**CHECKLIST FOR:**
**LONG TERM DISABILITY WRAP FOR FULLY-INSURED PLANS**

## General Information

Employer's Full Name: _____

Address: _____

_____

Telephone: _____

Employer Identification Number: _____

Plan Sponsor *(if different from Employer)*: _____

Plan Administrator *(if different from Employer)*: _____

Plan Year: _____ through _____

ERISA Plan Number: _____

Agent for Service of Process: _____

Address: _____

_____

Telephone: _____

Trustees *(if any)*: _____

Address: _____

_____

Telephone: _____

Name of Carrier: _____

Address: _____

_____

Telephone: _____

Title or Name of Contact Person for Questions: _____

Telephone: _____
Fax: _____
Email: _____

Original Effective Date: _____

Restated Date: _____

Participating Employer(s):_____
_____

*(Employers whose employees are eligible to participate in this plan – must be affiliated companies – if you are unsure whether the entities meet ERISA's requirements for affiliation, please describe the relationship.)*

Does HIPAA apply to the Employer(s)? Yes _____ No _____
*(HIPAA applies to group health plans and group health insurance coverage for any plan year if, on the first day of the plan year, the plan has 2 or more participants who are current employees. It does not apply to any plan or coverage providing "excepted benefits," which include limited scope dental or vision benefits if offered separately from any other benefits.)*

Does COBRA apply to the Employer(s)? Yes _____ No _____
*(COBRA applies to all group health plans maintained by all public and private employers, other than churches; governmental entities of the U.S., the District of Columbia and U.S. territories and possessions; state and local government agencies that are not recipients of PHSA fund; and employers, including related employers, whose total number of employees (full-time and part-time), including leased employees, was less than 20 on at least 50% of the typical business days in the prior calendar year.)*

Does FMLA apply to the Employer(s)? Yes _____ No _____
*(FMLA applies to private sector employers of 50 or more employees and public agencies.)*

Is this a Union Plan (maintained pursuant to a collective bargaining agreement): _____
If so, what is the Name of the Union: _____
If so, what is the Local Number: _____
If so, what is the Local Location: _____

Is this a Government Plan: _____
If so, is HIPAA applicable: _____
*(A "Government Plan" is any plan established or maintained for its employees by the U.S. Government, the government of any state or political subdivision thereof, or by any agency or instrumentality of the foregoing. It also includes any plan to which the Railroad Retirement Act of 1935 or 1937 applies, and which is financed by contributions required under that Act, and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act.)*

Is this a Church Plan: _____
If so, is HIPAA applicable: _____
*(A "Church Plan" is a plan established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches which is exempt from tax under §501 of the Internal Revenue Code of 1954 ("IRC"). It does not include a plan where the employees or their beneficiaries are*

*employed in connection with one or more unrelated trades or businesses (as described in IRC §513) or if less than substantially all of the individuals included in the plan are employees or beneficiaries. "Employee" means a duly ordained, commissioned or licensed minister of a church in the exercise of his ministry, regardless of the source of his compensation, or an employee of an organization which is exempt from tax under IRC §501 and which is controlled by or associated with a church or a convention or association of churches.)*

Type of Benefit Plan: ***(Please list FULL name of plan (i.e., PPOBlue High Option II, Keystone HMO, etc.):***

_____

_____

Address:

_____

_____

Telephone: _____

_____

***Please enclose a copy of your most recent benefit materials received from Highmark, Concordia, Fashion Advantage, VBA, etc.***

Are employees required to contribute for their coverage? Yes ____ No ____

Are employees required to contribute for dependent coverage? Yes ____ No ____

## DEFINITIONS

***"Employee"***
Such person must be scheduled to work at least [_____] hours per week and at least [_____] months per year in order to be considered "full-time."

This excludes…

| | |
|---|---|
| | …temporary employees… |
| | …seasonal employees… |
| | …casual employees… |
| | …leased employees… |
| | …inactive employees (for non-health related reasons)… |
| | …individual contractors. |

## ELIGIBILITY FOR PARTICIPATION

**When am I eligible for coverage?**
Each *employee* will become eligible for coverage under this *Plan* with respect to himself on …

| | |
|---|---|
| | …his date of hire… |
| | …the 1st day following completion of a *service waiting period* of [_____] days… |
| | …the 1st day of the month following completion of a *service waiting period* of [_____] days… |

provided the *employee* has begun work for his *participating employer*.

