California State Firefighters' Employee Welfare Benefits Corporation

INDIVIDUAL SAFETY MEMBER

Long Term Disability Program - Summary of Benefits

How Benefits are Funded	LTD coverage is underwritten by Standard Insurance Company - A.M. Best rated A (Excellent). Financial size category XII ($1billion to $1.25 billion)
Percentage of Wages Protected	**70%** of the first $8,572 of your Pre-Disability Earnings
Maximum Monthly Benefit	**$6,000** (70% of $8,572) reduced by deductible income.
Minimum Monthly Benefit	$50 monthly for work related disabilities. $200 monthly for disabilities that are not work-related
Maximum Benefit Period	**To age 65** if age 61 or younger when Disability began. Maximum Benefit Period for Disabilities that occur after age 61 will be determined by your age when Disability began
Own Occupation Benefit Period	24 months following the waiting period
Waiting Period	Non Industrial: 30 days Industrial: 90 calendar days
Rehabilitation Benefit	Provides training, education, family care and job search expenses.
Reasonable Accommodation Expense Benefit	Reimburses employers up to $25,000 for approved modifications to disabled employees' work place.
Sick Leave Integration Benefit	Receive 100% of base pay through use of 50% leave time and 50% LTD benefit
Cost of Living Benefit (COLA) (Non-Industrial)	Based on increases in Consumer Price Index (CPI-W), up to 5% compounded annually. Non Industrial Disabilities only.
Mental Disorders	Benefits are limited to 3 months for each continuous period of disability, or as long as hospitalized.
Drug & Alcohol Use	Benefits limited to 12 months
Musculoskeletal & Connective Tissue Disorders	For certain conditions, benefits are limited to 24 months for each continuous period of disability
Survivors Benefits	Eligible dependents will receive a lump sum benefit equal to 6 times the member's last LTD monthly benefit, after reductions by deductible income.
Death Benefit	$15,000 (CSFEWBC Self Funded)

Monthly Premium: $22.00

*Rate is guaranteed to 12/31/2016

What is deductible income?

Deductible income is income you receive or are entitled to receive while LTD benefits are payable. It is used to reduce the amount of your LTD benefits and includes, but is not limited to, the following:

- Sick pay, and other forms of salary continuation, including donated amounts, (but not vacation pay, or lump sum buy-back of your sick leave) you receive from your employer.
- Any amount you receive or are entitled to receive because of your temporary or vocational disability under workers' compensation law or similar law, including amounts for partial or total disability.
- Any amount you, your spouse, or your children under age 18 receive or are entitled to receive because of your disability under the Federal Social Security Act or any similar act or plan.
- Any amount you receive because of your retirement under the Federal Social Security Act or any similar act or plan.
- Any amount you receive or are entitled to receive because of your disability under any state disability income benefit law or similar law.
- Any amount you receive because of your disability under any other group insurance coverage to the extent that it exceeds 80% of your pre-disability earnings when added to your LTD benefit.
- Any amount you receive or are entitled to receive because of your disability, or any amount you receive because of your retirement, under your employer's retirement plan, including a public employee retirement system, a state teacher retirement system, and a plan arranged and maintained by a union or employee association for the benefits of its members.
- Any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.
- Earnings from work you perform while you are disabled.

What exclusions apply to this coverage?

You are not covered for a disability caused or contributed to by any of the following:

- Your committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot (except while performing your official duties).
- An intentionally self-inflicted injury, while sane or insane.
- War or any act of war (declared or undeclared, and any substantial armed conflict between organized forces of a military nature)
- A pre-existing condition or the medical or surgical treatment of a pre-existing condition unless on the date you become disabled, you have been continuously covered under the plan for the 12-month exclusion period and actively at work for at least one full day after the end of the exclusion period.

What is a pre-existing condition?

A pre-existing condition is a mental or physical condition, for which you have done any of the following at any time during the Pre-existing Condition Period shown below:

- Received medical treatment, care or services.
- Taken prescribed medications.

The pre-existing condition period is the 180-day period just before your LTD coverage becomes effective.

