

# VOLUNTARY LONG-TERM DISABILITY INSURANCE BENEFITS SUMMARY



## For Members of Independent Business Owners Benefits Association

<b>ELIGIBILITY</b>	
<b>Eligibility Requirement</b>	<ul style="list-style-type: none"> <li>You must be a current Independent Business Owner (IBO) under the age of 60 and member of the Independent Business Owners Benefits Association.</li> <li>You must be a citizen or permanent resident of the United States.</li> <li>You must be able to perform normal activities and not be confined (at home, in a hospital, or in any other care facility).</li> </ul>
<b>Minimum Work Hours</b>	You must be working a minimum of 30 hours per week.
<b>Coverage Payment</b>	You pay 100% of the premium for this coverage.
<b>BENEFITS</b>	
<b>Monthly Benefit</b>	<p>You can elect a benefit in \$100 increments, up to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount of \$10,000. (less other income sources) Your guarantee issue amount is \$4,000.</p> <p>Your premium will be lower if you have been tobacco free for 12 months or more.</p> <p>Premium amounts will increase as you reach the attained age of the next higher age band in the premium rate structure. The Benefits Administrator will provide you with notice of any change in premium amounts in advance of the change.</p>
<p><i>Note: Guarantee Issue means the amount of insurance applied for which does not require evidence of insurability (health application). Guarantee Issue is available during Open Enrollment periods at select, pre-determined times. Guarantee Issue is available to New IBO's (must enroll within 60 days of becoming an IBO), but any coverage amounts over the Guarantee Issue Amount will require evidence of insurability. All coverage amounts outside of Open Enrollment or over the Guarantee Issue will require evidence of insurability. If you have questions about Guarantee Issue and/or Open Enrollment periods, call USI Affinity at 1-800-254-2327.</i></p>	
<b>Monthly Benefit for IBO's in Non Preferred* Industries</b>	You can elect a benefit of \$500 or 60% of your before-tax monthly earnings. The amount cannot exceed \$500. (less other income sources)
<b>Benefits Begin (Elimination Period)</b>	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin 90 days after the onset of your disabling injury or illness.
<b>Maximum Benefit Period</b>	If you become disabled, benefits are payable for 2 years.
<b>Minimum Monthly Benefit</b>	\$100
<b>DEFINITIONS</b>	
<b>Definition of Disability</b>	Disability means an injury or sickness has caused a significant change in your mental or physical functional capacity in which you are unable to perform all of the material duties of your regular occupation or any gainful occupation. Disability is determined relative to your ability or inability to work. It is not determined by the availability of a suitable position.
<b>Definition of Monthly Earnings</b>	Monthly Earnings is the average net monthly earnings from salary, wages, bonuses, commissions, fees or other payments received for personal services rendered or work performed in any occupation. The average is based on your net monthly earnings for the most recent 12-month or 24-month period, whichever produces the higher average. Normal and usual business expenses are to be deducted. Income taxes are not to be deducted. Monthly earnings does not include dividends, rents, royalties, annuities or other forms of unearned income. Proof of Earnings is required.
<b>FEATURES</b>	
<b>Partial Disability Benefits</b>	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
<b>Vocational Rehabilitation Benefit</b>	If you become disabled and participate in the vocational rehabilitation program, which offers services that help you return to work and ability, you will be eligible for a monthly benefit increase of 5%.

<b>Survivor Benefit</b>	If you pass away while receiving long-term disability benefits, your benefits will be provided to your beneficiaries for a period of time after your death.
<b>Waiver of Premium</b>	The premium for your long-term disability coverage is waived while you are receiving benefits.
<b>EXCLUSIONS &amp; LIMITATIONS</b>	
<b>Pre-existing Conditions Limitation</b>	Disabilities that occur during the first 24 months of coverage due to a pre-existing condition during the 12 months prior to coverage are excluded.
<b>Other Exclusions</b>	Information about other exclusions for this plan will be included in the certificate booklet. Please contact USI Affinity at 1-800-254-2327 if you have questions prior to enrolling.
<b>Termination of Coverage</b>	<p>Insurance will end on the last day of the month in which the earliest of the following events occurs:</p> <ul style="list-style-type: none"> <li>• You are no longer eligible for insurance under the Policy;</li> <li>• You reach the age of 65; or</li> <li>• You begin active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 60 days or less).</li> <li>• On the day the Policy terminates; or in accordance with the Grace Period provision.</li> </ul> <p>If you are disabled on the day the policy terminates, benefits will continue subject to the When Benefits End provision located in the Benefits section of the Certificate</p>

\*Long Term Disability limitation - If you are engaged in the following non-preferred industries, you can only apply and obtain a monthly benefit of \$500 or less: commercial fishing, hunting and trapping, coal mining, metal mining, underground mining, chemical and fertilizer mining, wrecking and demolition, oil and gas field extraction, steeple-jacking, antenna installation, ammunition and explosives, taxi-cab and bus drivers, water transportation, commercial and non-commercial pilots, refuse and sanitation systems (sewage), scrap and waste materials, automobile and motorcycle repair, bail bondsmen, professional sports racing, amusement parks, justice, public order and safety (police, fire, and ambulance), military personnel, asbestos, logging and saw mills, flight instructors, nuclear energy, detective and armored car, security guards and “any occupation which requires carrying a weapon”.

