Liberty Mutual Insurance | Group Benefits

East China School District

All Full-Time Superintendent, Assistant Superintendents and Executive Directors

This kit contains everything you need to enroll in your group benefits from Liberty Mutual Insurance*. This kit contains information about the following products:

Product Summary

1. Long-Term Disability
2. Life and AD&D Insurance

Capitalized terms in this enrollment kit are defined in the policy, certificate, and/or schedule of benefits. Please refer to these documents for definitions and details. If any conflict exists between these documents and this enrollment kit, the terms of the policy, certificate, and schedule of benefits will prevail.

*Liberty Mutual Insurance is the marketing brand for Liberty Mutual Group and its related subsidiaries.

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I. Disability Benefit Summaries

Your major medical plan may cover many of the costs associated with a disease or an illness. But the financial impact of not being able to work for an extended period can be devastating. Disability Income insurance provides partial income replacement if you are Disabled following a qualifying Sickness or Injury.

Provision	Long-Term Disability
Eligible Class	All Full-Time Superintendent, Assistant Superintendents and Executive Directors
Minimum Hours Per Week – minimum hours of work per week to be eligible for coverage	30 regularly scheduled hours
Benefit Amount – specified dollar amount or percentage of your salary you will receive less Other Income Earnings and Other Income Benefits	60% of Monthly Earnings up to $7,000 per month
Employee Contributions	No, 0%
Definition of Disability – criteria for determining benefits eligibility	24 months of Own Occupation, then Any Occupation thereafter
Evidence of Insurability (EOI) – proof of your medical history upon which acceptance for insurance will be determined by Liberty	None
Eligibility Waiting Period – period of time or date on which you are eligible for coverage	First of the month coincident with or next following date of hire
Elimination Period – period of days of Disability after which benefits are payable	90 days (180 day accumulation period)
Maximum Benefit Period – period of time benefits are payable	Reducing Benefit Duration w/ SSNRA
Successive Period of Disability – a disability claim may be reinstated for the same disability if you return to work for no more than a specified period of time	6 months
Survivor Benefit – pays a specified benefit to an Eligible Survivor	3 months
Pre-Existing Condition Limitation - See Summary of Limitations and Exclusions below	3 months prior 12 months after
Conversion – ability to convert to another group policy if employment terminates	None

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SUMMARY OF LIMITATIONS/EXCLUSIONS

1. You must be actively at work on the effective date of your coverage. You must be legally working in the United States.

2. The policy may contain limitations for certain conditions including Mental Illness, Substance Abuse, Chronic Fatigue Conditions, Nonverifiable Symptoms, Musculoskeletal, and Connective Tissue Disorders.

3. Benefits are not payable for any person's disability caused by, contributed by, or resulting from: war, declared or undeclared, or any act of war; intentionally self-inflicted injuries, commission of or attempt to commit a felony, active Participation in a Riot, or intoxication. Cosmetic change procedures may not be covered.

4. This coverage contains a Pre-Existing Condition Limitation. Benefits will not be paid for a Disability arising during a defined period after the coverage effective date if the Disability is caused by or contributed to by or results from an Injury or Sickness that was medically evaluated, diagnosed, or treated prior to the effective date of coverage. The effective date for coverage may be delayed for an individual who is not in Active Employment due to injury or sickness on the date when insurance may be otherwise effective.

5. Limitations and exclusions may vary by state. See certificate or group policy for additional information.

The information above is a summary of the group disability income insurance coverage and is for illustrative purposes only. A certificate with complete plan information will be provided. Please refer to the certificate or the group policy for a complete description of coverage, terms, conditions, exclusions, and limitations. If any conflict exists between the policy and this enrollment kit, the terms of the policy will prevail.

COST ESTIMATOR

What is the cost for Long-Term Disability coverage?

This coverage is provided to you and paid by your employer.

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II. Life and Accidental Death & Dismemberment Benefit Summaries

Optional term life insurance coverage can offer important financial protection. Consider what would happen to the people who depend on you if they could no longer rely on your income. You can purchase coverage for yourself and also insure the lives of your Spouse and your Dependent Children. Accidental Death and Dismemberment insurance coverage provides an additional benefit in event of death or dismemberment as a result of a covered accident or event.

