

# Long Term Disability Insurance Plan for Members of the American String Teachers Association

## Monthly Benefit Amount

Under this plan you may apply for up to \$4,000 of monthly benefits. The maximum benefit amount payable as the result of Total Disability due to a covered accident or sickness will be the lesser of:

- The amount you are approved for; or
- 66% of your Basic Monthly Pay

If you are self-employed, Basic Monthly Pay means the your average net monthly income (gross revenues less business expenses) from the personal practice of your profession or personal conduct of your main business. This average is based on net income for the twelve months, or 24 months, whichever produces the higher average, before the determination is made. If you have been self-employed for less than 12 months, it is based on the whole time you were self-employed. If your practice is incorporated, earned income includes the cost to your company of fringe benefits and your share of total surplus. Income does not include investment returns, rents, royalties, and the like income which is not directly produced from your current work.

If you are not self-employed, Basic Monthly Pay means your regular monthly rate of pay, not counting commissions, bonuses, overtime pay or any other fringe benefit or extra compensation, in effect on the last day of Active employment prior to becoming Disabled.

## Benefit Duration

Your disability benefit duration depends on the age in which you begin to receive benefits. The table below details the benefit duration for Total Disability due to a covered accident or sickness.

Age Benefits Begin	Benefit Duration
Under Age 60	to Normal Retirement Age *
Age 60 – 62	Up to 60 months
Age 63 – 64	Up to 24 months
Age 65 – 69	Up to 12 months

\*The Social Security Administration has implemented a change to the definition of Normal Retirement Age (NRA) from age 65 to age 67. The NRA will gradually increase to age 67 depending on year of birth as identified below.

Social Security Administration - Normal Retirement Age Chart		
Year of Birth	Year	Months
1960 or later	67	0
1959	66	10
1958	66	8
1957	66	6
1956	66	4
1955	66	2
1943-1954	66	0
1942	65	10
1941	65	8
1940	65	6
1939	65	4
1938	65	2
Before 1937	65	0

Note: Persons born on January 1st of any year should refer to the normal retirement age for the previous year. 9/19/2005

## Eligibility

You are eligible to apply for the Long Term Disability Income Plan if you are under age 60, an active Association member residing in the U.S., and are Actively-at-Work at the time you apply.

Actively at Work means you are performing all the regular duties of an occupation for wage or profit on a full-time basis (at least 30 hours per week).

## Quarterly Rates - 90 Day Waiting Period

Attained Age	Rate Per \$100 of Monthly Benefit	\$1,000 of Coverage	\$2,000 of Coverage	\$4,000 of Coverage
Under 30	\$4.30	\$43.00	\$86.00	\$172.00
30-34	\$6.25	\$62.50	\$125.00	\$250.00
35-39	\$8.95	\$89.50	\$179.00	\$358.00
40-44	\$12.90	\$129.00	\$258.00	\$516.00
45-49	\$16.90	\$169.00	\$338.00	\$676.00
50-54	\$22.05	\$220.50	\$441.00	\$882.00
55-59	\$30.15	\$301.50	\$603.00	\$1,206.00
60-64*	\$32.65	\$326.50	\$653.00	\$1,306.00
65-69*	\$34.75	\$347.50	\$695.00	\$1,390.00

Rates are based on the attained age on the Insured Person and increase you enter each new age category. Rates and/or coverage may be changed on a class basis. Calculate your premium by using the \$100 rate for your age. (i.e. for \$900 monthly benefit multiply the Rate per \$100 by 9).

\*Renewal Only

**Reduction At Age 65:** your monthly benefit will be the monthly benefit of this certificate or \$2,200, whichever is the lesser on the renewal date that occurs on or next following your 65th birthday. The reduction does not affect any claim originating prior to such renewal date. Your premium will be adjusted accordingly.

## Waiting Periods

You can save on premiums by choosing a longer waiting period. Depending on your financial obligations, you may choose a 60, 90 or 180 day waiting period. The rates above reflect a 90 day waiting period. For information concerning 60 or 180 Day waiting periods, contact INSURANCE SPECIALISTS, INC. at 1-888-ISI-1959.

## 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, coverage will not begin until the first day of the month on or next following the date you are Actively-at-Work for three consecutive months.

## Evidence of Insurability

Acceptance into this plan is subject to medical evidence of insurability as determined by The Hartford<sup>1</sup>. Depending on your age, the amount of coverage you request, and your answers on the application, a medical examination, medical test(s), 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.

## How to Apply

1. Complete the application and answer all questions in full. Sign your name and date the Application. Your application is subject to approval by The Hartford.
2. Mail your completed application to:  
ISI ADMINISTRATIVE CENTER  
P.O. Box 2327 • Beaufort, SC 29901
3. **Don't send any money now.** You will be billed once your application is approved. When your application is approved, you will receive your Certificate of Insurance. If you have any questions, call our toll-free ISI DIRECT LINE: 1-888-ISI-1959.

## 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.

## Total Disability Definition

Total Disability means disability which during the Waiting Period and up to the Maximum Payment Period, for which Total Disability Benefits are payable, wholly and continuously prevents you from performing the substantial and material duties of your usual occupation

## Drugs, Alcohol, Mental or Nervous Disorders

If you are Totally Disabled due to Mental or Nervous Disorders, alcoholism or drug abuse, the Maximum Payment Period will be reduced to 2 years during your lifetime unless you are confined in a hospital or other institution licensed to provide care and treatment for that disability.