*This information describes some of the features of the benefits plan. Certain benefits within the insurance may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan’s benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail. Long-term disability insurance is underwritten by Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company. Mutual of Omaha Insurance Company is licensed in all 50 states.*

IBO Insurance Benefits Program  
Group Voluntary Long Term Disability



**Non-Tobacco Quarterly Premium**

You can elect a benefit in \$100 increments, up to 60% of your before tax monthly earnings, not to exceed \$10,000.

$$\text{Monthly Earnings} \times \underline{\hspace{2cm}.60} = \underline{\hspace{2cm}} \text{ Max Benefit Amount (if this is more than \$10,000, use \$10,000 as your max)}$$

If you are a non-tobacco user, find the benefit amount you want to select from the gray rows of the premium table. The premium amount is found in the box where the row (age) and the column (benefit amount) intersect. Enter the benefit and premium amounts into their respective areas in your enrollment form.

*\*Premiums for 60-64 are renewal premiums only*

Non-Tobacco Users								
	\$500	\$600	\$700	\$800	\$900	\$1,000	\$1,100	\$1,200
< 40	\$6.27	\$7.53	\$8.79	\$10.05	\$11.31	\$12.57	\$13.83	\$15.09
40-44	\$9.42	\$11.31	\$13.20	\$15.09	\$16.98	\$18.87	\$20.76	\$22.65
45-49	\$14.85	\$17.82	\$20.79	\$23.76	\$26.73	\$29.70	\$32.67	\$35.64
50-54	\$24.00	\$28.80	\$33.60	\$38.40	\$43.20	\$48.00	\$52.80	\$57.60
55-59	\$39.39	\$47.28	\$55.17	\$63.06	\$70.95	\$78.84	\$86.73	\$94.62
60-64*	\$70.35	\$84.42	\$98.49	\$112.56	\$126.63	\$140.70	\$154.77	\$168.84
	<b>\$1,300</b>	<b>\$1,400</b>	<b>\$1,500</b>	<b>\$1,600</b>	<b>\$1,700</b>	<b>\$1,800</b>	<b>\$1,900</b>	<b>\$2,000</b>
< 40	\$16.35	\$17.61	\$18.87	\$20.13	\$21.39	\$22.65	\$23.91	\$25.17
40-44	\$24.54	\$26.43	\$28.32	\$30.21	\$32.10	\$33.99	\$35.88	\$37.77
45-49	\$38.61	\$41.58	\$44.55	\$47.52	\$50.49	\$53.46	\$56.43	\$59.40
50-54	\$62.40	\$67.20	\$72.00	\$76.80	\$81.60	\$86.40	\$91.20	\$96.00
55-59	\$102.51	\$110.40	\$118.29	\$126.18	\$134.07	\$141.96	\$149.85	\$157.74
60-64*	\$182.91	\$196.98	\$211.05	\$225.12	\$239.19	\$253.26	\$267.33	\$281.40
	<b>\$2,100</b>	<b>\$2,200</b>	<b>\$2,300</b>	<b>\$2,400</b>	<b>\$2,500</b>	<b>\$2,600</b>	<b>\$2,700</b>	<b>\$2,800</b>
< 40	\$26.44	\$27.70	\$28.96	\$30.22	\$31.43	\$32.74	\$34.00	\$35.26
40-44	\$39.50	\$41.38	\$43.26	\$45.14	\$47.02	\$48.90	\$50.78	\$52.66
45-49	\$62.38	\$65.35	\$68.32	\$71.29	\$74.26	\$77.23	\$80.20	\$83.17
50-54	\$100.79	\$105.59	\$110.39	\$115.19	\$119.99	\$124.79	\$129.59	\$134.39
55-59	\$165.48	\$173.36	\$181.24	\$189.12	\$197.00	\$204.88	\$212.76	\$220.64
60-64*	\$295.47	\$309.54	\$323.61	\$337.68	\$351.75	\$365.82	\$379.89	\$393.96
	<b>\$2,900</b>	<b>\$3,000</b>	<b>\$3,100</b>	<b>\$3,200</b>	<b>\$3,300</b>	<b>\$3,400</b>	<b>\$3,500</b>	<b>\$3,600</b>
< 40	\$36.52	\$37.78	\$39.04	\$40.30	\$41.56	\$42.82	\$44.08	\$45.34
40-44	\$54.54	\$56.42	\$58.30	\$60.18	\$62.06	\$63.94	\$65.82	\$67.70
45-49	\$86.14	\$89.11	\$92.08	\$95.05	\$98.02	\$100.99	\$103.96	\$106.93
50-54	\$139.19	\$143.99	\$148.79	\$153.59	\$158.39	\$163.19	\$167.99	\$172.79
55-59	\$228.52	\$236.40	\$224.28	\$252.16	\$260.04	\$267.92	\$275.80	\$283.68
60-64*	\$408.03	\$442.10	\$436.17	\$450.24	\$464.31	\$478.38	\$492.45	\$506.52
	<b>\$3,700</b>	<b>\$3,800</b>	<b>\$3,900</b>	<b>\$4,000</b>	<b>\$4,100</b>	<b>\$4,200</b>	<b>\$4,300</b>	<b>\$4,400</b>
< 40	\$46.60	\$47.86	\$49.12	\$50.38	\$51.54	\$52.79	\$54.05	\$55.31
40-44	\$69.58	\$71.46	\$73.34	\$75.22	\$77.24	\$79.13	\$81.01	\$82.90
45-49	\$109.90	\$112.87	\$115.84	\$118.81	\$121.89	\$124.87	\$127.84	\$130.81
50-54	\$177.59	\$182.39	\$187.19	\$191.99	\$196.68	\$201.47	\$206.27	\$211.07
55-59	\$291.56	\$299.44	\$307.32	\$315.20	\$323.12	\$331.00	\$338.88	\$346.76
60-64*	\$520.59	\$534.66	\$548.73	\$562.80	\$576.87	\$590.94	\$605.01	\$619.08
	<b>\$4,500</b>	<b>\$4,600</b>	<b>\$4,700</b>	<b>\$4,800</b>	<b>\$4,900</b>	<b>\$5,000</b>	<b>\$5,100</b>	<b>\$5,200</b>
< 40	\$56.57	\$57.82	\$59.08	\$60.34	\$61.59	\$62.85	\$64.11	\$65.36
40-44	\$84.78	\$86.66	\$88.55	\$90.43	\$92.32	\$94.20	\$96.08	\$97.97
45-49	\$133.79	\$136.76	\$139.73	\$142.70	\$145.68	\$148.65	\$151.62	\$154.60
50-54	\$215.87	\$220.66	\$225.46	\$230.26	\$235.05	\$239.85	\$244.65	\$249.44
55-59	\$354.65	\$362.53	\$370.41	\$378.29	\$386.17	\$394.05	\$401.93	\$409.81
60-64*	\$633.15	\$647.22	\$661.29	\$675.36	\$689.43	\$703.50	\$717.57	\$731.64

