

American String Teachers Association
Simplified Issue 65/3 Accident & Sickness Disability Plan

Eligibility Qualifications: To apply for this coverage, you must be an active member of the American String Teachers Association, Actively-at-work (at least 24 hours per week), but not in full time military service, a resident of the United States, able to answer "NO" to the (3) health questions, within height and weight requirements, favorably listed with the Medical Information Bureau, and not currently carrying coverage in this program.

Benefit Duration and Limits

- You may currently apply for up to \$4,000 per month
- Benefits are payable up to age 65 for covered accidents and 3 years for sickness following your chosen waiting period
- Coverage extends to age 70
- No Medical Exam is required
- The maximum benefit amount payable as the result of an insured person's Total Disability will be the lesser of: The monthly benefit amount elected; or 60% of the insured person's Basic Monthly Pay. But not less than \$100.00 per month

Quarterly Premiums - 90 Day Waiting Period*

| Attained Age | Rate Per \$100 | \$1,000 of Coverage | \$2,000 of Coverage | \$3,000 of Coverage | \$4,000 of Coverage |
|--------------|----------------|---------------------|---------------------|---------------------|---------------------|
| Under 30 | 3.75 | 37.50 | 75.00 | 112.50 | 150.00 |
| 30-34 | 5.27 | 52.70 | 105.40 | 158.10 | 210.80 |
| 35-39 | 7.01 | 70.10 | 140.20 | 210.30 | 280.40 |
| 40-44 | 8.73 | 87.30 | 174.60 | 261.90 | 349.20 |
| 45-49 | 10.96 | 109.60 | 219.20 | 328.80 | 438.40 |
| 50-54 | 14.59 | 145.90 | 291.80 | 437.70 | 583.60 |
| 55-59 | 23.41 | 234.10 | 468.20 | 702.30 | 936.40 |
| 60-64 | 33.89 | 338.90 | 677.80 | 1016.70 | 1355.60 |
| 65-69** | 41.70 | 417.00 | 834.00 | 1251.00 | 1668.00 |

Your actual premium may be less than these since premiums are based on your occupation. Benefits up to \$10,000 a month and other coverage options are available by calling ISI SALES DIRECT: 1-888-ISI-1959.

*For information concerning 30, 60, or 180 Day waiting periods, contact INSURANCE SPECIALISTS, INC. at 1-888-ISI-1959 Ext 7830.

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

Definition of Disability: Total Disability means a disability which (during the Waiting Period and 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. The disability must also require the regular care of a physician.

Disability Benefit Qualifications: Partial benefit will be paid if you return to work and suffer at least a 20% or more reduction of your earnings. Total Disability benefits apply when there is an earnings loss of 80% or more.

Waiver of Premium: The Hartford will waive the premium which becomes due for an insured person's coverage while he or she is Totally Disabled during the period that begins after the insured person has been Totally Disabled for a period of six months; and ends when the Total Disability Benefit is no longer payable.

Renewability: Coverage is renewable to age 70 as long as: Renewal Premiums are paid when due and the insured remains in full time practice as an Association Member.

Rehabilitative Employment Benefit: When Totally or Partially Disabled and you accept Rehabilitative Employment, The Hartford will continue to pay a monthly benefit. Your continued benefit will be your total monthly benefit less 50% of any income derived from Rehabilitative Employment. The sum of the monthly benefit amount and the total income received from Rehabilitative Employment may not exceed 100% of your base monthly earnings. A review will be made every six months to confirm disability status.

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

If you are self-employed, Basic Monthly Pay means your net monthly income (gross revenue 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 last day of Active employment prior to becoming Disabled. If you have been self-employed for less than 12 months, it is based on the whole time you were self-employed, prior to becoming Disabled. If your practice is incorporated, earned income does not include investment returns, rents, royalties, and the like income which is not directly produced from your current work.

TO APPLY COMPLETE, SIGN, DETACH, AND MAIL TO:
 ISI Administrative Center
 P.O. Box 2327 • Beaufort, SC 29901



Application for Insurance
 Hartford Life and Accident Insurance Company
 Hartford, Connecticut
 ISI Insurance Trust Policy Number AGP-5319

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|--|---------------|------------------------------|----------|
| Organization AMERICAN STRING TEACHERS ASSOCIATION | | Member Name | |
| Applicant Name | | Applicant Occupation | |
| Street Address | | | |
| City | | State | Zip code |
| Phone Number | | Social Security Number | |
| Birth Date | | Place of Birth (Town, State) | |
| Height (ft. in.) | Weight (lbs.) | Sex | |

Plan: Accident to age 65 & Sickness Benefit for 3 Years

By signing this form, I hereby certify that all of the information I have provided on this application is true and correct to the best of my knowledge and belief and that I during the last 5 years, have not had or been treated for cancer, tumor, high blood pressure, nervous system disorder, diabetes, any heart, blood or circulatory disorder, autoimmune disorder, gastro-intestinal disorder, any lung or respiratory disorder, kidney or genitourinary disorder, alcohol or drug dependency, mental or nervous disorder, bone, joint, back, muscle or connective tissue disorder, chronic fatigue syndrome, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)† or any other immune deficiency disorder (see reverse for complete definition), or have been confined in a hospital, nursing home, sanitarium or similar institution in the last 6 months (excluding maternity).

I certify that I have been actively engaged in the full-time duties of my occupation for the last 90-day period immediately before the date of this application.

I understand that my coverage will become effective after approval by the Company and receipt of the first payment of premium. By signing this application, I acknowledge that the Application is true and accurate for each person to be insured.

By signing below, I acknowledge that I have read and agree to all terms on the reverse of this form.

Monthly Benefits:

Select between \$100 and \$4,000 in \$100 increments:

Waiting Period: 30 Days 60 Days 90 Days 180 Days

Disability Insurance now being applied for may not exceed 70% of your monthly salary (exclusive of bonuses, commissions, and dividends).

FORM PA-9199 (5319) (HLA) (SI-DI)

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| Signature required to activate coverage | Date |
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