What limitations apply to this coverage?

LTD benefits are not payable for any period of time when you are:

- Not receiving appropriate care from a physician until maximum point of recovery.
- Confined for any reason in a penal or correctional institution.

In addition, payment of LTD benefits is limited in duration:

- To 12 months during your entire lifetime for a disability caused or contributed to by your alcoholism, drug addiction, or use of any hallucinogens
- To 3 months of each period of continuous disability caused or contributed to by a mental disorder (unless you are hospital-confined at the end of the 3 months)
- To 24 months for each period of continuous disability caused or contributed to by musculoskeletal for connective tissue disorders.

How is "disability" defined?

You will be considered to be "disabled" if you meet the following requirements:

Own Occupation Definition:

- During the Benefit Waiting Period and the Own Occupation Period you are required to be Totally Disabled or Partially Disabled from your Own Occupation
- You are Totally Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy, or Mental Disorder, you are unable to perform with reasonable continuity the Substantial and Material Acts necessary to pursue your Own Occupation and you are not working in your Own Occupation.
- You are Partially Disabled from your Own Occupation if you are not Totally Disabled and you are actually working in our Own Occupation but, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to earn 80% or more of your Indexed Pre-disability Earnings

Any Occupation Definition:

- After the Own Occupation Period you are required to be Disabled from all occupations or Partially Disabled
- You are Totally Disabled from all occupations if, as a result of Physical Disease, Injury, Pregnancy, or Mental Disorder, you are unable to engage with reasonable continuity in Any Occupation.
- You are Partially Disabled if you are not Totally Disabled and you are actually working in an occupation but, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to engage with reasonable continuity in that occupation or Any Occupation.

LTD benefits will end automatically if you are working in your own or any occupation and earning 80% or more of your Indexed Pre-disability Earnings.

How do I become covered?

To become insured, you must apply (complete and return the front page of the attached application form). Your coverage will not become effective until it has been approved. Regardless, you also must be capable of active work on the day before the scheduled effective date of your coverage (or an increase of coverage).

The effective date of coverage will be the first day of the first calendar month following the approval of your application.

What is a "Safety Member"?

A safety member is an employee who is eligible to receive benefits under California Labor Code Section 4850 and safety employee benefits under the County Employees Retirement Act of 1937 or Public Employees Retirement Systems (PERS) of California, or benefits comparable thereto, with their employer at the time of Disability is incurred.

Applicant Name:	Social Security #:

Describe below any yes answers to the Health Questionnaire (please provide the entire question number)

Question No.	Description of Injuries, Disorders and Operations.	Month/Year	Duration	Final Result	Physicians Consulted City and State

Acknowledgement and Authorization for Release of Information. *(Please read carefully.)*

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any attachments, are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application if pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, The Standard's liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, and the Medical Information Bureau Inc. (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to The Standard or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information of the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information obtained by authorization to determine my eligibility for group insurance coverage. I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I understand The Standard may release information it has about me to the MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation of file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and I have kept a copy of this Medical History statement.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid one year from the date of the signature below. A photocopy or facsimile of this authorization shall be considered as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it had been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.

_____ _____

Signature of Applicant Date

Information Practices Notice

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (Medical Information Bureau).
- We will use the authorization you signed on this form when we seek this information.
- MIB (MEDICAL INFORMATION BUREAU) - Information regarding your insurability will be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.
- Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: Post office Box 105, Essex Station, Boston, Massachusetts, 02112.
- Standard Insurance Company may release information in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may release information in its file to other insurance companies to whom yo may apply for life or health insurance, or to whom a claim for benefits may be submitted.
- DISCLOSURE TO OTHERS - The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS - You have a right to know what information we have about you in our underwriting file. You also have the right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon, 97204 or call 800-843-7979.

Note: Declinations do not effect either Guarantee Issue Amounts not subjected to Evidence of Good Health (Insurability) or other coverages already in force with Standard Insurance Company.

