Liberty Mutual

Roman Catholic Archdiocese of Boston

Group Voluntary Short-Term Disability Insurance

Enrollment Guide

Who's Eligible?

All active, full-time employees working a minimum of 1,000 hours per year (20 hours per week for year-round employees) are eligible to participate in the Roman Catholic Archdiocese of Boston Group Voluntary Short-Term Disability (STD) Insurance plan administered by Liberty Life Assurance Company of Boston.

What are my Coverage Options?

The Roman Catholic Archdiocese of Boston Voluntary STD Insurance plan is sponsored by your employer. If you purchase this coverage, become disabled (as defined in the plan), and remain disabled through the elimination period, you will receive 60% of your weekly earnings, less other deductible sources of income (e.g. state mandated benefits, sick pay, etc. See your plan booklet for details). The maximum weekly benefit is $1,000. Your weekly short-term disability benefit is tax free.

Please Note: Pre-existing condition exclusions may affect the payment of benefits.

Disability Facts ... Did you Know?

- Over 54 million Americans, or 19% of the population, are considered disabled.[1]
- In the home, a disabling injury occurs every 3 seconds.[2]
- In the United States, a disabling injury occurs every second.[2]
- Almost 25% of today's 20-year-olds will become disabled before reaching the age of 67.[3]
- Nearly 90% of disabling accidents and illnesses are not work related.[2]
- Maternity leave is considered a disability and is covered under your disability insurance.

1. U.S. Census Bureau, December 2008
2. National Safety Council, Injury Facts, 2008 Edition
3. Social Security Administration Fact Sheet, 2008

What is the Cost for Short-Term Disability Insurance?

The cost of this program is paid for by you. Rates are effective as of January 1, 2012.

Roman Catholic Archdiocese of Boston Voluntary Short-Term Disability Plan Benefit Amount and Cost Table.

		Monthly Cost by Age Group									
Age Band		0-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Annual Salary	Weekly Benefit	*Rate: $0.940	Rate: $0.999	Rate: $0.920	Rate: $0.744	Rate: $0.636	Rate: $0.676	Rate: $0.842	Rate: $1.048	Rate: $1.282	Rate: $1.459
$15,000	$173	$16.27	$17.29	$15.92	$12.88	$11.01	$11.70	$14.57	$18.14	$22.19	$25.25
$20,000	$231	$21.69	$23.05	$21.23	$17.17	$14.68	$15.60	$19.43	$24.18	$29.58	$33.67
$25,000	$288	$27.12	$28.82	$26.54	$21.46	$18.35	$19.50	$24.29	$30.23	$36.98	$42.09
$30,000	$346	$32.54	$34.58	$31.85	$25.75	$22.02	$23.40	$29.15	$36.28	$44.38	$50.50
$35,000	$404	$37.96	$40.34	$37.15	$30.05	$25.68	$27.30	$34.00	$42.32	$51.77	$58.92
$40,000	$462	$43.38	$46.11	$42.46	$34.34	$29.35	$31.20	$38.86	$48.37	$59.17	$67.34
$45,000	$519	$48.81	$51.87	$47.77	$38.63	$33.02	$35.10	$43.72	$54.42	$66.57	$75.76
$50,000	$577	$54.23	$57.63	$53.08	$42.92	$36.69	$39.00	$48.58	$60.46	$73.96	$84.17
$55,000	$635	$59.65	$63.40	$58.38	$47.22	$40.36	$42.90	$53.43	$66.51	$81.36	$92.59
$60,000	$692	$65.08	$69.16	$63.69	$51.51	$44.03	$46.80	$58.29	$72.55	$88.75	$101.01
$65,000	$750	$70.50	$74.93	$69.00	$55.80	$47.70	$50.70	$63.15	$78.60	$96.15	$109.43
$70,000	$808	$75.92	$80.69	$74.31	$60.09	$51.37	$54.60	$68.01	$84.65	$103.55	$117.84
$75,000	$865	$81.35	$86.45	$79.62	$64.38	$55.04	$58.50	$72.87	$90.69	$110.94	$126.26
$80,000	$923	$86.77	$92.22	$84.92	$68.68	$58.71	$62.40	$77.72	$96.74	$118.34	$134.68
$85,000	$981	$92.19	$97.98	$90.23	$72.97	$62.38	$66.30	$82.58	$102.78	$125.73	$143.09
$90,000	$1,000	$94.00	$99.90	$92.00	$74.40	$63.60	$67.60	$84.20	$104.80	$128.20	$145.90

*The rate is equal to monthly cost per $10 of weekly benefit.

