatment; traveling in any country in which the U.S. State Department issued travel restrictions; piloting or learning to pilot or acting as a member of the crew of any aircraft; mental or emotional disorders, unless hospitalized; being under the influence of drugs or intoxicants unless prescribed by a Physician; commission or the attempt to commit a criminal act; participation as a professional in athletics or underwater activities; participating in bodily contact sports; skydiving; hang gliding; parachuting; mountaineering; any race; bungee cord jumping; speed contests; spelunking or caving, heliskiing, extreme skiing; dental treatment except as a result of accidental Injury to sound, natural teeth; any non-emergency treatment or surgery, routine physical examinations, hearing aids, eyeglasses or contact lenses; pregnancy and childbirth (except for complications of pregnancy); curtailment or delayed return for other than covered reasons; services not shown as covered; travel within 100 miles of your permanent residence, unless in a foreign country, or travel in a foreign location in excess of 90 days for any one trip. EA reserves the right to suspend, curtail or limit its services in any area in the event of rebellion, riot, military uprising, war, labor disturbances and strikes, nuclear accidents, acts of God, or refusal of the authorities in the country of assistance to permit EA to fully provide services. EA will however, endeavor to provide services to the best of its ability during any such occurrence. The medical professional and/or attorneys suggested and/or designated by EA and/or providing services on behalf of EA are not employees of EA and, therefore, EA is not responsible or liable for their negligence or other acts or omissions.

Available 24 hours a day

From the US and Canada: 1 866 294 2469

From other countries +1 240 330 1509 (call collect)