NATIONAL INSURANCE SERVICES

EAU CLAIRE AREA SCHOOL DISTRICT
ADMINISTRATORS VOLUNTARY SHORT TERM DISABILITY
ENROLLMENT

⇒ **If enrolling for the first time or if you are currently enrolled in Short Term Disability**, please:

- Complete the top portion of the enrollment form
- Select a flat weekly benefit amount (note corresponding *monthly premium* amounts)
- Benefit amount cannot exceed 66-2/3% of your annual salary divided by 52 (please see calculation sheets attached)
- First 9 benefit amounts do not require medical questionnaire during initial enrollment period
- Last 3 benefit amounts **always** require a medical questionnaire
- Please sign "Employee Coverage Authorization" section of form

⇒ **If choosing not to enroll**, please:

- Sign the "Waiver of Insurance" section of the form
- If not enrolling during the only open enrollment session, all late enrollees will be required to submit a medical questionnaire and be approved before coverage would be effective (regardless of the amount selected).

PLEASE RETURN ALL FORMS TO TAMI ROWE BY May 24, 2013

Benefits will be effective July 1, 2013

VERY IMPORTANT INFORMATION

Should you submit a medical questionnaire for one of the three higher benefit amounts, and are denied, you will automatically be given the highest benefit level that does not require medical questions ($504).

This is your only opportunity to sign up for the short term disability benefit within the open enrollment period without medical questions required for the first nine benefit amounts.

ADMINISTRATORS
VOLUNTARY SHORT TERM DISABILITY
BENEFIT INFORMATION*

- **Benefit begins** 1st day Accident and 4th day Sickness
- **Minimum Benefit Duration** is the greater of 45 consecutive calendar days or until eligible to receive benefits under the long-term disability plan
- Can collect short term disability benefit PLUS sick leave and / or workers' comp.
- Benefits are paid over the summer months
- Benefits are received tax-free (if premiums are paid with post tax dollars i.e. not through a flex plan)
- Benefit dovetails with Long Term Disability
- Maternity is covered – Standard 6 weeks (natural child birth), 8 weeks (cesarean).
- Premiums are automatically waived while collecting short or long term disability
- 12/12 pre-ex applies. This provision applies to all new enrollees and employees electing to increase their weekly benefit amount. Benefits will not be paid during the first 12 months of coverage for Pre-Existing Conditions. That is, if the insured employee received medical treatment, took prescribed drugs, or consulted a physician for an illness or injury in the 12 months before becoming covered under the plan or before increasing their benefits under the plan, that particular sickness or injury or anything related to that condition will not qualify the insured employee for benefits during the first 12 months of the plan.

Disability and disabled mean that during the Elimination Period and the Benefit Payment Period the insured person is, as a result of physical disease, injury, pregnancy, substance abuse or mental disorder, unable to perform a majority of the material duties of his or her own occupation.

Disabilities that occur during the summer are covered as long as the disability would have prevented you from engaging in your normal occupation if school were in session.

*A full short term disability certificate booklet will be provided once enrollment is completed.

QUESTIONS, PLEASE CALL Lance Pfarrer at 800-627-3660

VOLUNTARY SHORT TERM DISABILITY

BENEFIT AMOUNT SELECTION

- Weekly Benefit cannot be more than 66-2/3% of annual salary divided by 52.
- Listed below are the salary limits for the weekly benefit amounts available.
- You can choose any benefit amount you prefer as long as it is at or below 66-2/3% of your annual salary divided by 52.

You can apply for this weekly benefit Or any benefit less than this……	If your annual salary is:
$147.00	$11,465
$175.00	$13,649
$224.00	$17,471
$273.00	$21,292
$301.00	$23,476
$357.00	$27,844
$420.00	$32,758
$462.00	$36,034
$504.00	$39,310
$580.00*	$45,237
$667.00*	$52,023
$767.00*	$59,823

Following are some examples:

- Annual salary of $15,000 can apply for a benefit amount of $175 or less
- Annual salary of $22,000 can apply for a benefit amount of $273 or less
- Annual salary of $30,000 can apply for a benefit amount of $357 or less
- Annual salary of $40,000 can apply for a benefit amount of $504 or less

*To be eligible for these benefit levels, you must provide proof of insurability by answering a health questionnaire and meeting medical requirements.