If employment is terminated and the *employee* returns to *active employment* within [_____] from the date of termination, the *service waiting period* will be waived and coverage will take effect on the first day the *employee* returns to *active employment*.
**VARIABLE – KEEP or REMOVE**

**When does coverage begin?**
Newly hired *employees* who enroll in the *Plan* immediately upon hire will become eligible for coverage on the…

| | |
|---|---|
| | …first day of the first pay period after the *employee* completed one full pay period of employment… |
| | …date the *employee* applies for insurance… |
| | …date the *insurance company* approves the *employee's* application. |

Newly hired *employees* who enroll in the *Plan* after the first pay period, but within 31 days after the date of hire, will become eligible for coverage on the…

| | |
|---|---|
| | …first day of the first pay period after the *employee* completed one full pay period of employment… |
| | …date the *employee* applies for insurance… |
| | …date the *insurance company* approves the *employee's* application. |

**What if I am temporarily not working?**
If the *employee* is on a temporary lay-off, and the premium is paid, the *employee* will be covered through the end of the month that immediately follows the month in which the layoff begins.
**VARIABLE – KEEP or REMOVE**

## TERMINATION OF COVERAGE

Does coverage terminate when the *participant* enters the *uniformed services*? _____

**OPTION I (date/day of the event)**
The coverage of any *employee* for himself under this Plan will terminate on the earliest to occur of the following dates:

- The date of termination of the *Plan*;
- The day of the month in, or with respect to which, he requests that such coverage be terminated, provided such request is made on or before such date;
- The date of the expiration of the last period for which the *employee* has made a contribution, in the event of his failure to make, when due, any contribution for coverage for himself to which he has agreed in writing;
- The date of the month in which he ceases to be eligible for such coverage under the *Plan*;
- [The date of the month in which a *participant* becomes a member of the *uniformed services*;]
- The date and time of the month in which the termination of employment occurs;
- Immediately after an *employee* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information; or
- The last day of the month for which the *participating employer* has made the required contribution. ]

**OPTION II – (last day of the month in which the event occurs)**
The coverage of any *employee* for himself under this *Plan* will terminate on the earliest to occur of the following dates:

- The last day of the month following termination of the *Plan*;
- The last day of the month in, or with respect to which, he requests that such coverage be terminated, provided such request is made on or before such date;
- The last day of the month for which the *employee* has made a contribution, in the event of his failure to make, when due, any contribution for coverage for himself to which he has agreed in writing;
- The last day of the month in which he ceases to be eligible for such coverage under the *Plan*;
- [The last day of the month in which a *participant* becomes a member of the *uniformed services*;]
- The last day of the month in which the termination of employment occurs;

- The last day of the month in which an *employee* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information; or
- The last day of the month for which the *participating employer* has made the required contribution. ]

**PLEASE CHOOSE – OPTION I or OPTION II**

## CLAIM PROCEDURES

**When must disability claims be filed?**
Disability claims must be filed with the *insurance company* within [_____] **(days OR months)** of the date of the onset of the disability.

## YOUR LONG-TERM DISABILITY BENEFITS

| | |
|---|---|
| **Benefit limits:** | |
| Monthly Benefit | [_____]% of weekly earnings (not including overtime, bonuses or commissions) to a maximum of $[_____] per week |
| Minimum Benefit | $[_____] |
| Maximum Period of Payment | [_____] period of total disability |
| **Benefits are payable:** | |
| For *Illness* | Beginning on the [_____] day [, retroactive to the [_____] day if hospital confined/ |
| For *Injury* | Beginning on the [_____] day [, retroactive to the [_____] day if hospital confined/ |

**When will I receive payments?**
You will begin to receive payments:

| | |
|---|---|
| | When the *insurance company* approves your claim |
| | When any applicable waiting period has expired; and/or |
| | When the *claimant* has exhausted their sick leave. |

Payments will be made on a…

| | |
|---|---|
| | …monthly basis. |
| | …bi-weekly basis. |
| | Other (please specify): |

**What will my payment amount be?**
When an *employee* is totally disabled and eligible for payments under the *Plan*, the gross monthly payment is [_____]% of the *employee*'s monthly rate of basic earnings, subject to a specified monthly maximum.

This amount will be reduced by any *other income* payable for the same month (see "*other income*" below).
**VARIABLE – KEEP or REMOVE**

**Will I receive partial payments if I return to work?**

| | |
|---|---|
| | The *Plan* will not provide any partial payments upon your return to work |
| | The *Plan* will provide partial payments if you return to work on a part-time basis. |

Partial payments are calculated by subtracting [_____]% of the gross pay for the basic hours worked from the gross payment.
**VARIABLE – KEEP or REMOVE**

*Employees* working reduced hours must provide proof of earnings.

