Financial security that's with you all the way.

Voluntary Disability insurance from New York Life Group Benefit Solutions.

A disability doesn't always mean a serious handicap. It can be any illness or injury that prevents you from earning your salary. Consider what would happen if you couldn't work or pay your bills. How might this affect your savings and your lifestyle? Disability insurance from New York Life Group Benefit Solutions (NYL GBS), can help provide the financial protection you'll need if you experience a covered illness or injury that keeps you out of work.

Why is disability insurance important?
Disability insurance can pay you benefits if you suffer a covered disability. Think of it as insurance for a portion of your paycheck. Payments may come directly to you or someone you designate and can help pay for things like:

- Groceries
- The mortgage
- Utilities
- Medical bills

Who's eligible for disability insurance, and what are the plan options?
All active, Employees of the Employer regularly working a minimum of .50 full-time equivalent per week, as defined by your Employer, excluding temporary or seasonal Employees. Coverage is available for Short-term disability (STD).

Short-term disability	Weekly benefit*	Maximum weekly benefit	Benefit waiting period	Maximum benefit period (includes benefit waiting period)
	60% of your weekly covered earnings	$1,500	For Accident - 14 days For Sickness - 14 days	For Accident - 13 weeks For Sickness - 13 weeks

Employee's Monthly Cost of Coverage:

Age	Monthly Rate per $10 of Weekly Benefit
0-54	$0.084
55-59	$0.102
60-64	$0.121
65-99	$0.132

How to Calculate Your Monthly Cost:

Step 1: Divide your annual salary by 52 to calculate your weekly earnings.

Step 2: Multiply this amount by the benefit percentage defined above in the Available Coverage section. For example, 60% would be .60. Now, you have your gross weekly benefit.

Step 3: Use the chart above to find your Monthly rate based on age. Multiply this rate by your gross weekly benefit, or the maximum gross weekly benefit, whichever is less.

Step 4: Divide the total by 10. The result is your Monthly cost.

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

What features are included with my coverage?

Your NYL GBS Disability insurance includes access to a suite of programs[1] and services, available from day one. They're included with your plan so you're automatically enrolled, and it's our way of saying thanks for being a valued customer.

Employee Assistance & Wellness Support[2]

Emotional support for you and/or family members at no additional cost. Access available 24 hours a day, seven days a week. Includes work/life assistance, coaching, online articles, resources and videos for work/life issues.

Financial, Legal & Estate Support[2]

Professional support for all types of financial, legal or estate issues including tax consultations, credit questions and much more. Assistance also includes identity theft and fraud resolution services and online tools for state-specific wills and other important legal documents.

If I sign-up, how does it work?

- After you select your plan options and enroll in disability insurance from NYL GBS, you'll pay for your chosen plan amount through convenient payroll deductions.
- Once enrolled, If you experience a covered injury or illness that prevents you from working, you'll receive a percentage of your covered earnings for a specified amount of time.

Contact your Human Resources Department to review the Disability Summary of Benefits and policy documents to learn more about plan details, costs, exclusions and limitations.

*Your benefit amount will be reduced by any amounts payable to you by any of the sources listed under the "Effects of Other Income Benefits" section.

[1] These programs are NOT insurance and do not provide reimbursement for financial losses. Some restrictions may apply. Not available for policies issued by New York Life Group Insurance Company of NY. Programs are provided through third party vendors who are solely responsible for their products and services. Full terms, conditions and exclusions are contained in the applicable client program description and are subject to change. Program availability may vary by plan type and location and are not available where prohibited by law.

[2] These programs are NOT insurance and do not provide reimbursement for financial losses. Some restrictions may apply. Customers are required to pay the entire discounted charge for any discounted products or services available through these programs. Some service available at the option of employer for an additional cost. Programs are provided through third party vendors who are solely responsible for their products and services. Full terms, conditions and exclusions are contained in the applicable client program description and are subject to change. Program availability may vary by plan type and location and are not available where prohibited by law. These programs are not available under policies issued by New York Life Group Insurance Company of NY. Services are provided exclusively by ComPsych® effective January 1, 2023. ComPsych is solely responsible for its services and is not affiliated with New York Life Insurance Company or any of its affiliates.

New York Life Group Benefit Solutions products and services are provided by Life Insurance Company of North America and New York Life Group Insurance Company of NY, subsidiaries of New York Life Insurance Company. Life Insurance Company of North America is not authorized in NY and does not conduct business in NY.

Policy forms: Disability -TL-004700 et al.

New York Life Insurance Company

51 Madison Avenue
New York, NY 10010

123467 c 0722 SMRU1902924 (Exp.09.26.2024) Marion County SR 65165091-

EVIDENCE OF INSURABILITY FORM

VOLUNTARY SHORT-TERM DISABILITY

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Life Insurance Company of North America (LINA)
(herein called the Insurance Company)
For info and customer service call 1-866-607-2360

PO Box 20310
Lehigh Valley, PA 18003

- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

Important: Please enter all dates in mm/dd/yyyy format. Return form to: New York address above, Fax 1-800-440-0856, Email: bethlehemmail@newyorklife.com

Employer Use: (Mandatory Data Needed) In order to process this form, the employer must complete this information.

Employer: Marion County Policy(s) VDT961169

Class: _____ Location: _____ Date of Hire: _____ Annual Salary: _____ Verified By: _____

Reason for Request: (i.e. New Hire, Late Entrant, Initial/Ongoing Enrollment, etc.) _____

	VDT961169	
DISABILITY AMOUNT TO BE UNDERWRITTEN		

EMPLOYEE SECTION

Employee Name (first, middle, last) _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Phone _____ ID # _____ Birthdate _____ Gender: ☐ M ☐ F

IMPORTANT
Please complete each section that follows.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee info in this section if you are applying for Disability Insurance more than 31 days of becoming eligible due to a life status change or during an ongoing enrollment event.

Height and Weight Information

Employee Height ____ft.____in. Weight _____lbs.

PHYSICIAN SECTION

Employee Physician Name _____ Phone Number _____

Street Address _____ City _____ State _____ Zip _____

SECTION A: Please indicate your answers for each question in this section by checking the Yes or No box for the question.

Within the last 5 years has the proposed insured been: diagnosed with any of these conditions; told by a medical professional he/she has or may have any of the conditions; or been treated by a medical professional for any of the conditions shown below?	Employee Yes	Employee No
A. High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?		
B. Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?		
C. Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?		
D. Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?		
E. HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?		
F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?		
G. Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?		
H. Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?		
I. Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?		
J. Alcohol or drug abuse or dependency?		
K. Any condition affecting hearing or vision, including any loss of sight or hearing, or dizziness or Vertigo?		
L. Carpal Tunnel Syndrome; neck, back, knee or joint condition, strain, sprain or other type of injury?		
M. Any bone, joint, or muscle condition persisting for, or having been treated for, 6 months or longer?		
N. Fibromyalgia, chronic pain, Chronic Fatigue, Irritable Bowel Syndrome (IBS), Multiple Sclerosis, or Temporomandibular Joint (TMJ) Disease?		
O. Received any form of physical therapy; been seen by a chiropractor or other non-MD medical practitioner or therapist for any reason?		

If you answered "Yes" to any questions above, please provide details in the table below.

Name _____ Social Security #_____

SECTION B: Please indicate your answers for each question in this section by checking the Yes or No box for the question.	Employee	
Within the last 5 years has the proposed insured been:	Yes	No
A. Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?		
B. Smoked cigarettes:		
1. For how many years has the proposed insured smoked?		
2. Approximately how many cigarettes are, or were, smoked on average per day?		
3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking?		
C. Used any controlled or illegal drug or other substance?		
D. Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?		
E. Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?		
F. Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?		

If you answered "Yes" to any questions above, please provide details in the table below.

Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.

Name of Employee	*Medical Condition*	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

AGREEMENTS AND AUTHORIZATION

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

(1) This request will be a part of the policy that provides the insurance.
(2) I may need to provide more medical info.
(3) I may need to take medical tests and report the results to the Insurance Company.
(4) I must report any change in my health that happens before the insurance is effective.
(5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

Authorization. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original. I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request. I understand that the info will be used to assess my request for insurance. I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law. I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

Pre-Existing Condition Limitation: "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance. I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

Caution: Any person who includes any false or misleading information on an application for an insurance policy, may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk assumed.

Sign Here _____ *Employee's Signature* _____ *Month/Day/Year*

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.