

# **Voluntary Group Term Life Insurance Program**

**For Employees and Families of  
School District of Litchfield**

- **Affordable Cost - High Limit Coverage**
- **Dependent Coverage Available**
- **Guaranteed Acceptance Amounts for Employee, Spouse and Dependent Children**
- **Conversion and Portability Provisions**
- **Living Benefit**

**VOLUNTARY GROUP TERM LIFE INSURANCE:**

This plan offers you and your dependents an excellent opportunity to purchase affordable group term life insurance on a payroll deduction basis. The important plan features including high limits, guaranteed acceptance, conversion, portability rights and the Living Benefit Rider are summarized in this brochure. Please review it carefully and make your selection.

**ELIGIBILITY:** All active full-time employees who are working a minimum of 35 hours per week are eligible to participate. Employees hired after July 1, 2005 must complete 30 days of continuous employment prior to enrollment. Insurance is also available for a spouse under age 70 of an eligible employee. For eligible employees who have an "Affidavit of Domestic Partnership" on file with the School District of Litchfield, the word "spouse", as it appears in this brochure, will be deemed to include a domestic partner.

Unmarried eligible dependent children from 14 days to 20 years of age or to age 26 if a full-time student may be insured if the employee or spouse is insured. Spouse insurance terminates at age 75; dependent children's at age 20, or 26 if a full-time student.

**BENEFITS:** You and your spouse may select an amount of insurance from a minimum of \$10,000, in increments of \$10,000. The maximum amount available to employees up to age 75, and to their spouses under age 70, is \$500,000.

Eligible dependent children age 14 days to 6 months may be covered for \$1,000 and for your choice of \$2,500, \$5,000, \$7,500 or \$10,000 from 6 months to age 26.

Reduction: If this insurance is purchased prior to age 75, the amount of insurance will be reduced in accordance with the table below on the anniversary date coinciding with or next following your last birthday.

At Age	Reduction To % Of Your Pre-Age 75 Amount Of Insurance
75	60%
80	35%
85	27.5%
90	20%
95	7.5%
100	5%

Neither you nor your spouse may hold more than a total of \$500,000 of group term life insurance with Reliance Standard Life Insurance Company (hereinafter "RSL") under the master policy. Insurance over that amount will be void and the premiums refunded.

**GUARANTEED ISSUE:** During an approved enrollment period, you must be an eligible employee who is actively performing all the regular duties of your occupation to enroll. You must complete, sign

and return the application to your employer during the enrollment period. As long as you have not: been previously declined for insurance coverage by RSL; had your coverage postponed; had your application withdrawn; or voluntarily terminated your insurance with RSL, medical evidence will not be required:

- if you are newly eligible and apply (within 31 days of becoming eligible) for an amount of insurance up to \$60,000 if you are under age 60 when you apply, or \$10,000 if you are between age 60 and 70 when you apply.

- if you were previously eligible and are now applying for initial or additional coverage of \$10,000, as long as your new total amount of insurance is no greater than \$60,000 if you are under age 60 when you apply, or \$10,000 if you are between age 60 and 70 when you apply.

- if you report a life event change that occurred since the last enrollment (such as marriage, birth or specific changes of employment status) and apply, within 31 days of the life event, for an amount of insurance up to \$60,000 if you are under age 60 when you apply, or \$10,000 if you are between age 60 and 70 when you apply.

Your spouse under age 60 is eligible for \$20,000 of guaranteed issue coverage provided you apply for at least \$50,000 of coverage. Your spouse must apply within 31 days of becoming eligible, and if employed, must be actively performing all the regular duties of his/her occupation; if not employed, must be engaged in normal activities for a person of like age and sex.

No medical evidence is required on dependent children.