Basic Employee Life

Provision	Basic Employee Life
Eligible Class	All Full-Time Superintendent, Assistant Superintendents and Executive Directors
Minimum Hours Per Week - minimum hours of work per week to be eligible for coverage	30 regularly scheduled hours
Benefit Amount - amount your beneficiary will receive	2 times annual earnings to a maximum of $250,000 and a minimum of $10,000
Employee Contributions	No, 0%
Guaranteed Issue Amount – amount of insurance coverage you may receive without providing Evidence of Insurability	The lesser of 2 times annual earnings or $250,000
Evidence of Insurability (EOI) - proof of your medical history upon which acceptance for insurance will be determined by Liberty	None
Eligibility Waiting Period - period of time or date on which you are eligible for coverage	First of the month coincident with or next following date of hire
Reduction Schedule – benefit adjustment based on age	Benefits reduce to: 65% at age 65 50% at age 70
Accelerated Death Benefit – amount of benefit a Covered Employee may elect to receive upon satisfactory Proof of Terminal Condition*	80% to a maximum of $200,000 with a minimum of 10% or $5,000 (whichever is greater)
Conversion – ability to convert to an individual life insurance policy if coverage terminates	Included
Portability - ability to continue group term life insurance coverage if all or part of coverage terminates	Included

* The receipt of an Accelerated Death Benefit may be taxable. A Covered Employee should consult his or her tax consultant or legal advisor before applying for an Accelerated Death Benefit.

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Basic Employee AD&D

Provision	Basic Employee AD&D
Eligible Class	All Full-Time Superintendent, Assistant Superintendents and Executive Directors
Minimum Hours Per Week - minimum hours of work per week to be eligible for coverage	30 regularly scheduled hours
Benefit Amount – amount Liberty pays under the Accidental Death and Dismemberment Benefit	2 times annual earnings to a maximum of $250,000 and a minimum of $10,000
Employee Contributions	No, 0%
Eligibility Waiting Period - period of time or date on which you are eligible for coverage	First of the month coincident with or next following date of hire
Reduction Schedule – benefit adjustment based on age	Benefits reduce to: 65% at age 65 50% at age 70
Additional Benefits	
Seat Belt Benefit	Lesser of 10% of Full Amount or $10,000
Air Bag Benefit	Lesser of 10% of Full Amount or $10,000
Repatriation Benefit	$2,000 maximum benefit
Disappearance Benefit	$250,000 Maximum Benefit Amount
Exposure Benefit	$250,000 Maximum Benefit Amount
Common Carrier Benefit	Lesser of 100% of Full Amount or $250,000
Child Education Benefit	Maximum One-Time Benefit (Per Dependent Child): $2,500 Maximum Lifetime Family Benefit Amount: $10,000
Coma Benefit	1% of Full Amount per month, for a maximum of 60 months

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SUMMARY OF LIMITATIONS/EXCLUSIONS

1. For plans offering Optional Life, no benefits are payable for any loss for death that results from, is contributed to, or is caused by suicide occurring within 24 months from effective date.
2. For plans offering Accidental Death and Dismemberment, no benefits are payable for any loss that is contributed to or caused by: war, declared or undeclared, or any act of war; any intentionally self-inflicted injuries; suicide or suicide attempt; active Participation in a Riot; committing or attempting to commit a felony; disease, bodily or mental illness (or medical or surgical treatment thereof), infections not occurring as a direct result of an Accidental Bodily Injury; certain controlled substances; boarding, leaving or being in or on any kind of aircraft; intoxication; certain hazardous sports; or loss suffered as a result of Accidental Bodily Injury during any period of incarceration.
3. The effective date for coverage may be delayed for an individual who is not in Active Employment due to injury or sickness on the date when insurance may be otherwise effective.
4. Limitations and exclusions may vary by state. See certificate or group policy for additional information.

The information above is a summary of the group term life insurance coverage and is for illustrative purposes only. A certificate with complete plan information will be provided. Please refer to the certificate or the group policy for a complete description of coverage, terms, conditions, exclusions, and limitations. If any conflict exists between the policy and this enrollment kit, the terms of the policy will prevail.

COST ESTIMATOR

What is the cost for employee Basic Term Life and Basic AD&D insurance?

This coverage is paid for by your employer.

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East China School District Enrollment Form

Please print clearly and return completed form to your benefits department.

Employer Information

Employer Name	
East China School District	
Enrollment Type	
☐ Annual Enrollment	☐ New Hire Employee ☐ Qualified Life Event ☐ Rehire Date: _ _ / _ _ / _ _ *(If not annual enrollment, check one box only)*

Employee Information

Employee Name (Last, First, Middle)			
Residence Address 1 (Street)	**Residence Address 2 (Apt #, Unit #)**		
Residence Address 3 (City, State, ZIP Code)			
Social Security Number	**Date of Birth**	**Gender**	**Marital Status**
_ _ _ - _ _ - _ _ _ _	_ _ / _ _ / _ _ _ _	☐ Male ☐ Female	☐ Single ☐ Married/Domestic Partner
Email Address		**Phone Number**	
		(_ _ _) - _ _ - _ _ _ _	

Long Term Disability and Basic Life Coverage

Coverage may be delayed if you are not in Active Employment due to Injury or Sickness on the date when insurance may be otherwise effective. Please see the certificate or the group policy for additional information.

Type of Coverage	Coverage Elected	Decline Coverage
Long-Term Disability (Employer Paid)	☒ 60% of Basic Monthly Earnings to a monthly maximum of $7,000	
Employee Basic Life and AD&D (Employer Paid)	**Coverage Amount** Employee Only ☑ 2 times annual earnings to a maximum of $250,000 and a minimum of $10,000	

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Employee Signature & Authorization

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.

