

# *Business Overhead Expense Insurance Plan for Members of the American String Teachers Association*

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## **Eligibility**

You are eligible to apply for the Business Overhead Expense Plan if you are under age 60, reside in the U.S. and are actively-at-work (at least 24 hours per week) at the time you apply.

## **Covered Expenses**

Covered Monthly Business Overhead Expense means the overhead expenses you incur in the operation of your office. Covered expenses include: rent, electricity, heat, telephone, laundry and water; depreciation, insurance for the office including professional malpractice insurance, employees' salaries and payments for group insurance and pension plans; monthly pro-rata portion of annual contributions and membership fees and dues; accountants' services; rental of business equipment (except automobiles or motor vehicles); and other such expenses necessary to operate your office including the average principal of any monthly installment loan payment for equipment relating to your occupation.

Business Overhead Expenses do not include: salary, fees, drawing account or any other remuneration paid to you, your associate or replacement; payments of principal of any debt or income taxes; salaries for family members; the cost of merchandise, materials, income tax, or other supplies; or the cost of business related implements or equipment, or leased automobile.

## **Waiver of Premium**

We will waive the premium which becomes due for your coverage while you are Totally Disabled during the period that begins after you have been Totally Disabled for a period of 6 months; and ends when the Total Disability Benefit is no longer payable.

## **Quarterly Rates - 30 Day Waiting Period**

The chart below indicates the quarterly rate per \$100 of Monthly Benefit, as well as Monthly Benefit examples for \$2,500, \$5,000, and \$10,000 amounts.

Attained Age	Rate per \$100	\$2,500 Example	\$5,000 Example	\$10,000 Example
Under 30	\$0.90	\$22.50	\$45.00	\$90.00
30-39	\$1.40	\$35.00	\$70.00	\$140.00
40-49	\$2.40	\$60.00	\$120.00	\$240.00
50-59	\$4.40	\$110.00	\$220.00	\$440.00
60-69	\$9.40	\$235.00	\$470.00	\$940.00

*Rates and/or benefits may be changed on a class basis. Rates are based on the attained age of the insured person and increase as you enter each new age category.*

*The advantage of Overhead coverage is that it allows you to maintain your office with low-cost monthly benefits without using income from your personal disability policy to cover financial obligations such as home mortgage payments and family living expenses.*

## **Benefit Duration**

The maximum benefit period for any one disability is 24 months. The Waiting Period and Maximum Payment Period apply separately to each period of Total Disability.

## **Covered Risks**

If you become Totally Disabled as the result of an Injury or Sickness while covered under the Policy, we will pay the lesser of the benefit amount you select:

1. From \$100 to \$10,000; but not to exceed 60% of your Basic Monthly Pay;
2. the Monthly Business Office Overhead Expenses actually incurred;
3. or the monthly average of the your Business Overhead Expenses incurred in the six months prior to the date Total Disability begins, for each month of your Total Disability, subject to the Maximum Payment Period chosen.

Total Disability means disability which during the Waiting Period during which Total Disability Benefits are payable, wholly and continuously prevents an Insured Person from performing the substantial and material duties of his or her usual occupation.

## **Effective Date of Coverage**

Your coverage becomes effective the first of the month following the approval of your application form and receipt of the first premium payment. If you are to become covered under the Policy, or covered for increased benefits under the Policy, and are not actively-at-work on that date, your coverage will not begin until the first day of the month on or next following the date he or she is actively-at-work.

## **Evidence of Insurability**

Acceptance into this plan is subject to medical evidence of insurability as determined by The Hartford. Depending on your age, the amount of coverage you request, and your answers on the application, a medical examination, medical tests), or other evidence of good health may be required. Any exams/tests requested by the company will be conducted at your convenience and at no expense to you.

## **Renewability**

Your coverage will remain in force as long as you pay your premiums when due, remain an active Association member\*, you are under age 70, you remain actively at work (except due to disability covered by this policy), the Association participates and the Master policy remains in force.

*\*If you transfer to a similar organization that sponsors a like disability policy with The Hartford, you are entitled to coverage under that plan. If you are actively engaged on a full-time basis in the business or profession named in the application, you may apply for a Conversion without evidence of good health within 31 days after the Policy terminates.*

### 30 Day Waiting Period

A 30-Day self-insurance or waiting period is required following the start of your Total Disability before benefits are payable for covered business overhead expenses.

### Recurrent Disabilities

Periods of disability due to the same or related medical causes and separated by less than 3 months during which you are Actively-at-Work; will be considered one Period of Disability.

### Notice of Insurance Information Practices

Your application is our major source of information. However, The Hartford may also collect or verify information by contacting individuals or organizations which have information or records about you or others to be insured.

Information regarding your insurability will be treated as confidential. Such information will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business. The Hartford or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt from you, the Bureau will arrange disclosure of any information it may have in your file within 15 days. Medical information will be disclosed only to your attending physician. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112; telephone number 1-866-692-6901 (TTY 1-866-346-3642 for hearing impaired).

The Hartford or its reinsurer(s) may also release information in your file to other insurance companies to which you may apply for life or health insurance, or to which a claim for benefits may be submitted.

Upon written request, The Hartford will provide you with information in your file. Medical information will be disclosed only through a physician you designate. Details regarding your right to correct or amend information in your file will be furnished upon written request.

If you would like further details, contact:  
The Hartford  
P.O. Box 2999 • Hartford, CT 06104-2999  
Attn. Group Benefits Department

### General Exclusions

This Policy does not cover: intentionally self-inflicted injury, suicide or attempted suicide, while sane or insane; war or act of war, whether declared or not; any injury sustained while riding on, boarding or alighting from, any aircraft: a) as a pilot, crew member or student pilot; b) operated by military authority (land, sea, or air), unless it is a Military Transport Aircraft used for transport and operated by the United States Air Mobility Command (AMC) or an AMC type service of a national government recognized by the United States; or c) being used for tests, experimental purposes, stunt flying, racing or endurance tests; the commission or attempted commission of a felony by you; sickness contracted or injury sustained while on full-time active duty as a member of the Armed Forces (land, water, air) of any country or international authority.