*please see next page for additional options*

	<b>\$5,300</b>	<b>\$5,400</b>	<b>\$5,500</b>	<b>\$5,600</b>	<b>\$5,700</b>	<b>\$5,800</b>	<b>\$5,900</b>	<b>\$6,000</b>
<b>&lt; 40</b>	\$66.62	\$67.88	\$69.14	\$70.39	\$71.65	\$72.91	\$74.16	\$75.42
<b>40-44</b>	\$99.85	\$101.74	\$103.62	\$105.50	\$107.39	\$109.27	\$111.16	\$113.04
<b>45-49</b>	\$157.57	\$160.54	\$163.52	\$166.49	\$169.46	\$172.43	\$175.41	\$178.38
<b>50-54</b>	\$254.24	\$259.04	\$263.84	\$268.63	\$273.43	\$278.23	\$283.02	\$287.82
<b>55-59</b>	\$417.69	\$425.57	\$433.46	\$441.34	\$449.22	\$457.10	\$464.98	\$472.86
<b>60-64*</b>	\$745.71	\$759.78	\$773.85	\$787.92	\$801.99	\$816.06	\$830.13	\$844.20
	<b>\$6,100</b>	<b>\$6,200</b>	<b>\$6,300</b>	<b>\$6,400</b>	<b>\$6,500</b>	<b>\$6,600</b>	<b>\$6,700</b>	<b>\$6,800</b>
<b>&lt; 40</b>	\$76.68	\$77.93	\$79.19	\$80.45	\$81.71	\$82.96	\$84.22	\$85.48
<b>40-44</b>	\$114.92	\$116.81	\$118.69	\$120.58	\$122.46	\$124.34	\$126.23	\$128.11
<b>45-49</b>	\$181.35	\$184.33	\$187.30	\$190.27	\$193.25	\$196.22	\$199.19	\$202.16
<b>50-54</b>	\$292.62	\$297.41	\$302.21	\$307.01	\$311.81	\$316.60	\$321.40	\$326.20
<b>55-59</b>	\$480.74	\$488.62	\$496.50	\$504.38	\$512.27	\$520.15	\$528.03	\$535.91
<b>60-64*</b>	\$858.27	\$872.34	\$886.41	\$900.48	\$914.55	\$928.62	\$942.69	\$956.76
	<b>\$6,900</b>	<b>\$7,000</b>	<b>\$7,100</b>	<b>\$7,200</b>	<b>\$7,300</b>	<b>\$7,400</b>	<b>\$7,500</b>	<b>\$7,600</b>
<b>&lt; 40</b>	\$86.73	\$87.99	\$89.25	\$90.50	\$91.76	\$93.02	\$94.28	\$95.53
<b>40-44</b>	\$130.00	\$131.88	\$133.76	\$135.65	\$137.53	\$139.42	\$141.30	\$143.18
<b>45-49</b>	\$205.14	\$208.11	\$211.08	\$214.06	\$217.03	\$220.00	\$222.98	\$225.95
<b>50-54</b>	\$330.99	\$335.79	\$340.59	\$345.38	\$350.18	\$354.98	\$359.78	\$364.57
<b>55-59</b>	\$543.79	\$551.67	\$559.55	\$567.43	\$575.31	\$583.19	\$591.08	\$598.96
<b>60-64*</b>	\$970.83	\$984.90	\$998.97	\$1,013.04	\$1,027.11	\$1,041.18	\$1,055.25	\$1,069.32
	<b>\$7,700</b>	<b>\$7,800</b>	<b>\$7,900</b>	<b>\$8,000</b>	<b>\$8,100</b>	<b>\$8,200</b>	<b>\$8,300</b>	<b>\$8,400</b>
<b>&lt; 40</b>	\$96.79	\$98.05	\$99.30	\$100.56	\$101.82	\$103.07	\$104.33	\$105.59
<b>40-44</b>	\$145.07	\$146.95	\$148.84	\$150.72	\$152.60	\$154.49	\$156.37	\$158.26
<b>45-49</b>	\$228.92	\$231.89	\$234.87	\$237.84	\$240.81	\$243.79	\$246.76	\$249.73
<b>50-54</b>	\$369.37	\$374.17	\$378.96	\$383.76	\$388.56	\$393.35	\$398.15	\$402.95
<b>55-59</b>	\$606.84	\$614.72	\$622.60	\$630.48	\$638.36	\$646.24	\$654.12	\$662.00
<b>60-64*</b>	\$1,083.39	\$1,097.46	\$1,111.53	\$1,125.60	\$1,139.67	\$1,153.74	\$1,167.81	\$1,181.88
	<b>\$8,500</b>	<b>\$8,600</b>	<b>\$8,700</b>	<b>\$8,800</b>	<b>\$8,900</b>	<b>\$9,000</b>	<b>\$9,100</b>	<b>\$9,200</b>
<b>&lt; 40</b>	\$106.85	\$108.10	\$109.36	\$110.62	\$111.87	\$113.13	\$114.39	\$115.64
<b>40-44</b>	\$160.14	\$162.02	\$163.91	\$165.79	\$167.68	\$169.56	\$171.44	\$173.33
<b>45-49</b>	\$252.71	\$255.68	\$258.65	\$261.62	\$264.60	\$267.57	\$270.54	\$273.52
<b>50-54</b>	\$407.75	\$412.54	\$417.34	\$422.14	\$426.93	\$431.73	\$436.53	\$441.32
<b>55-59</b>	\$669.89	\$677.77	\$685.65	\$693.53	\$701.41	\$709.29	\$717.17	\$725.05
<b>60-64*</b>	\$1,195.95	\$1,210.02	\$1,224.09	\$1,238.16	\$1,252.23	\$1,266.30	\$1,280.37	\$1,294.44
	<b>\$9,300</b>	<b>\$9,400</b>	<b>\$9,500</b>	<b>\$9,600</b>	<b>\$9,700</b>	<b>\$9,800</b>	<b>\$9,900</b>	<b>\$10,000</b>
<b>&lt; 40</b>	\$116.90	\$118.16	\$119.42	\$120.67	\$121.93	\$123.19	\$124.44	\$125.70
<b>40-44</b>	\$175.21	\$177.10	\$178.98	\$180.86	\$182.75	\$184.63	\$186.52	\$188.40
<b>45-49</b>	\$276.49	\$279.46	\$282.44	\$285.41	\$288.38	\$291.35	\$294.33	\$297.30
<b>50-54</b>	\$446.12	\$450.92	\$455.72	\$460.51	\$465.31	\$470.11	\$474.90	\$479.70
<b>55-59</b>	\$732.93	\$740.81	\$748.70	\$756.58	\$764.46	\$772.34	\$780.22	\$788.10
<b>60-64*</b>	\$1,308.51	\$1,322.58	\$1,336.65	\$1,350.72	\$1,364.79	\$1,378.86	\$1,392.93	\$1,407.00

IBO Insurance Benefits Program  
Group Voluntary Long Term Disability



**Tobacco Quarterly Premium**

You can elect a benefit in \$100 increments, up to 60% of your before tax monthly earnings, not to exceed \$10,000.

$$\underline{\hspace{2cm}} \times \underline{\hspace{2cm}} .60 = \underline{\hspace{2cm}}$$

Monthly Earnings  Max Benefit Amount (if this is more than \$10,000, use \$10,000 as your max)

If you are a tobacco user, find the benefit amount you want to select from the gray rows of the premium table. The premium amount is found in the box where the row (age) and the column (benefit amount) intersect. Enter the benefit and premium amounts into their respective areas in your enrollment form.

*\*Premiums for 60-64 are renewal premiums only*

Tobacco Users								
	\$500	\$600	\$700	\$800	\$900	\$1,000	\$1,100	\$1,200
< 40	\$7.80	\$9.36	\$10.92	\$12.48	\$14.04	\$15.60	\$17.16	\$18.72
40-44	\$11.79	\$14.16	\$16.53	\$18.90	\$21.27	\$23.64	\$26.01	\$28.38
45-49	\$18.54	\$22.26	\$25.98	\$29.70	\$33.42	\$37.14	\$40.86	\$44.58
50-54	\$29.97	\$35.97	\$41.97	\$47.97	\$53.97	\$59.97	\$65.97	\$71.97
55-59	\$49.26	\$59.10	\$68.94	\$78.78	\$88.62	\$98.46	\$108.30	\$118.14
60-64*	\$87.99	\$105.57	\$123.15	\$140.73	\$158.31	\$175.89	\$193.47	\$211.05
	\$1,300	\$1,400	\$1,500	\$1,600	\$1,700	\$1,800	\$1,900	\$2,000
< 40	\$20.28	\$21.84	\$23.40	\$24.96	\$26.52	\$28.08	\$29.64	\$31.20
40-44	\$30.75	\$33.12	\$35.49	\$37.86	\$40.23	\$42.60	\$44.97	\$47.34
45-49	\$48.30	\$52.02	\$55.74	\$59.46	\$63.18	\$66.90	\$70.62	\$74.34
50-54	\$77.97	\$83.97	\$89.97	\$95.97	\$101.97	\$107.97	\$113.97	\$119.97
55-59	\$127.98	\$137.82	\$147.66	\$157.50	\$167.34	\$177.18	\$187.02	\$196.86
60-64*	\$228.63	\$246.21	\$263.79	\$281.37	\$298.95	\$316.53	\$334.11	\$351.69
	\$2,100	\$2,200	\$2,300	\$2,400	\$2,500	\$2,600	\$2,700	\$2,800
< 40	\$32.77	\$34.33	\$35.89	\$37.45	\$39.01	\$40.57	\$42.13	\$43.69
40-44	\$49.54	\$51.90	\$54.26	\$56.62	\$58.98	\$61.34	\$63.70	\$66.06
45-49	\$77.91	\$81.62	\$85.33	\$89.04	\$92.75	\$96.46	\$100.17	\$103.88
50-54	\$125.98	\$131.98	\$137.98	\$143.98	\$149.98	\$155.98	\$161.98	\$167.98
55-59	\$206.85	\$216.70	\$226.55	\$236.40	\$246.25	\$256.10	\$265.95	\$275.80
60-64*	\$369.42	\$387.01	\$404.60	\$422.19	\$439.78	\$457.37	\$474.96	\$492.55
	\$2,900	\$3,000	\$3,100	\$3,200	\$3,300	\$3,400	\$3,500	\$3,600
< 40	\$45.25	\$46.81	\$48.37	\$49.93	\$51.49	\$53.05	\$54.61	\$56.17
40-44	\$68.42	\$70.78	\$73.14	\$75.50	\$77.86	\$80.22	\$82.58	\$84.97
45-49	\$107.59	\$111.30	\$115.01	\$118.72	\$122.43	\$126.14	\$129.85	\$133.56
50-54	\$173.98	\$179.98	\$185.98	\$191.98	\$197.98	\$203.98	\$209.98	\$215.98
55-59	\$285.65	\$295.50	\$305.35	\$315.20	\$325.05	\$334.90	\$344.75	\$354.60
60-64*	\$510.14	\$527.73	\$545.32	\$562.91	\$580.50	\$598.09	\$615.68	\$633.27
	\$3,700	\$3,800	\$3,900	\$4,000	\$4,100	\$4,200	\$4,300	\$4,400
< 40	\$57.73	\$59.29	\$60.85	\$62.41	\$64.08	\$65.65	\$67.21	\$68.77
40-44	\$87.30	\$89.66	\$92.02	\$94.38	\$96.56	\$98.91	\$101.27	\$103.62
45-49	\$137.27	\$140.98	\$144.69	\$148.40	\$152.15	\$155.86	\$159.57	\$163.28
50-54	\$221.98	\$227.98	\$233.98	\$239.98	\$245.88	\$251.87	\$257.87	\$263.87
55-59	\$364.45	\$374.30	\$384.15	\$394.00	\$403.81	\$413.66	\$423.51	\$433.36
60-64*	\$650.86	\$668.45	\$686.04	\$703.63	\$721.40	\$738.99	\$756.59	\$774.18
	\$4,500	\$4,600	\$4,700	\$4,800	\$4,900	\$5,000	\$5,100	\$5,200
< 40	\$70.34	\$71.90	\$73.46	\$75.02	\$76.59	\$78.15	\$79.71	\$81.28
40-44	\$105.98	\$108.33	\$110.69	\$113.04	\$115.40	\$117.75	\$120.11	\$122.46
45-49	\$167.00	\$170.71	\$174.42	\$178.13	\$181.84	\$185.55	\$189.26	\$192.97
50-54	\$269.87	\$275.86	\$281.86	\$287.86	\$293.85	\$299.85	\$305.85	\$311.84
55-59	\$443.21	\$453.05	\$462.90	\$472.75	\$482.60	\$492.45	\$502.30	\$512.15
60-64*	\$791.78	\$809.37	\$826.97	\$844.56	\$862.16	\$879.75	\$897.35	\$914.94