Your state may have a specific fraud warning. Please review the following Fraud Warning Statements to determine if a specific fraud warning applies to you.

I request coverage as indicated above. For payment by payroll deduction, I authorize and instruct the policyholder to deduct and remit to Liberty Life Assurance Company of Boston the applicable premium from my salary.

My coverage effective date may be delayed if I am not Actively at Work or in Active Employment because of Injury or Sickness. If applying for spouse/domestic partner coverage, coverage is subject to the delayed effective date provisions.

If applying for spouse/domestic partner coverage, coverage is subject to the delayed effective date provisions.

New York residents only - 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.

☐	ACCEPT: I request coverage as indicated above. I authorize my employer to deduct from my earnings my contributions for the coverage(s) selected.
☐	DECLINE: I hereby decline all optional coverage as offered by my employer. I certify that I have been given the opportunity by my employer to enroll for coverage. I understand that Liberty has the right to require evidence of insurability in order to consider any later request to change this decision and that my request may be denied.
Employee Signature:	Date: _ _ / _ _ / _ _

Completion of this enrollment form does not guarantee coverage. Evidence of Insurability may be required. Please see the certificate and/or group policy for additional information.

Fraud Warning Statements

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 - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or 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.

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.

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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.

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.

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

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.

Tennessee, Virginia, 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.

Louisiana, Rhode Island, New Mexico, West Virginia - 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.

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Beneficiary Designation Guide

Remember the following when completing your Beneficiary Designation form:

- Clearly identify your beneficiaries, providing each beneficiary's full name, date of birth, Social Security number, address, and relationship to you.
- You can name primary and contingent beneficiaries:
  - **Primary:** The primary beneficiary is the individual who will receive the insurance proceeds at the time of your death.
  - **Contingent:** A contingent beneficiary, or secondary beneficiary, is the individual who will receive the insurance proceeds if all primary beneficiaries die before you. Naming a contingent beneficiary is important, as you may outlive the primary beneficiary.
- If you name more than one primary or contingent beneficiary, make sure the beneficiary percentages add up to 100 percent for each class of beneficiary (primary and contingent).
- **Minor child:** Although you may name a minor child as a beneficiary, benefits cannot be paid directly to the minor child. Benefits will be paid to the court-appointed guardian of the minor child's estate (or property).
- Make sure you sign and date the Beneficiary Designation Form.
- If you do not name a beneficiary, or if no beneficiary survives you, we will pay benefits as provided in the policy.

To assist you, here are some examples of clear beneficiary designations.

One primary and two contingent beneficiaries	One primary and three contingent beneficiaries
Primary Beneficiary: Jane Smith, spouse, 100% **Contingent Beneficiaries:** Paul Jones, brother, 50% Mary Park, sister, 50%	**Primary Beneficiary:** Gayle Rich, spouse, 100% **Contingent Beneficiaries:** Teresa Rich, daughter, 40% Susan Rich, daughter, 40% Jason Rich, brother, 20%

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East China School District Beneficiary Designation Form

- This beneficiary information applies to all coverages applicable to the covered employee and will replace any prior beneficiary designation.
- The primary beneficiary(ies) will receive the insurance proceeds in the event of the insured's death.
- In the event all primary beneficiaries predecease the insured, the contingent beneficiary(ies) will receive the insurance proceeds.
- If no beneficiary is named, or if no beneficiary survives the insured, settlement will be made in accordance with the terms of the Policy.
- To change your beneficiaries, you must complete a new form.
- If you wish to name more beneficiaries than this form provides space for, complete your list on an additional copy of this form and attach it.

Primary Beneficiary (the total of all primary beneficiaries must equal 100%)

	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
1.		__/__/__	___-__-____		
	Address			Phone Number	
				(___)-___-____	
2.	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
		__/__/__	___-__-____		
	Address			Phone Number	
				(___)-___-____	
3.	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
		__/__/__	___-__-____		
	Address			Phone Number	
				(___)-___-____	
				TOTAL	

The total share of all primary beneficiaries must equal 100%.

Contingent Beneficiary (the total of all contingent beneficiaries must equal 100%)

	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
1.		__/__/__	___-__-____		
	Address			Phone Number	
				(___)-___-____	
2.	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
		__/__/__	___-__-____		
	Address			Phone Number	
				(___)-___-____	
3.	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
		__/__/__	___-__-____		
	Address			Phone Number	
				(___)-___-____	
4.	Name (Last, First, Middle)	Date of Birth	Social Security Number	Relationship	% of Benefit
		__/__/__	___-__-____		
	Address			Phone Number	
				(___)-___-____	
				TOTAL	

The total share of all contingent beneficiaries must equal 100%.

Employee Signature: _____ Date: __/__/__

Complete this form and return it to your employer. Retain a copy for your records.

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