Mosse & Mosse Associates
Corporate Benefit Consultants
AN NFP COMPANY
50 Salem St., Bldg B • Lynnfield, MA 01940
Phone: 781-224-1709 • Fax: 781-224-1724
www.mosseandmosse.com

Shrewsbury Public Schools
New Hire Disability Program Outline

- *Guaranteed Issue. The benefit is a guaranteed issue product for new hires, meaning you cannot be denied access to the plan for any reason if you sign up for the program in the first 30 days from your hire date. However, if you do not elect the coverage during this period and then wish to join the plan at a later date, you have to prove evidence of insurability and you may be denied access to the plan.*

- Benefit: 60% of gross pay to a maximum of $6,000 per month. All benefits will be paid tax free, both federal and state, because the employees are paying the premium.

- **Elimination Period: Either 30 or 90 Calendar days.** This is the length of time that one has to be out of work before collecting benefits. Employees can choose either a 30 day or 90 day elimination period on the attached enrollment form.

- Benefit Duration: benefits payable for disability to age 65/SSNRA (age 60 and older follow ADEA schedule, see attached).

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

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

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

- Integration/Minimum benefit: plan offsets with workers' compensation social security and disability retirement awards. Minimum benefit is $100 per month.

- Own Occupation to age 65. This is the definition of disability and states when an individual is considered disabled. This definition states that an individual is disabled if he or she is unable to perform one of the material and substantial duties of his or her own occupation.

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

When do potential benefit payments begin?

We have two elimination period options for our staff, either 30 calendar days or 90 calendar days. The elimination period is the length of time that an employee would need to be out before they are eligible to apply for benefits.

How much does the plan cost?

The rates for our program are the most competitive in the marketplace for the benefits in our contract.

Age Band	Rates with 30 Day Elimination Period	Rates with 90 Day Elimination Period
< 24	$0.19	$0.14
25-29	$0.52	$0.20
30-34	$0.52	$0.24
35-39	$0.54	$0.32
40-44	$0.70	$0.44
45-49	$0.99	$0.68
50-54	$1.33	$0.97
55-59	$1.49	$1.16
60-64	$2.60	$1.25
65-69	$3.40	$1.21

Formula for individual cost:

Annual Salary / $100 x Rate = Annual Premium

Annual Premium / pay period = Cost/pay

Cost Example: Age 45, earning $50,000, 90 Day Elimination Period Plan:

$50,000 / $100 x $0.68 = $340.00 Annual Cost

$340 / 26 pays = $13.08 per pay period

How do I sign up?

If you wish to take advantage of this coverage, please complete the enrollment form by filling out your name, date of birth, check "yes" under acceptance for the plan you would like to enroll in, and sign the bottom of the form.

If you have any questions about the program or would like some additional information, please feel free to contact our consultant at Mosse & Mosse Associates, Brian Fitzgerald, at 781-224-1709 x139 or email him at brf@mosseandmosse.com.

Maximum Benefit Period

Duration of Benefit Schedule - SSNRA

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

Duration of Benefit Schedule – ADEA

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

*Maximum Benefit Period is SSNRA or ADEA whichever is greater

Voluntary Group Long Term Disability Employee Application

ASSURANT Employee Benefits

Group no. **5458996** Account no. _____ Cert no. _____

(Please print or type.)

Proposed effective date _____

Name of employer **Shrewsbury Public Schools**

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

Name _____ Social Security no. _____
LAST FIRST MI

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

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

Hours worked per week _____ Hire date _____ Job title _____

Work location _____
CITY STATE

ACCEPTANCE *(Please select one option.)*

Option #1: Benefits are eligible after completion of a 30 day elimination period

☐ **Yes,** I would like to participate in the Voluntary Group Long Term Disability Insurance plan with the **30 calendar day elimination period.**

--or--

Option #2: Benefits are eligible after completion of a 90 day elimination period

☐ **Yes,** I would like to participate in the Voluntary Group Long Term Disability Insurance plan with the **90 calendar day elimination period.**

I understand that by signing and submitting this form to elect coverage, I am authorizing payroll deductions from my salary.

REFUSAL

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

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

_____ _____
EMPLOYEE SIGNATURE DATE

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

Age _____ Premium _____ Effective date _____ Coverage amount $_____