**EFFECTIVE DATE:** Coverage for amounts up to the guaranteed issue limit will begin on: (1) the latter of (a) the date the application is signed or (b) July 1, 2005, for employees employed prior to July 1, 2005; or (2) the first day of the month following the date the application is signed, for employees employed on or after July 1, 2005; provided applicable premium is paid and any service waiting period has been satisfied. **Applications for insurance amounts over the guaranteed issue limits (for employees under age 70 and spouses under age 60), any amounts for employees age 70 and over and spouses age 60 but less than 70, and applications made beyond the first 31 days of becoming eligible are subject to medical evidence submitted to and approved by RSL.** Insurance will become effective on: (1) the latter of (a) the date the application is approved, or (b) July 1, 2005, for employees employed prior to July 1, 2005; or (2) the first day of the month following the date the application is signed, provided RSL agrees to insure each applicant, for employees employed on or after July 1, 2005; provided applicable premium is paid and any service waiting period has been satisfied. De-

pendent children coverage will begin on: (1) the latter of (a) the date the application is signed, or (b) July 1, 2005, for employees employed prior to July 1, 2005; or (2) the first day of the month following the date the application is signed, for employees employed on or after July 1, 2005, provided you or your spouse are insured for this coverage and your dependent children are not confined in a hospital or at home.

**Non-guaranteed issue amounts are not effective until approved by RSL. Payroll deduction of premiums for non-guaranteed issue coverage prior to such approval does not mean coverage is effective.** If coverage is not approved, any premium that has been collected will be returned.

**LIVING BENEFIT:** This benefit is designed to offset the high cost of medical care if you, your insured spouse or insured dependent children should become terminally ill. It provides an advance payment of 50% of the death benefit to a maximum of \$250,000.

Coverage must be in-force for 60 days prior to being diagnosed as terminally ill. An insured will be considered as terminally ill if he/she suffers from a physical condition which is certified by a physician to be expected to result in death within 12 months. In the event of death, the death benefit payable to the beneficiary will be reduced by the amount of any living benefit payment that was made. This benefit is payable one time only for any insured covered under this benefit. In no event will the amount of the living benefit plus the death benefit payable exceed the amount that would be payable if no living benefit was available.

**DISABILITY WAIVER OF PREMIUM:** All premiums due during your disability will be waived for you and your dependents if you become totally disabled prior to age 60 and disability lasts for six consecutive months. Premiums will be refunded back to the date disability began. Your coverage will remain in force without any premium payments as long as your disability continues, you are under age 70 and you are not retired. This benefit is not available for disabilities resulting from intentionally self-inflicted injury or war (declared or undeclared).

**EXCLUSIONS AND LIMITATIONS:** Death by suicide is not covered during the first two years insurance is in force. Insurance coverage is incontestable after it has been in force two years during the insured's lifetime, except for non-payment of premium.

**PREMIUM:** The semi-monthly premium for the amount of group term life insurance coverage you select for yourself, your spouse, and dependent children is payable through the convenience of payroll deduction. The following chart shows the semi-monthly premium cost per \$10,000 unit of life

insurance coverage, by age bracket and smoking status.

To determine your premium, take your smoking status and age at your last birthday, find the rate in the following chart per \$10,000 unit of life insurance, and multiply that rate by the number of \$10,000 units you desire. Do the same thing for your spouse at his/her age for the number of units desired. If you have used any form of tobacco in the last 12 months, you will be considered a smoker.

Your eligible children may be provided \$1,000 of coverage between 14 days and 6 months of age and your choice of \$2,500, \$5,000, \$7,500 or \$10,000 of coverage between 6 months and age 26. The cost semi-monthly, regardless of the number of children, is determined by the age 6 months to age 26 benefit option you select as follows:

Dependent Children (6 months to age 26 Benefit)	Semi-Monthly Cost
\$ 2,500	\$ .21
5,000	.41
7,500	.61
10,000	.81

Newborn children automatically become insured at 14 days of age if you insure other dependent children.

