



Request For Group Long Term Disability Insurance

Company Name: _____

Policy Number: _____

LONG TERM DISABILITY BENEFITS

Coverage Effective Date:	Rate Guarantee: <input type="checkbox"/> 12 months <input type="checkbox"/> 24 months <input type="checkbox"/> 36 months
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Employee Assistance Program:
 Would you like to include the Employee Assistance Program (EAP) in your policy? Yes No
 Important Note: There is a \$.73 per employee per month charge for this service. This charge is in addition to the insurance premium.

Eligibility: PLEASE TYPE EXACTLY AS IT SHOULD APPEAR IN THE CONTRACT (Ex. All Active Full-Time Employees)

Class 1

Class 2

Definition of Full-time Employment: Minimum number of hours for full-time eligibility _____ hrs/ wk	Number of Eligible Employees:	Number of Employee Enrolled:
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Service Waiting Period for Employees: (Applicable to employees who have not satisfied the Service Waiting Period on or before the policy effective date)
 _____ Days Weeks Months No Waiting Period
Coverage begins: 1st of the month following completion of waiting period
 Immediately upon completion of waiting period
 Other: _____

Earnings Definition:
 Salary Only W-2 K-1 Salary & Commissions** Salary & Bonuses** Salary, Commissions & Bonuses**
 **Commissions or Bonuses averaged over: 12 months 24 months 36 months

FMLA (Family Medical Leave Act): Include FMLA information in your policy? yes no

Employer Contribution: Class 1: _____ % Class 2: _____ % If employer contribution is less than 100%, employee contribution will be: <input type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax <input type="checkbox"/> Varies by employee	Will employee salaries be "grossed up" to pay for coverage? <input type="checkbox"/> yes <input type="checkbox"/> no
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***LTD Quoted Rate:**
 \$ _____ per % of salary ***Important Note: Quoted Rate(s) may be impacted based on final census rating or optional benefits chosen.**

Elimination Period: <input type="checkbox"/> 180 days <input type="checkbox"/> 90 days <input type="checkbox"/> Other _____	Maximum Period Payable (ADEA Schedule): <input type="checkbox"/> ADEA 1 <input type="checkbox"/> ADEA 2 <input type="checkbox"/> ADEA 4 <input type="checkbox"/> ADEA 5 <input type="checkbox"/> Other _____
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Benefit Amount: Class 1 <input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> other _____ to \$ _____ Class 2 <input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> other _____ to \$ _____	Minimum Benefit Guarantee: <input type="checkbox"/> \$100 or 10% of benefit <input type="checkbox"/> Other _____
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Definition of Disability (Own Occupation Period): Class 1: <input type="checkbox"/> 24 months <input type="checkbox"/> 36 months <input type="checkbox"/> 60 months <input type="checkbox"/> Age 65 Class 2: <input type="checkbox"/> 24 months <input type="checkbox"/> 36 months <input type="checkbox"/> 60 months <input type="checkbox"/> Age 65	Deductible Sources of Income (Integration Method): <input type="checkbox"/> Full Family Social Security <input type="checkbox"/> Primary Social Security <input type="checkbox"/> Other _____
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Survivor Income Benefit: <input type="checkbox"/> 3-mos. <input type="checkbox"/> 6-mos. <input type="checkbox"/> 12-mos. <input type="checkbox"/> 24-mos.	Work Incentive Benefit: <input type="checkbox"/> 12 months <input type="checkbox"/> 24 months Enhanced Work Incentive Benefit: <input type="checkbox"/> Include <input type="checkbox"/> Exclude
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Benefit Limitations & Exclusions:
 Mental Disorder: 12 month Limitation 24 month Limitation
 Substance Abuse: 12 month Limitation 24 month Limitation Full Coverage
 Self-Reported Symptoms: 12 month Limitation 24 month Limitation Full Coverage | Included Mandatory Rehabilitation: yes no

Prior Carrier Information (If applicable): No Prior Coverage **(A copy of prior plan certificate must accompany the Request for Insurance)**

Name of Prior Carrier	Policy Termination Date	How long was the coverage in force?
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Additional LTD Benefits

The following are Additional LTD Benefits that may be added to your policy. Addition of these benefits may increase your final rate.
Please contact your local sales office representative for expanded explanations of these benefits.

Additional Benefits	
Presumptive Disability Benefit: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> without paralysis or <input type="checkbox"/> with paralysis	
LTD Conversion Benefit: <input type="checkbox"/> Yes <input type="checkbox"/> No	Education Benefit: <input type="checkbox"/> Yes <input type="checkbox"/> No Benefit Amount: <input type="checkbox"/> \$100, <input type="checkbox"/> \$200, <input type="checkbox"/> Other
COLA Benefit (Cost of Living Adjustment): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Annual increase matches CPI-W <input type="checkbox"/> Flat Annual Percentage Increase -- <input type="checkbox"/> 3% (standard) or <input type="checkbox"/> Other Maximum number of adjustments <input type="checkbox"/> 2 years , <input type="checkbox"/> 5 years or <input type="checkbox"/> 10 years	
(Not available in NJ or CT) Optional Catastrophic Employee Disability Benefit: <input type="checkbox"/> Yes <input type="checkbox"/> No Benefit percentage: <input type="checkbox"/> 10%, <input type="checkbox"/> 20%, <input type="checkbox"/> 30% or <input type="checkbox"/> 40% Note: Respite Care Benefit is not available in CA	(Not available in NJ, CT, VT or CA) Optional Catastrophic Spousal Disability Benefit: <input type="checkbox"/> Yes <input type="checkbox"/> No Benefit Amounts: <input type="checkbox"/> \$500, <input type="checkbox"/> \$1,000, <input type="checkbox"/> \$1,500 or <input type="checkbox"/> \$2,000
Business Protection Benefit: <input type="checkbox"/> Yes <input type="checkbox"/> No (only available on groups of 250 employees or less) Maximum Period Payable <input type="checkbox"/> 12 months or <input type="checkbox"/> Other	
LTD Accidental Death & Dismemberment Benefit: <input type="checkbox"/> Yes <input type="checkbox"/> No Principal Sum: <input type="checkbox"/> 1, <input type="checkbox"/> 2 or <input type="checkbox"/> 3 times annual insured salary	
Supplemental Pension Accrual Benefit: <input type="checkbox"/> Yes <input type="checkbox"/> No Benefit Amount: <input type="checkbox"/> 1%, <input type="checkbox"/> 2%, <input type="checkbox"/> 3% or <input type="checkbox"/> Other (Not available for 401(k) plans, 403 (b) plans or other similar plans) (% of average monthly earnings)	