Madison National Life Insurance Company
Independence Holding Group

Administrators Enrollment Form

Return to:
National Insurance Services
250 S. Executive Drive, Suite 300
Brookfield, WI 53005-4273
Attn: Billing Department
1-800-627-3660

EMPLOYEE INFORMATION

NAME OF EMPLOYER			GROUP NUMBER
EAU CLAIRE AREA SCHOOL DISTRICT			**000033**
NAME OF EMPLOYEE (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY #	☐ SINGLE ☐ MARRIED	☐ MALE ☐ FEMALE
HOME ADDRESS OF EMPLOYEE (STREET, CITY, STATE, ZIP CODE)	**U.S. CITIZEN?** ☐ YES ☐ NO-*(SEE ☑ BELOW)*	DATE OF BIRTH	EMPLOYMENT DATE
JOB TITLE	JOB DUTIES	HOURS WORKED PER WEEK	ANNUAL SALARY

COVERAGE(S) ELECTED

☐ SHORT TERM DISABILITY (Weekly Benefit cannot exceed 66-2/3% of annual salary divided by 52)

CHECK BENEFIT DESIRED

Weekly Benefit	Rate per Month
☐ $147.00	$7.74
☐ $175.00	$9.02
☐ $224.00	$11.60
☐ $273.00	$14.19
☐ $301.00	$15.47
☐ $357.00	$18.48
☐ $420.00	$21.51
☐ $462.00	$23.65
☐ $504.00	$25.80
☐ $580.00*	$29.54
☐ $667.00*	$33.97
☐ $767.00*	$39.06

*To be eligible for these benefit levels, you must provide proof of insurability by answering a health questionnaire and meeting medical requirements.

All late enrollees will require a health questionnaire.

☑ If an enrollee is not a United States citizen, please attach a copy of his or her Visa.

EMPLOYEE COVERAGE AUTHORIZATION

WARNING: 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 may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

By signing this Application I understand and agree that:

- I authorize my Employer to make any required deductions, if any, from my salary to pay the premium of my insurance coverage

in effect.

- All statements and answers I have given are complete and true to the best of my knowledge and belief.
- Coverage is not in effect until final approval is given by Madison National Life Insurance Company, Inc.
- No person, except an officer of Madison National Life, is authorized to vary or modify a contract.

Employee/Applicant Signature	**Date**

EMPLOYEE WAIVER OF INSURANCE

I have been given the opportunity to apply for group insurance as presented to me, but do NOT wish to take the coverage(s). I understand that if my dependents or I decide to apply for this Group insurance plan at a later date, Evidence of Insurability will be required at my own expense, and must be approved by Madison National Life Insurance Company, Inc.

Employee/Applicant Signature	**Date**

Mail the original of the form to the address in top right corner of Page 1. A copy goes to the insured employee and also to the group administrator to be retained.

FOR NATIONAL INSURANCE SERVICES USE ONLY:		
Notes:		
Date Received:	**Effective Date of Coverage:**	**Plan No.**

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601
Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717

Return application to:
National Insurance Services
250 South Executive Drive, Suite 300
Brookfield, WI 53005-4273
Attention: Billing Department

Evidence of Insurability

(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es):		**Reason for Applying:** ☐ New Hire ☐ Late Enrollee
☐ Life/AD&D	☐ Supp. Life:$ _____	☐ Increase in Coverage amount ☐ Reinstatement
☐ Long Term Disability	☐ AD&D:$ _____	☐ Adding Dependent(s) ☐ Applying for coverage over GI
☐ Short Term Disability	☐ AD&D:$	☐ Other:

APPLICANT INFORMATION

Applicant's Name: Last, First, MI	**Sex:** ☐ M ☐ F	**Age:**	**Date of Birth:** / /

Height:	**Weight:**	**Applicant's Social Security No.** - -	**Already Enrolled?** ☐ Yes ☐ No

Applicant's Home Address: (Street, City, State, Zip)	**Applicant's Daytime Phone No.** ( )

Applicant's Current Physician's Name:	**Date Last Visited:** / /	**Reason for Visit:**

Physician's Address: (Street, City, State, Zip)	**Physician's Phone No.**

Employee Member Name: (if different than Applicant)	**Employee's Job Title:**

Employee's Date of Hire:	**No. of Hours Employee Works Per Week:**	**Employee's Annual Salary:** $

Employer Name:	**Employer's Address:** (Street, City, State, Zip)

HEALTH QUESTIONS

Check Yes or No, circle all applicable "Yes" disorders or procedures and give details below.

I. Are you currently pregnant? ☐ Yes ☐ No **If "Yes", what is your expected due date:**

II. In the past 5 years have you been diagnosed or treated by a medical professional for any of the following conditions?