#### SEMI-MONTHLY PREMIUM RATES PER \$10,000 OF LIFE INSURANCE

Age (last birthday as of the anniversary date)	Smoker Rate	Non-Smoker Rate
Under Age 30	\$.40	\$.24
30-34	.49	.25
35-39	.74	.35
40-44	1.23	.57
45-49	2.08	.97
50-54	3.45	1.63
55-59	5.34	2.84
60-64	5.96	3.61
65-69	8.14	5.50
70 and Over*	14.72	10.75

\* Note: For insureds age 75 and older, the above rates are equivalent to per \$10,000 of coverage in effect prior to age 75.

#### EXAMPLE:

	Amount of Insurance	Semi- Monthly Cost
Employee - 33 (Smoker)	\$50,000	\$ 2.45
Spouse - 28 (Non-Smoker)	30,000	0.72
Three Children - 6 months to age 26	2,500	.21
<b>Total Semi-Monthly Cost</b>		<b>\$ 3.38</b>

Semi-Monthly premium rates are based on your age at your last birthday and smoking status. They will change on the anniversary date coinciding with or next following your last birthday as you advance to a higher age bracket.

**PORTABILITY:** If you terminate employment after your coverage has started, you may elect within 31

days of termination of eligibility, to continue your group term life insurance. Premiums will be billed directly to you on a quarterly, semi-annual or annual basis as you choose and will be based on the prevailing rate charged to all insureds who choose to continue coverage under the Portability provision. Insurance for your spouse terminates at age 75.

**CONVERSION:** If premiums are not waived due to total disability, you may convert your insurance to an individual permanent life insurance policy with RSL within 31 days of termination of coverage. You may also convert if you are no longer a member of an eligible class, or if your employer no longer participates in the group insurance trust. Under these circumstances, your spouse under age 70 and your insured dependent children may also convert. For each insured child who attains the maximum age for eligibility, up to five times their current amount of life insurance coverage may be converted.

**TERMINATION:** RSL may not terminate insurance coverage unless: premium is not paid when due; or insurance coverage is converted to an individual plan of insurance; or the maximum age is attained; or the Master Policy terminates.

In addition to the above, insurance coverage on dependents may also be terminated when the dependent is no longer eligible.

**BENEFICIARY DESIGNATION:** You can designate your own beneficiary and you may change the designation (except an irrevocable designation) as your circumstances change. You will be the beneficiary for dependent coverage unless another person is designated.

**IT IS EASY TO APPLY:** Complete the application following the instructions.

This brochure describes the highlights of Group Term Life Master Policy Form Number LRS 8349-01-1188, but is not a contract. If a conflict exists between a statement in this brochure and any provision in the Policy, the Policy will govern. The Master Policy has been issued to a Rhode Island Trust and is subject to Rhode Island law.

Underwritten By:

**RELIANCE STANDARD**  
Life Insurance Company

Home Office: Chicago, Illinois  
Administrative Office: Philadelphia, Pennsylvania

## NOTICE REGARDING INFORMATION PRACTICES

In considering this Application, Reliance Standard Life Insurance Company (herein referred to as we, us, or our) collects certain information about all proposed insureds (herein referred to as you, your, or yours). The precise information varies according to the amount and type of coverage you apply for. Generally, we seek information about you: (1) age; (2) occupation; (3) physical condition; (4) medical history; (5) hobbies; and (6) other relevant activities.

You are our most important source of information, but we may also verify or collect information on you or your family from: (1) physicians; (2) other health care providers; (3) employers; (4) other insurers to which you have applied; (5) consumer investigative organizations; and (6) the Medical Information Bureau (herein referred to as MIB).

The MIB is a non-profit organization of life insurance companies which operates an information exchange for its members. This information may alert us to a need for further investigation, but under MIB rules such information cannot be used: (1) either wholly or in part to increase the premium for insurance; or (2) to deny issuance of insurance.

We may collect information by: (1) phone; (2) correspondence; or (3) personal contact.

Information will be treated as confidential. Reliance Standard Life Insurance Company or its reinsurers may, however, with your authorization make a brief report to the MIB. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. The information supplied to other member companies may alert them to a need for further investigation.

In some circumstances, however, information may be released to third parties without your authorization (with the exception of the MIB). These include persons or organizations who are: (1) performing business functions for us; (2) conducting actuarial or scientific studies or audits; (3) our reinsurers; or (4) other insurers to which you have applied. Please be assured that although such disclosures may occur, they are not always or even often made. When a disclosure is necessary, only as much information as is reasonably necessary to achieve the intended purpose will be disclosed.

You have the right to acquire and, if necessary, correct any personal information we or the MIB collect. Upon written requests to us, we will, within thirty (30) days of receipt: (1) inform you of the nature and substance of the recorded information; (2) permit personal viewing and copying of the information in our possession; (3) disclose the identities of those persons such information has been disclosed to within the last two years; and (4) provide you with procedures for correction, amendment or deletion of the recorded information. Medical information will be disclosed to a physician that you choose. You may write to us for a fuller explanation of our information practices.

You may also contact the MIB directly by writing to Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660 to arrange for disclosure of any information on you. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

**A** Applicant's Name (First-Middle-Last)  Male  
 Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ State of Birth \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_ Date Hired \_\_\_\_\_

Amount of Coverage Applied For \$ \_\_\_\_\_

Initial Application (with RSL)

Change in Amount of Coverage (with RSL)

Total Amount with Change \$ \_\_\_\_\_

**Name of Beneficiary and Relationship**

\_\_\_\_\_

**B** Are you actively performing all the duties of your occupation or profession?  YES  NO  
IF NO, EXPLAIN.

\_\_\_\_\_

Have you used tobacco in any form in the past twelve months?  YES  NO

Is this insurance now applied for intended to replace, in whole or in part, any insurance on the life of the applicant, spouse or dependent children?  YES  NO

IF YES, PROVIDE NAME OF COMPANY AND AMOUNT OF INSURANCE.  
\_\_\_\_\_

**Guaranteed Issue Amounts -**

Initial Enrollment or Newly Eligible:

Employee Under Age 60: \$60,000.00

Employee Age 60 to 70: \$10,000.00

Spouse Under Age 60: \$20,000.00 (provided the employee applies for at least \$50,000.00)

**D** Spouse's Name (First-Middle-Last)  Male  Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ State of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Has your spouse used tobacco in any form in the past twelve months?  YES  NO

Amount of Coverage Applied For \$ \_\_\_\_\_

Initial Application (with RSL)

Change in Amount of Coverage (with RSL)

Total Amount with Change \$ \_\_\_\_\_

**Eligible Dep. Children Coverage:**  YES  NO

**If Dependent Children are to be covered, please select an amount below:**

All children age 14 days to 6 months: \$1,000

All children age 6 months to 26 years:

\$2,500  \$5,000  \$7,500  \$10,000

Name of Beneficiary: (Unless otherwise listed below, Employee is automatically the Beneficiary for Spouse and Dependent Children Insurance.)

**Name of Beneficiary and Relationship**

\_\_\_\_\_

**C** Have...You or your spouse had; been told you had/have; or been treated for any of the following within the past five years:

**1** Consultation with any physician or received any medical care, treatment or advice?  YES  NO

**2** To the best of your knowledge, any physical impairment or disease?  YES  NO

**3** AIDS, AIDS related complex, or disorder of the immune system?  YES  NO

**4** A disease of the nervous, genitourinary or digestive systems, heart or lungs, high blood pressure, diabetes, cancer or a tumor of any kind?  YES  NO

If you answered YES to any of the questions in Section C, give details in #5 below.