**Concurrent Disabilities:** Benefits during any Period of Disability as the result of: more than one sickness; or more than one accident; or both sickness and accident; will be considered the same as if the disability resulted from only one cause.

*This brochure explains the general purpose of the insurance described, but in no way changes or affects the Master Policy AGP-5321 as actually issued. In the event of a discrepancy between this brochure and the policy, the terms of the policy apply. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the Hartford Life and Accident Insurance Company detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in full or discontinued. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy issued to the policyholder. This program may vary and may not be available to residents of all states. Policy Form # SRP-1311 AB (5321)*

#### Underwritten By:

Hartford Life and Accident Insurance Company  
Hartford, CT • 06104-2999



<sup>1</sup>The Hartford<sup>®</sup> is The Hartford Financial Services Group, Inc. and its subsidiaries, including the issuing company of Hartford Life and Accident Insurance Company.

**BUSINESS OVERHEAD EXPENSE INSURANCE APPLICATION FORM**

Name of Organization <b>AMERICAN STRING TEACHERS ASSOCIATION</b>		Name of Policyholder <b>ISI INSURANCE TRUST</b>		ISI Insurance Trust Policy Number <b>AGP-5321</b>	
Name of Applicant (First, Middle, Last)			Height	Weight	Sex
Place of Birth (City, State)		Date of Birth	Age Last Birthday	E-mail Address	
Home Address (Street, City, State, Zip Code)				Home Phone	
Business Address (Street, City, State, Zip Code)				Work Phone	
Occupation		Name of Firm		Basic Monthly Pay	
Duties					
Coverage Requested is to be <input type="checkbox"/> New Coverage <input type="checkbox"/> Change in Coverage		Monthly Benefit Desired (Up to \$10,000 in \$100 increments)		Premiums to be paid <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annually <input type="checkbox"/> Annually	

Have you been actively engaged in the full-time duties of your occupation during the 90-day period immediately before the date of this application?  
 Yes  No

**Other Insurance Information**

Do you have any Business Overhead Expense Insurance in force or pending in this or any other company?  Yes  No *If yes, give details below.*

Name	Company	Monthly Benefit	Benefit Period	Waiting Period	To be replaced?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Please answer the following and give details of all "yes" answers on the reverse side of this application. Yes No

1	Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession for:		
	A A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system?		
	B Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?		
	C Colitis, ulcer, kidney disease or any disease or disorder of the digestive, urinary or reproductive systems?		
	D Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?		
	E Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?		
	F Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?		
	G Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)* or any other immune deficiency disorder?		
2	During the past 5 years has anyone proposed for coverage consulted any physician, surgeon, psychologist, psychiatrist or other practitioner for any reason not previously noted on this application; or have you been confined or treated in any hospital, sanatorium or similar institution?		
3	Are you now pregnant? <i>If yes, when is the baby due:</i>		
	<i>Are there any medical complications?</i>		

\*AIDS Related Complex (ARC) is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia) of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythematosus, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

If you answered "yes" to any of the questions on the reverse side, please explain the details. (Attach sheet of paper if additional space is needed)

Question Number	Disorder or Reason	Dates To/From	Give details for any "Yes" answer. Explain nature of illness, number of attacks, duration, severity, treatment, names and addresses of physicians, hospitals, and date of full recovery.

**AUTHORIZATION**

I hereby certify that I have read or have had read to me all statements and answers in this application, and in any other application or medical form required by the Company, and that they are full, complete, and true to the best of my knowledge and belief. I also understand that any misrepresentation contained herein or relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk. I understand that any intent to defraud or knowingly facilitate a fraud against the Company, by submitting an application or filing a claim containing a false or deceptive statement is insurance fraud. I also agree that a copy of this application shall be attached to and form a part of any certificate issued. I also understand that the Company may request whatever additional evidence of insurability it needs. Subject to the deferred effective date provision, I understand that coverage will not become effective until the Company grants its underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium.

I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; consumer reporting agency; Medical Information Bureau, Inc.; or employer; to give Hartford Life and Accident Insurance Company or its legal representative information about my physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, other insurance coverage or employment status.

Hartford Life and Accident Insurance Company will use the information to decide if and to what extent I am eligible for insurance coverage or benefits under the policy. This information will be treated as confidential. I understand the Medical Information Bureau, Inc. will release records or information only to the Hartford Life and Accident Insurance Company.

I authorize The Hartford Life and Accident Insurance Company to give information about me to: its reinsurer(s), the Medical Information Bureau, Inc., any other insurance company to whom I may apply for life or health insurance, or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application or as required by law.

I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on the authorization. This authorization expires two (2) years from the effective date of my coverage or, if no coverage has been issued one (1) year from the date of this application.

I understand that a photocopy of this form is as valid as the original, and that I have a right to receive a copy of this form upon request. I certify that I have received the Notice of Insurance Information Practices. I further understand that any condition excluded or limited by the policy or by a health waiver attached to my certificate will not be covered under this policy at any time.

**FRAUD WARNING**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. In certain states, penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the State Insurance Regulatory Agency and/or Division of Insurance. If while in the state of Florida, a person knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, the person is guilty of a felony in the third degree. Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false, misleading or deceptive information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to substantial civil and/or criminal penalty where and to the extent allowed by state law.

Signature of Applicant	Date
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Signature and date required to process your application

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