The plan maximum monthly benefit amount is $1,000. If your annual earnings are not noted in the above chart, please refer to the worksheet below to estimate your cost of insurance. Rates are subject to change.

How Much Will I Pay?

The following example calculates the monthly cost for a 54-year old employee with annual earnings of $40,000.

Calculation Example		Example	You
Step 1	Indicate your annual earnings.	$40,000	$
Step 2	Enter your weekly earnings. *Divide Step 1 by 52*	$769.23	$
Step 3	*Calculate 60% of your weekly earnings. Multiply Step 2 by .60.*	$461.54	$
Step 4	The maximum weekly benefit amount is $1,000. If the amount in Step 3 is greater than $1,000, indicate $1,000 here. Otherwise, indicate the amount from Step 3.	$461.54	$
Step 5	Use the table below to calculate your monthly cost by age. *Multiply Step 4 by $0.0842.*	$38.86	

Age	Monthly Rate	Age	Monthly Rate	Age	Monthly Rate	Age	Monthly Rate	Age	Monthly Rate
0-24	$0.0940	30-34	$0.0920	40-44	$0.0636	50-54	$0.0842	60-64	$0.1282
25-29	$0.0999	35-39	$0.0744	45-49	$0.0676	55-59	$0.1048	65+	$0.1459

This worksheet allows you to approximate your contributions for Voluntary Short-Term Disability insurance coverage. Cost of insurance may change in the future due to age and/or salary level. Rates are subject to change.

The above information provides highlights of the insurance program. It does not and is not intended to cover the program in detail. Please refer to the policy for a complete description of the coverage, limitations and exclusions.

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Roman Catholic Archdiocese of Boston

Enrollment Form

Voluntary Short-Term Disability Insurance

Please return completed form to your location's benefits administrator.

Employer Name	Group Policy Number
Roman Catholic Archdiocese of Boston	
Location Name	Location Number
Employer Address (City, State, Zip Code)	Coverage Effective Date
	1/1/2012*

*Payroll deductions will begin after 1/1/2012

Employee Name (Last, First, Middle)			
Address (City, State, Zip Code)			
Social Security Number	Date of Birth (MM/DD/YY)	Gender	Marital Status
		☐ Male ☐ Female	☐ Single ☐ Divorced ☐ Married ☐ Widowed
Hire Date (MM/DD/YY)	Annual Salary	Type of Enrollment	
	$	☐ New Employee	☐ Annual/Open Enrollment

Coverage Elections

Please indicate your coverage election below. Please see your plan booklet for additional information.

Type of Coverage	Selection	Coverage Elected
Employee Voluntary Short-Term Disability	☐ Yes ☐ No	60%

Employee Signature and Authorization

☐ ACCEPT: I declare that all information given in this enrollment form is true and complete to the best of my knowledge and belief. I request coverage under my employer's plan of benefits as indicated above. I authorize my employer to deduct from my earnings my contributions for the coverage(s) selected. I understand that with respect to coverages I have declined, Liberty has the right to require Evidence of Insurability in order to consider any later request to change this decision and that my request may be denied. I am an employee in active employment working at the employer's regular place of business.

☐ DECLINE: I hereby decline all optional coverage as offered by my Employer. I certify that I have been given the opportunity by my Employer to enroll for coverage. I understand that Liberty has the right to require Evidence of Insurability in order to consider any later request to change this decision and that my request may be denied. I am an employee in active employment working at the Employer's regular place of business.

Employee Signature: Date:

Completion of this enrollment form does not guarantee coverage. Evidence of Insurability may be required. Please see your plan booklet for additional information.

Submit completed form to your location's benefits administrator and retain a copy for your records.