## Exclusions and Limitations

This policy does not cover: 1) Intentionally self-inflicted Injury, suicide or attempted suicide, while sane or insane; 2) War or act of war, whether declared or not; 3) Any Injury sustained while riding on, boarding or alighting from, any aircraft: a) as a pilot, crew member or student pilot; b) operated by any military authority (land, sea or air), unless it is a Military Transport Aircraft used for transport and operated by the United States Military 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; 4) The commission or attempted commission of a felony by you; 5) 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.

## Successive Periods of Disability

Periods of Disability due to the same or related medical causes; and separated by less than 6 months during which you are Actively at Work; will be considered one Period of Disability. Periods of Disability separated by at least 6 months during which you are Actively at Work will be considered separate Periods of Disability.

## 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.

## Underwritten By:

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



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

## Termination

Your coverage will terminate on the earliest to occur of: the date the Policy is cancelled; the Premium Due Date on or next following the date you ceases to be an active Association member; the Premium Due Date on or next following the date you attain age 70; the Premium Due Date on or next following the date you ceases to be Actively-at-Work (at least 30 hours a week) - except due to disability covered by the Policy; or the Premium Due Date the required premium contribution is not made.

## 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  
Attn. Group Benefits Department  
P.O. Box 2999  
Hartford, CT 06104-2999

*This brochure explains the general purpose of the insurance described, but in no way changes or affects the Master Policy AGP-5319 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 A (HLA) (5319)*



**APPLICATION FOR LONG TERM DISABILITY INCOME INSURANCE**

Please Print. Use Dark Ink. Do Not Erase. Initial All Changes.

ISI Insurance Trust Policy Number AGP-5319

Name of Association <b>AMERICAN STRING TEACHERS ASSOCIATION</b>		Primary Insured's Name (First, Middle, Last)		
Place of Birth (City, State)	Date of Birth	Sex	Weight (Lbs.)	Height (Ft. In.)
E-mail		Home Phone		Work Phone
Street Address		City	State	Zip Code
Occupation		Employer		
Duties			Basic Monthly Pay	

Coverage being requested is for:  New Coverage  Change in Coverage

Indicate the monthly benefit desired (in \$100 increments to a maximum of \$4,000): \$ \_\_\_\_\_

Indicate waiting period desired:  60 Days  90 Days  180 Days

Indicate premiums to be paid:  Quarterly  Semi-annually  Annually

**BENEFICIARY** Print full name and relationship to you.

Name (First, Middle, Last)	Relationship
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**OTHER INSURANCE INFORMATION**

1	Do you have any disability income insurance in force or pending with this or any other company? (If yes, provide details)	Yes	No
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COMPANY: \_\_\_\_\_ MONTHLY BENEFIT: \_\_\_\_\_ WAITING PERIOD: \_\_\_\_\_  
BENEFIT PERIOD: \_\_\_\_\_ TO BE REPLACED: \_\_\_\_\_

2	Is the monthly benefit amount applied for equal to or less than 66% of your basic monthly earned income less any other disability income insurance you may have in force?	Yes	No
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3	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
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**PLEASE ANSWER THE FOLLOWING AND GIVE DETAILS OF ALL "YES" ANSWERS BELOW:**

4	Have you ever been diagnosed or treated by a member of the medical profession for:	Yes	No
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4 a	A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system?	Yes	No
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4 b	Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?	Yes	No
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4 c	Colitis, ulcer, kidney disease, or any disease or disorder of the digestive, urinary or reproductive system?	Yes	No
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4 d	Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?	Yes	No
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4 e	Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?	Yes	No
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4 f	Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?	Yes	No
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4 g	Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)*?	Yes	No
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5	During the past 5 years have you consulted any physician, surgeon, psychologist psychiatrist or other medical or dental practitioner or anything other than a routine physical, eye examination or dental examination for any reason not previously noted on this application; or been confined or treated in any hospital, sanatorium or similar institution?	Yes	No
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6	Are you now pregnant? If yes, when is the baby due: _____ Are there any medical complications? _____	Yes	No
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\*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. Explain nature of illness, number of attacks, duration, severity, treatment, names and addresses of physicians, hospitals and date of full recovery. (Attach sheet of paper if necessary)

QUESTION #	NAME	DISORDER OR REASON	DATES TO/FROM	DETAILS

**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 The Hartford<sup>1</sup> 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.

The Hartford 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 The Hartford.

I authorize the The Hartford 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 and the Investigative Consumer Report Pre Notification. I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the 12 month period prior to my effective date of coverage will not be covered until I have gone 12 months ending on or after my effective date of coverage without medical advice or treatment for that condition, or until two (2) years after my effective date of coverage, whichever comes first, provided that the condition is not specifically excluded or limited by the policy or by a Health Waiver attached to my certificate. Applications to increase coverage will be subject to a new pre existing conditions limitation.

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.

**STATE NOTICE**

Any person who includes any false or misleading information on an application or filing a claim 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.

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Applicant's Signature Date  
*Signature and date required to process your application.*

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