5 Question #	Person to Whom It Applies	Illness or Nature of Injury	Date	Doctor's Full Name and Address

**HOW TO APPLY:**

COMPLETE IN INK. PLEASE PRINT OR TYPE ALL INFORMATION, WITH THE EXCEPTION OF SIGNATURES.

1. For the Guaranteed Issue Amount, complete Sections A and B.

2. If you desire coverage in excess of the Guaranteed Issue Amount, or you are a late enrollee, complete Sections A, B and C.

3. If you desire coverage on your spouse only and/or your children, complete all Sections of the application.

4. Please sign and date the back of this application.

5. Return the application to your personnel office for processing.

**NOTE:** Coverage is available for domestic partners of eligible employees who have an "Affidavit of Domestic Partnership" on file with the School District of Litchfield. The word "spouse", as it appears in this application, will be deemed to include "domestic partner".

FOR HOME OFFICE ADMINISTRATIVE USE ONLY:

Billing Date \_\_\_\_\_

- **I REPRESENT** that to the best of my knowledge and belief each of the statements and answers is complete and true. I understand that the guaranteed amount of insurance for which I am applying will become effective on: (1) the latter of (a) the date the application is signed or (b) July 1, 2005, for employees employed prior to July 1, 2005; or (2) the first day of the month following the date the application is signed, for employees employed on or after July 1, 2005. I further understand that any amount of insurance for which I am applying which is above the guaranteed amount will be effective on: (1) the latter of (a) the date the application is approved by the Insurance Company or (b) July 1, 2005, for employees employed prior to July 1, 2005; or (2) the first day of the month following the date the application is signed, provided the Insurance Company agrees to insure me, for employees employed on or after July 1, 2005.
- **I CERTIFY** that I am an employee of the sponsoring organization or otherwise meet the eligibility requirements for applying for this insurance.
- **I AUTHORIZE** my employer to deduct the applicable premium from my salary as consideration for Term Life Insurance on me and/or my family issued by RELIANCE STANDARD LIFE INSURANCE COMPANY. I understand coverage will be effective as stated above, provided premiums are paid and service waiting periods are satisfied, as applicable. I authorize you to adjust these deductions based on underwriting changes, or rate changes resulting from age changes. During the continuance of this agreement, my employer will forward the premium to the Insurance Company as it falls due. This authorization may be revoked by me by written notice to my employer.
- **I ACKNOWLEDGE** receipt of the "Notice Regarding Information Practices".
- **I AUTHORIZE** any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, organization, institution, person or the Medical Information Bureau (MIB) to release any information or record(s) on me or my health to be used in determining the acceptability of my application for insurance. I authorize any such information or record(s) to be released to Reliance Standard Life Insurance Company, its reinsurers or authorized representatives. I also authorize Reliance Standard Life Insurance Company or its reinsurers to make a brief report to the MIB. This Authorization, or a photographic copy, shall be as binding as the original and valid for a period not exceeding twelve (12) months from this date. I understand that I may elect to be interviewed if an investigative consumer report is to be prepared in connection with this application and that I am entitled to a copy thereof. I further understand that I am entitled to receive a copy of this Authorization upon request.
- **PLEASE NOTE:** During an open enrollment, applications for amounts of insurance up to the guaranteed issue limit will not require medical evidence provided this application is complete, signed and received by your employer during the open enrollment and the applicant was not previously declined for insurance coverage by Reliance Standard Life Insurance Company, postponed, had an application withdrawn or voluntarily terminated insurance with Reliance Standard Life Insurance Company.
- **Please review the front of the application for completeness before signing. Incomplete sections may cause coverage to be delayed or declined.**

Signature	X _____	_____
	Applicant	Date
	X _____	_____
	Spouse (only if coverage on spouse is requested)	Date

• **REQUEST TO WAIVE COVERAGES OFFERED**

I certify that I have been advised of the features and benefits of the program offered to me through my employer and have decided not to participate.

_____	_____
EMPLOYEE SIGNATURE	DATE