*please see next page for additional options*

	<b>\$5,300</b>	<b>\$5,400</b>	<b>\$5,500</b>	<b>\$5,600</b>	<b>\$5,700</b>	<b>\$5,800</b>	<b>\$5,900</b>	<b>\$6,000</b>
<b>&lt; 40</b>	\$82.84	\$84.40	\$85.97	\$87.53	\$89.09	\$90.65	\$92.22	\$93.78
<b>40-44</b>	\$124.82	\$127.17	\$129.53	\$131.88	\$134.24	\$136.59	\$138.95	\$141.30
<b>45-49</b>	\$196.68	\$200.39	\$204.11	\$207.82	\$211.53	\$215.24	\$218.95	\$222.66
<b>50-54</b>	\$317.84	\$323.84	\$329.84	\$335.83	\$341.83	\$347.83	\$353.82	\$359.82
<b>55-59</b>	\$522.00	\$531.85	\$541.70	\$551.54	\$561.39	\$571.24	\$581.09	\$590.94
<b>60-64*</b>	\$932.54	\$950.13	\$967.73	\$985.32	\$1,002.92	\$1,020.51	\$1,038.11	\$1,055.70
	<b>\$6,100</b>	<b>\$6,200</b>	<b>\$6,300</b>	<b>\$6,400</b>	<b>\$6,500</b>	<b>\$6,600</b>	<b>\$6,700</b>	<b>\$6,800</b>
<b>&lt; 40</b>	\$95.34	\$96.91	\$98.47	\$100.03	\$101.60	\$103.16	\$104.72	\$106.28
<b>40-44</b>	\$143.66	\$146.01	\$148.37	\$150.72	\$153.08	\$155.43	\$157.79	\$160.14
<b>45-49</b>	\$226.37	\$230.08	\$233.79	\$237.50	\$241.22	\$244.93	\$248.64	\$252.35
<b>50-54</b>	\$365.82	\$371.81	\$377.81	\$383.81	\$389.81	\$395.80	\$401.80	\$407.80
<b>55-59</b>	\$600.79	\$610.64	\$620.49	\$630.34	\$640.19	\$650.03	\$659.88	\$669.73
<b>60-64*</b>	\$1,073.30	\$1,090.89	\$1,108.49	\$1,126.08	\$1,143.68	\$1,161.27	\$1,178.87	\$1,196.46
	<b>\$6,900</b>	<b>\$7,000</b>	<b>\$7,100</b>	<b>\$7,200</b>	<b>\$7,300</b>	<b>\$7,400</b>	<b>\$7,500</b>	<b>\$7,600</b>
<b>&lt; 40</b>	\$107.85	\$109.41	\$110.97	\$112.54	\$114.10	\$115.66	\$117.23	\$118.79
<b>40-44</b>	\$162.50	\$164.85	\$167.21	\$169.56	\$171.92	\$174.27	\$176.63	\$178.98
<b>45-49</b>	\$256.06	\$259.77	\$263.48	\$267.19	\$270.90	\$274.61	\$278.33	\$282.04
<b>50-54</b>	\$413.79	\$419.79	\$425.79	\$431.78	\$437.78	\$443.78	\$449.78	\$455.77
<b>55-59</b>	\$679.58	\$689.43	\$699.28	\$709.13	\$718.98	\$728.83	\$738.68	\$748.52
<b>60-64*</b>	\$1,214.06	\$1,231.65	\$1,249.25	\$1,266.84	\$1,284.44	\$1,302.03	\$1,319.63	\$1,337.22
	<b>\$7,700</b>	<b>\$7,800</b>	<b>\$7,900</b>	<b>\$8,000</b>	<b>\$8,100</b>	<b>\$8,200</b>	<b>\$8,300</b>	<b>\$8,400</b>
<b>&lt; 40</b>	\$120.35	\$121.91	\$123.48	\$125.04	\$126.60	\$128.17	\$129.73	\$131.29
<b>40-44</b>	\$181.34	\$183.69	\$186.05	\$188.40	\$190.76	\$193.11	\$195.47	\$197.82
<b>45-49</b>	\$285.75	\$289.46	\$293.17	\$296.88	\$300.59	\$304.30	\$308.01	\$311.72
<b>50-54</b>	\$461.77	\$467.77	\$473.76	\$479.76	\$485.76	\$491.75	\$497.75	\$503.75
<b>55-59</b>	\$758.37	\$768.22	\$778.07	\$787.92	\$797.77	\$807.62	\$817.47	\$827.32
<b>60-64*</b>	\$1,354.82	\$1,372.41	\$1,390.01	\$1,407.60	\$1,425.20	\$1,442.79	\$1,460.39	\$1,477.98
	<b>\$8,500</b>	<b>\$8,600</b>	<b>\$8,700</b>	<b>\$8,800</b>	<b>\$8,900</b>	<b>\$9,000</b>	<b>\$9,100</b>	<b>\$9,200</b>
<b>&lt; 40</b>	\$132.86	\$134.42	\$135.98	\$137.54	\$139.11	\$140.67	\$142.23	\$143.80
<b>40-44</b>	\$200.18	\$202.53	\$204.89	\$207.24	\$209.60	\$211.95	\$214.31	\$216.66
<b>45-49</b>	\$315.44	\$319.15	\$322.86	\$326.57	\$330.28	\$333.99	\$337.70	\$341.41
<b>50-54</b>	\$509.75	\$515.74	\$521.74	\$527.74	\$533.73	\$539.73	\$545.73	\$551.72
<b>55-59</b>	\$837.17	\$847.01	\$856.86	\$866.71	\$876.56	\$886.41	\$896.26	\$906.11
<b>60-64*</b>	\$1,495.58	\$1,513.17	\$1,530.77	\$1,548.36	\$1,565.96	\$1,583.55	\$1,601.15	\$1,618.74
	<b>\$9,300</b>	<b>\$9,400</b>	<b>\$9,500</b>	<b>\$9,600</b>	<b>\$9,700</b>	<b>\$9,800</b>	<b>\$9,900</b>	<b>\$10,000</b>
<b>&lt; 40</b>	\$145.36	\$146.92	\$148.49	\$150.05	\$151.61	\$153.17	\$154.74	\$156.30
<b>40-44</b>	\$219.02	\$221.37	\$223.73	\$226.08	\$228.44	\$230.79	\$233.15	\$235.50
<b>45-49</b>	\$345.12	\$348.83	\$352.55	\$356.26	\$359.97	\$363.68	\$367.39	\$371.10
<b>50-54</b>	\$557.72	\$563.72	\$569.72	\$575.71	\$581.71	\$587.71	\$593.70	\$599.70
<b>55-59</b>	\$915.96	\$925.81	\$935.66	\$945.50	\$955.35	\$965.20	\$975.05	\$984.90
<b>60-64*</b>	\$1,636.34	\$1,653.93	\$1,671.53	\$1,689.12	\$1,706.72	\$1,724.31	\$1,741.91	\$1,759.50

# Voluntary Long Term Disability Enrollment Form

Brought to you by:

Underwritten by: United of Omaha Life Insurance Company



Policyholder Section					
Policyholder Name: <b>Independent Business Owners Benefits Association</b>		Class Type:		Group ID: G000AKS5	
IBO Member Section Please print clearly.					
Last Name:		First Name:		MI:	
Social Security Number:		Birth Date (MM/DD/YYYY):		Gender:      Marital Status:	
Street Address:					
E-mail Address: May USI Affinity send you updates by email? <input type="checkbox"/> Yes <input type="checkbox"/> No		If your coverage is approved, may we use your email address to send you plan Documents? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, you will receive several large pdf files. If no, documents will be mailed.			
City:	State:	Zip Code:	Telephone: (    )    -		
Occupation/Industry:	Describe Duties:		Are you an IBO? <input type="checkbox"/> Yes <input type="checkbox"/> No	IBO#:	
Application Type:	IBO Level:		Length of time as an IBO:    ___ Months    ___ Years		
<input type="checkbox"/> New Coverage <input type="checkbox"/> Coverage Change      Reason for Change / Coverage Change _____ <input type="checkbox"/> Reapplying for Coverage      Date Prior Coverage under this Plan was Terminated _____					
Voluntary Long-Term Disability Coverage Election					
<b>IBO Member Coverage Only</b>		<b>Enroll</b>	<b>Decline</b>	<b>Benefit Amount</b>	<b>Premium Amount</b>
Have you, the IBO Member, used tobacco in any form (ex. smoking cigarettes or chewing tobacco) within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Long-Term Disability		<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____
<b>Compute Your Monthly Benefit</b>					
Current Basic Monthly Earning \$ _____ X .60 = \$ _____ Monthly benefit amount may not exceed 60% of your basic monthly earnings					
Billing Mode Select one.					
<input type="checkbox"/> Quarterly		<input type="checkbox"/> Semiannually		<input type="checkbox"/> Annually	
Enrollment Information					
You are required to pay premiums for all coverage. The premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the policy as well as your age on the effective date of your coverage.					
Agreement and Signature					
<p>I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not ensure my eligibility for coverage. I understand and agree that I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage.</p> <p>Should I apply for waived coverage in the future, I understand that evidence of insurability may be required, acceptable to the insurance company. I understand that if coverage is applied for in the future, it must be during an enrollment period or due to a life change event as defined by the policy, and that a waiting period may apply.</p> <p>By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summaries provided to me for each line of coverage. The above requirements will apply unless otherwise stated in the policy, or unless prohibited by any applicable state or federal law.</p>					
SIGNATURE OF IBO MEMBER _____			DATE _____ / _____ / _____		
Additional Information					
<b>Fraud Warning:</b> 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. USI Affinity is a licensed insurance agency representing and compensated by the insurer based on the amount of insurance sold.					

Mail completed enrollment forms to:

USI Affinity  
P.O. Box 338  
Grand Rapids, MI 49501-0338

# Group Disability Insurance Evidence of Insurability Form



Underwritten by: United of Omaha Life Insurance Company

Home Office: Omaha, Nebraska

<b>Section 1: Employer Information</b> (Please print clearly. Required fields are marked with an asterisk (*).)						
<b>Group/Employer's Name*</b>			<b>Class Description</b>		<b>Group ID Number*</b>	
Independent Business Owners Benefits Association Administered by USI Affinity					G000AKS5	
<b>Street Address</b>				<b>Telephone</b>		
648 Monroe Avenue NW, Suite 300				1-800-254-2327		
<b>City*</b>			<b>State*</b>	<b>Zip Code</b>		
Grand Rapids			MI	49503		
<b>Section 2: Employee/Member Information</b> (Please print clearly. Required fields are marked with an asterisk (*).)						
<b>Last Name*</b>		<b>First Name*</b>		<b>Middle Name</b>		
<b>Street Address*</b>			<b>E-mail Address</b>			
<b>City*</b>		<b>State*</b>	<b>Zip Code*</b>		<b>Telephone*</b>	
					( ) - - - -	
<b>Full-Time Employment Date</b> (MM/DD/YYYY)*			<b>Job Title/Description*</b>			
NA			NA			
<b>Consent to E-mail Correspondence</b>						
<input type="checkbox"/> Check this box if you consent to receiving future correspondence regarding this form via e-mail.						
<b>Section 3: Employee/Member Personal Information</b> (Please print clearly. Required fields are marked with an asterisk (*).)						
<b>Birth Date</b> (MM/DD/YYYY)*		<b>State of Birth*</b>	<b>Gender*</b>	<b>Weight*</b>	<b>Height*</b>	<b>Annual Salary*</b>
___/___/_____		___	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____ Pounds	___ Ft. ___ In.	
<b>Section 4: Requested Coverage</b>						
<b>Indicate the type of coverage you are applying for:</b>						
<input type="checkbox"/> Short-Term Disability (STD)		<input checked="" type="checkbox"/> Long-Term Disability (LTD)		<input type="checkbox"/> Both STD and LTD		
<b>Section 5: Health Information</b> (Please print clearly. A response is required for each health question.)						
<b>Part A – Health Questions</b>						
<b>Health Question 1</b>						
During the past seven years, have you ever been diagnosed by or received medical care from a medical professional for, or had any disease or disorder associated with, any of the following*: (Check all that apply.)						
<input type="checkbox"/> Urinary tract or kidney? <input type="checkbox"/> Liver or hepatitis? <input type="checkbox"/> Anemia or blood? <input type="checkbox"/> Skin or connective tissue? <input type="checkbox"/> Chronic Epstein-Barr? <input type="checkbox"/> Cancer or tumor? <input type="checkbox"/> Alcohol or drug abuse? <input type="checkbox"/> Spine, neck or back? <input type="checkbox"/> Fibromyalgia or myalgia?		<input type="checkbox"/> High blood pressure, arteries or veins? <input type="checkbox"/> Stroke or cerebral vascular condition? <input type="checkbox"/> Diabetes or glandular condition? <input type="checkbox"/> Stomach, upper or lower digestive tract? <input type="checkbox"/> Coronary arteries of the heart? <input type="checkbox"/> Lung or respiratory disorder? <input type="checkbox"/> Chronic fatigue syndrome? <input type="checkbox"/> Arthritis or joints (including replacements)?		<input type="checkbox"/> Breasts or reproductive organs (including implants, infertility, irregular menstruation, complications from pregnancy)? <input type="checkbox"/> Epilepsy or any nervous, mental or emotional disorder? <input type="checkbox"/> Neurological condition (including Multiple Sclerosis, Parkinson's, seizures, Alzheimer's)? <input type="checkbox"/> Any disease of the immune system (except HIV)?		
<input type="checkbox"/> None of the Above						
<b>Health Question 2</b>					<b>Response*</b>	
During the past seven years, have you been diagnosed or treated by a member of the medical profession for having: Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or Human Immunodeficiency Virus (HIV) infection (symptomatic or asymptomatic)?					<input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>Health Question 3</b>					<b>Response*</b>	
During the past seven years, other than questions 1 and 2 above, have you:						
<input type="checkbox"/> Been diagnosed or treated by a medical professional? <input type="checkbox"/> Had surgery or been hospitalized? <input type="checkbox"/> Had a medical or diagnostic examination or evaluation?		<input type="checkbox"/> Had or been advised to seek treatment for any illness, injury or disorder? <input type="checkbox"/> Received medical care?			<input type="checkbox"/> YES <input type="checkbox"/> NO	