A. HEART		**D. PAIN & DISCOMFORT**	
1. Heart ailment?	☐ Yes ☐ No	1. Arthritis, bursitis or gout?	☐ Yes ☐ No
2. Chest pain, angina or shortness of breath?	☐ Yes ☐ No	2. Recurrent back pain or slipped disk?	☐ Yes ☐ No
3. Irregular heart beat or heart murmur?	☐ Yes ☐ No	3. Disorder of the back, neck or spine?	☐ Yes ☐ No
4. Rheumatic fever?	☐ Yes ☐ No	4. Disorder of the muscles, bones or joints?	☐ Yes ☐ No
5. Disease or abnormality of heart muscle, nerves or vessels?	☐ Yes ☐ No	5. Temporomandibular joint (TMJ) Disorder?	☐ Yes ☐ No
6. Stress test; electrocardiogram or echocardiogram?	☐ Yes ☐ No	6. Recurrent abdominal pain?	☐ Yes ☐ No
B. TUMORS/CYSTS		**E. OTHER**	
1. Cancer of any type?	☐ Yes ☐ No	1. Stroke, seizure disorder or epilepsy?	☐ Yes ☐ No
2. Tumors, cysts, or polyps?	☐ Yes ☐ No	2. Migraine or persistent headaches?	☐ Yes ☐ No
C. BLOOD AND URINE		3. Nervous/mental disorder, depression or anxiety?	☐ Yes ☐ No
1. High or low blood pressure or hypertension?	☐ Yes ☐ No	4. Dizziness or paralysis?	☐ Yes ☐ No
2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes?	☐ Yes ☐ No	5. Asthma, emphysema, breathing or lung disorder?	☐ Yes ☐ No
3. Disorder of kidneys or bladder or kidney stones?	☐ Yes ☐ No	6. Indigestion, ulcers or irritable bowel?	☐ Yes ☐ No
4. Diabetes, high or low blood sugar?	☐ Yes ☐ No	7. Chronic fatigue?	☐ Yes ☐ No
5. Protein, blood or sugar in urine?	☐ Yes ☐ No	8. Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No
6. Night sweats, persistent swollen glands or diarrhea?	☐ Yes ☐ No	9. Aids Related Complex (ARC)?	☐ Yes ☐ No
		10. Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No

HEALTH QUESTIONS *continued….*

Check all applicable disorders and give details below.

III. In the past 5 years have you been diagnosed or treated by a medical professional for a disease or disorder of the:

A. Brain or nervous system?	□ Yes □ No	D. Prostate, ovaries or uterus?	□ Yes □ No
B. Eyes, ears, nose or throat?	□ Yes □ No	E. Stomach, intestine, gallbladder or liver?	□ Yes □ No
C. Skin or lymph nodes?	□ Yes □ No	F. Thyroid, spleen or any gland?	□ Yes □ No

IV. In the past 5 years, have you:

A. Sought or received advice for the use of alcohol or other chemicals or drugs?	□ Yes □ No	C. Been treated or evaluated in a hospital or medical or psychiatric facility?	□ Yes □ No
B. Scheduled or undergone any surgery?	□ Yes □ No	D. Sustained illness requiring medical care or hospitalization?	□ Yes □ No

V. In the last 12 months, have you used tobacco of any kind? □ Yes □ No

VI. Please list all prescribed and non-prescribed medications you currently take:

If you answered "Yes" to any Health Questions in this form, please explain below. (Please use another sheet of paper if necessary.)

Dates	Conditions	Doctor Names and Addresses	Results

ACKNOWLEDGEMENTS, AUTHORIZATIONS & SIGNATURE

I understand all statements and answers I have given are to be relied upon and form the basis of any coverage issued to me and/or my dependents under the Group Policy. 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 Madison National Life Insurance Company, Inc. of any change in my medical condition while my enrollment is pending. I agree that if my enrollment is approved by Madison National Life Insurance Company, Inc., the effective date of any coverage will be determined in accordance with the terms of the Group Policy, including any Actively at Work requirement.

I acknowledge this Evidence of Insurability form (when approved), the Group Policy, Certificate of Insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of Madison National Life Insurance Company, Inc., can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related facility, state or local government agency, insurance or reinsurance company, consumer reporting agency, or employer, to give to Madison National Life Insurance Company, Inc., its legal representative or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization, in connection with this form, shall be valid for 24 months from my signature date and that I have the right to revoke this authorization at any time. I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.

WARNING: 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 may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Applicant's Signature	**Date**
Parent/Guardian Signature (for Dependent enrollees under age 18)	**Date**

FOR INSURER USE ONLY:	Decision: □ Approved □ Postponed □ Declined	Effective Date:
Underwriter's Signature:		Date: