



California State Firefighters' Employee Welfare Benefits Corporation

INDIVIDUAL MEMBER

Long Term Disability Program - Summary of Benefits

How Benefits are Funded	Funded and administered first 5 years by the CSFEWBC with assets in excess of \$7 million*. Claims are funded by Standard Insurance Company - A.M. Best rated A (Excellent). Financial size category XII (\$1 billion to \$1.25 billion), from the sixth year of benefit eligibility to age 65.
Percentage of Wages Protected	The lesser of: 70% of the first \$8,572 Pre-Disability Earnings; and 75% of your Pre-Disability Earnings reduced by deductible income
Maximum Monthly Benefit	\$6,000 (70% of \$8,572) before reduction by deductible income
Maximum Benefit Period	Safety Members: To age 65 for both accident and illness
Own Occupation Benefit Period	24 months following the waiting period
Waiting Period	Non-Industrial: 30 days (Required use of sick leave may be frozen after 60 days) Industrial: 60 calendar days
Freeze of Sick Leave	After 60 days
Minimum Benefit/ Medical Expense Benefit	\$700 per month combined benefit. Minimum benefit pays \$500 per month after satisfying the waiting period and while receiving sick leave. Medical Expense Benefit pays \$200 per month for 12 months after satisfying the waiting period and is for Non-Industrial Disabilities only.
Sick Leave Integration Benefit	Receive 100% of base pay through use of 30% leave time and 70% 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 & Nervous Disorders	Benefits are limited to 3 months for each continuous period of disability, or as long as hospitalized
Musculoskeletal & Connective Tissue Disorders	For certain conditions, benefits are limited to 24 months for each continuous period of disability
Drug & Alcohol Use	Benefits are limited to 12 months lifetime
Pays Benefits During Disputed Worker's Compensation Cases	After 30 days – 70% of wages to a maximum monthly benefit of \$6,000 (Repayable if determined to be an industrial disability)
Disability Pension Advance	Up to 70% of wages (max. \$6,000 per month benefit) may be advanced during retirement processing
Survivors Benefits	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 Death Benefit (Natural and Accidental causes)

Monthly Premium: \$15.00

What is deductible income?

Deductible income is income you receive or are eligible 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, 4850 pay and other forms of salary continuation (but not vacation pay, or lump sum buy-back of your sick leave).
- Any amount you receive or are eligible 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 eligible to receive because of your disability under the Federal Social Security Act or any similar legislation.
- Any amount you receive or are eligible to receive because of your disability under any state disability income benefit law or similar law.
- Any amount you receive or are eligible to receive because of your disability under any group insurance coverage.
- Any disability or retirement benefits you receive or are eligible to receive under your current Employer's retirement plan or a former 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 benefit of its members.

If any of these plans has two or more payment options, the option which comes closest to providing you a monthly income for life with no survivors benefit will be Deductible Income, even if you chose a different option.

- 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 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:

- Consulted a Physician.
- Received medical treatments or services.
- Taken prescribed drugs or 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 under the ongoing care of a physician.
- Confined for any reason in a penal or correctional institution.

- Scheduled to be away from work without pay.

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 for safety members for 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 and 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 next 24 months of disability you are required to be Disabled only from your Own Occupation.
- You are Disabled from your Own Occupation if, as a result of sickness, injury, or pregnancy you are unable to perform with reasonable continuity the Material Duties of your Own Occupation.

Any Occupation Definition:

- After the Own Occupation Period you are required to be Disabled from all occupations.
- You are Disabled from all occupations if, as a result of sickness, injury, or pregnancy you are unable to perform with reasonable continuity the Material Duties of any gainful occupation for which you are reasonably fitted by education, training, and experience.

Partial Disability Definition:

- During the Benefit Waiting Period and the Own Occupation Period, you are Partially Disabled when you work in your Own Occupation but, as a result of sickness, injury, or pregnancy you are unable to earn more than 50% of your Indexed Predisability Earnings.
- During the Any Occupation Period, you are Partially disabled when you work in an occupation but, as a result of sickness, injury or pregnancy you are unable to earn more than 50% of your Indexed Predisability Earnings in that occupation and in all other occupations for which you are reasonably fitted under the Any Occupation Definition of Disability.

How do I become covered?

To become insured under this plan, 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 in coverage).

The effective date of your coverage and any subsequent increase in your 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 entitled to Safety Employee Benefits under the County Retirement Act of 1937 or PERS of California, Safety Member Status, or the equivalent.

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:

MS 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 609789-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

(A safety member is an employee who is entitled to Safety Employee Benefits under the County Retirement Act of 1937 or PERS of California, Safety Member Status, or the equivalent.)

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 California State Firefighters' Employee Welfare Benefits Corporation Group Long Term Disability Plan. 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 more room is required.)*

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you had any physical, mental or emotional condition, injury, sickness, or surgery in the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you consulted or been attended by a physician or practitioner for any cause in the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you now unable to work full time because of any physical, mental or emotional condition, injury, or sickness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following: | | |
| *High blood pressure, cardiovascular disease, heart ailment, arteriosclerosis, or stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| *Mental condition, depression, epilepsy, or nervous system disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| *Cancer, diabetes, or nephritis? | <input type="checkbox"/> | <input type="checkbox"/> |
| *Arthritis, strained or injured back, slipped disc, or any bone, joint, or muscle disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| *Lung, kidney, stomach, genital, urinary, or intestinal ailment? | <input type="checkbox"/> | <input type="checkbox"/> |
| *Blindness or deafness? | <input type="checkbox"/> | <input type="checkbox"/> |
| *Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or an immune system disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you sought or received advice or treatment for the use of alcohol or drugs in the past 10 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. In the past 10 years have you had a persistent cough, unintentional weight loss of 10 pounds or more, persistent fatigue, persistent lymph node enlargement, prolonged night sweats, pneumonia, lesions, or growths? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you take medication for any physical, mental or emotional condition, injury, or sickness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you plan any operation or visit to a doctor or practitioner for an existing physical, mental or emotional condition, injury, or sickness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

HEIGHT	WEIGHT	PHYSICIAN OR MEDICAL FACILITY WITH APPLICANT'S COMPLETE MEDICAL RECORDS Name and Full Mailing Address
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609789-B

Refer to Plan Documents for complete details. CA License Number 0425842

Standard Insurance Company | Medical Underwriting | 900 SW Fifth Avenue | Portland, OR 97204 | Please complete and sign application

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 is 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), any 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 on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designations 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 you 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.



California State Firefighters' Employee Welfare Benefits Corporation

Plans arranged and administered by:



Myers-Stevens & Toohy & Co., Inc.

26101 Marguerite Parkway | Mission Viejo, CA 92692

CA License No. 0425942 | 800-827-4695 | fax 949-348-2630