DETACH FORM HERE

Group Long Term Disability Application
INDIVIDUAL MEMBER - Long Term Disability Program

DIRECTIONS: This form must be completed when Evidence of Insurability is required under your plan. To apply for coverage (as a Member) read the notice(s) on back page of application. Then complete all items, sign, and date below. When finished, send original to Myers-Stevens & Toohey& Co., Inc. and keep a copy for your records

Please print clearly (black ink): Fax, Mail or Scan and E-Mail to:

Myers-Stevens & Toohey & Co., Inc. | 26101 Marguerite Parkway | Mission Viejo | CA 92692
phone 800.827.4695 | fax 949.348.2630 | CSFA@myers-stevens.com | license #0425842

California State Firefighters' Employee Welfare Benefits Corporation (Plan 648353-B)

Tell Us About Yourself:

Your Name		Sex _____Male _____Female	SSN
Home Address			
City		State	ZIP
Date of Birth	E-Mail Address	Home Phone	Work Phone
Full Name of Your Employer			Date Employed
Association Name		Monthly Salary $	

I am a: _____ Safety Employee

Safety Member to be an employee who is eligible to receive benefits under California Labor Code Section 4850 and safety employee benefits under the County Employees Retirement Act of 1937 or Public Employees Retirement Systems (PERS) of California, or benefits comparable thereto, with their employer at the time of Disability is incurred.

If payroll deduction is not available, I wish to be billed ☐ Quarterly ☐ Semi-Annually ☐ Annually

As a member in good standing of CSFA and having read the attached brochure describing the benefits. I hereby apply for coverage under my association's disability plan which is subject to the provisions of the group policy issued by Standard Insurance Company to California State Firefighters' Employee Welfare Benefits Corporation. I certify that I am working full-time and able to perform all the required duties of my occupation. Upon approval of this application, I authorize my employer to make the necessary deductions from my wages or salary to cover my contribution (if any) for the cost of this coverage. If payroll deduction is not available, I understand I will be billed direct.

Member's Signature _____ **Date** _____

Check "yes" or "no" for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.

	YES	NO
1. Are you now unable to work full-time because of any physical or mental condition, or injury?	☐	☐
2. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:		
A. Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal ailment, or digestive system disorder?	☐	☐
B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, blindness, deafness, or any other neurological or muscle disorder?	☐	☐
C. Cancer, tumor, lesions, leukemia, lymphoma, blood clotting or other malignancy or growth?	☐	☐
D. Cardiovascular disease, heart ailment, arteriosclerosis, abnormal pulse, high blood pressure, heart murmur, valve, circulatory, or vascular disorders?	☐	☐
E. Emphysema, asthma, bronchitis, sleep apnea, or other respiratory or lung disease?	☐	☐
F. Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Disorder (HIV)?	☐	☐
G. Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints, back, or spine, arthritic or disc conditions?	☐	☐
H. Diabetes, thyroid, gland, spleen, or nephritis?	☐	☐
I. Drug or alcohol abuse, or have you used alcohol, drugs or nicotine in a manner that has resulted in medical treatment?	☐	☐
J. Psychiatric or mental condition, depression, adjustment disorder, affective disorder, anxiety disorder, or obsessive-compulsive disorder?	☐	☐
3. In the past 10 years have you had any illness or injury not listed above which resulted in the use of prescribed medication or physician visits?	☐	☐
4. Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	☐	☐
5. Are you currently pregnant?	☐	☐

HEIGHT	WEIGHT	PHYSICIAN OR MEDICAL FACILITY WITH APPLICANT'S COMPLETE MEDICAL RECORDS Name and Full Mailing Address

DETACH FORM HERE

Refer to group policy for complete details. CA License Number 0425842
Standard Insurance Company | Medical Underwriting | 900 SW Fifth Avenue | Portland, OR 97204 | Please complete and sign application

California State Firefighters' Employee Welfare Benefits Corporation

Plans arranged by:

Myers-Stevens & Toohey & Co., Inc.
26101 Marguerite Parkway | Mission Viejo, CA 92692
CA License No. 0425942 | 800-827-4695 | fax 949-348-2630