**Section 5 Cont'd: Health Information** (Please print clearly. A response is required for each health question.)

Health Question 4	Response*
Have you been absent from work for more than five consecutive working days because of illness or injury during the past five years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Health Question 5	Response*
Within the past six months, have you been prescribed medication by a medical professional or taken any medication requiring a prescription?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Health Question 6	Response*
During the past seven years, have you regularly used unlawful drugs (including cocaine, hallucinogens or narcotics), or regularly used prescription drugs other than as prescribed (including sedatives, tranquilizers or narcotics), in any form?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Health Question 7	Response*
If female, are you pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, please provide anticipated delivery date (MM/DD/YYYY): ___ / ___ / _____	

**Part B – If you responded YES questions 1, 2, 3 or 4 above, you must complete the following, as applicable:**

Ques. #	Condition, Injury, Diagnosis, Symptom of Ill Health, Type of Operation and/or Findings of Exam	Date of Occurrence (MM/DD/YYYY)	Duration (WEEKS, MONTHS OR YEARS)	Degree of Recovery (% OF FUNCTION)

**Part C – If you responded YES to question 5 above, you must complete the following, as applicable:**

Medication Name (FROM PRESCRIPTION LABEL)	Dosage/Frequency	Dates Taken (MM/DD/YYYY - MM/DD/YYYY)	Reason for Taking

**Section 6: Required Fraud Warnings – Please Read** (State specific warnings apply to the residents of each specific 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.
- **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:** 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 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.
- **New Jersey:** Any person who includes any false or misleading information on an application for insurance 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 crime and may subject such person to criminal and civil penalties.
- **Puerto Rico:** Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between \$5,000 and \$10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.
- **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.
- **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.

**Section 7: Authorization to Disclose Personal Information & Application for Insurance****Part A – Definitions of Terms Used in Section 7**

**MIB Group, Inc. (MIB)** means a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members.

**Personal Information** means information about me, including health information such as medical history, mental and physical condition, drug and alcohol use and other information such as motor vehicle reports and criminal activity.

**Part B – Authorization to Receive and Disclose Personal Information**

**To the MIB:** I authorize you to disclose Personal Information to Mutual of Omaha Insurance Company (“Mutual of Omaha”) or a company affiliated with Mutual of Omaha. You are not authorized to disclose Personal Information about me to a consumer reporting agency. Personal Information received (a) will be used in connection with the underwriting of insurance; (b) will assist in verifying the accuracy of the information I have provided in my application for insurance; and (c) will assist in resolving any issues that may arise in connection with a claim.

I also authorize Mutual of Omaha and its affiliated companies to disclose Personal Information to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it.

**Name(s) used for medical records (if different than the name provided on the form):** \_\_\_\_\_

**Part C – Application for Insurance**

I apply for disability insurance for me. I understand that any insurance in excess of the guaranteed issue amount will not begin until Mutual of Omaha or a company affiliated with Mutual of Omaha approve the amount. Information in this form is given to obtain the insurance requested and is true and complete to the best of my knowledge and belief. I know that insurance could be void if these answers are not true and complete. I understand that insurance for new or additional coverage does not begin until my certificate is issued or amended and the first premium paid.

I understand that this form is only valid for 90 days from my signature date below. If Mutual of Omaha or a company affiliated with Mutual of Omaha request additional medical information to complete processing of this form, I understand that any delay in my response may make it necessary for me to submit a new form.

I understand that I may refuse to sign this form, and that if I refuse to sign, the insurance I am applying for will not be issued.

I will retain a copy of this form with my certificate/summary of coverage. I understand that I, or my authorized representative, may receive a copy of this form upon request. A copy of this form is as effective as the original.

By signing below, I acknowledge that (a) I understand and agree to the terms of this form; and (b) this form has been completed in accordance with the instructions provided by Mutual of Omaha or a company affiliated with Mutual of Omaha. I also acknowledge that incomplete information on this form may delay processing.

SIGNATURE OF EMPLOYEE/MEMBER \_\_\_\_\_ DATE \_\_/\_\_/\_\_\_\_

**Section 8: Form Submission**

To help ensure efficient processing, mail the completed form to:

Attn: USI Affinity  
P.O. Box 338  
Grand Rapids, MI 49501-0338

**FORM IS NOT COMPLETE UNTIL SIGNED AND DATED – RETAIN A COPY OF THIS FORM FOR YOUR RECORDS**