**VARIABLE – KEEP or REMOVE**

**What is my maximum monthly payment?**
The maximum monthly disability payment for all *employees* is $[_____].

**When will my payments terminate?**

| | |
|---|---|
| | Your payments will terminate [_____] **(days OR months)** after the date the first monthly payment was paid or would have been paid if the *claimant* was not entitled to *other income.* |
| | Payments will terminate upon the *claimant's* death or when any of the following events occur: |

| | |
|---|---|
| | The *claimant* ceases to be totally disabled. |
| | The *claimant* fails to furnish the required medical statements or medical releases, or refuses to be examined |
| | The *claimant* ceases to be under the care of a legally qualified physician |
| | The *claimant* starts work at a *reasonable occupation* |

| | |
|---|---|
| | Payments will terminate on the earliest of the following: |

| | |
|---|---|
| | The *claimant* is able to work in his *usual occupation* on a part-time basis, but chooses not to |
| | The date the *claimant* is no longer disabled under the terms of the *Plan* |
| | The date the *claimant's* disability earnings exceed the amount allowable under the *plan* |
| | The date the *claimant* dies |

**Other income**
The amount of a payment otherwise payable under the *Plan* is reduced by the amount of *other income*, as provided in this section.

*Other income* includes:

| | |
|---|---|
| | [_____]% % of gross wages earned from new employment; |
| | [_____]% of the increase in gross wages earned due to the availability to work additional time; |
| | Any disability income received with respect to this or any related disability under either of the following: |

| | |
|---|---|
| | Any employer plan payment including, but not limited to, disability income paid by the federal government related to the *claimant*'s participation in the armed services; or |
| | Any fund or other arrangement providing disability income for loss of time because of disability pursuant to any compulsory benefit act or law; |

| | |
|---|---|
| | *Other income* or disability payments, including sick leave paid in lump sum payments or periodic payments other than monthly, will be allocated to monthly periods; |
| | Any payments because of the *claimant*'s disability under any employer-contributed group insurance policy; |
| | Any income received under any unemployment compensation law; |
| | Any income to which the *claimant* or the *claimant*'s spouse, children, or dependents are entitled because of the *claimant*'s retirement (for any reason other than disability) under the federal Social Security Act, the Railroad Retirement Act, or any similar law of any national or state government; |
| | Disability income required or provided for under any law (including, for example, worker's compensation disability income or disability income of a similar nature, wage replacement disability income under any no-fault automobile insurance, and disability income under the federal Social Security Act). This includes any disability income to which the *claimant* or *claimant*'s spouse, children, or dependents are entitled by reason of the *claimant*'s disability. The amount of any such payment to which the *claimant* or the *claimant*'s spouse, children, or dependents are entitled is the amount that is awarded or, if greater, the maximum amount that would have been awarded by timely application and such timely reapplication and appeal as the *insurance company* shall deem warranted under the circumstances. |
| | Other: |

**VARIABLE – KEEP or REMOVE**

**The following are excluded from *other income*:**

| | |
|---|---|
| | If the only *other income* received by the *claimant* is Federal Social Security Disability Insurance, the *claimant*'s monthly payment will not be less than $[_____]; |
| | *Other income* does not include disability income payable under a *claimant*'s personal life, accident, critical illness, or health insurance policies; |
| | A *claimant*'s earning from other employment established prior to the date of total disability are not considered *other income*; |
| | Federal Social Security Disability income is not considered as *other income* when the benefit is for a non-custodial dependent and payments are provided to someone other than the *claimant*; |
| | Gross wages earned from employment the *claimant* was engage in immediately before the date of *injury*; |
| | 457(b), 403(b), 401(k) plan income; or |
| | Income from any profit sharing plan, thrift plan, or tax sheltered annuity. |
| | Other |

**VARIABLE – KEEP or REMOVE**

***Other income* requirements**

If it appears that the *claimant* may be off from work for more than [_____] months, the *claimant* shall be required to apply for Social Security Disability Insurance ("SSDI") or retirement benefits.

**VARIABLE – KEEP or REMOVE**

**How does the *insurance company* define a disability?**

You are disabled when you are limited from performing the material and substantial duties of your *usual occupation* due to your *sickness* or *injury*; and you have a [_____]% or more loss in your indexed monthly earnings due to the same *sickness* or *injury*.

The *insurance company* may require you to be examined by a physician, other medical practitioner, or vocational expert of the *insurance company's* choice. [The *insurance company* will pay for this examination.]

**VARIABLE – KEEP or REMOVE**

**How long must I be disabled before I am eligible for benefits under the *Plan?***

You must be continuously disabled for the later of:

| | |
|---|---|
| | [_____] days |
| | The date your paid accrued vacation and sick leave benefits expire |
| | Other: |

**Will my benefits be adjusted by a cost of living increase?**

| | |
|---|---|
| | No. The *insurance company* will not make cost of living adjustments to your benefits. |
| | The *insurance company* will make a cost of living adjustment after you have received one full year of payments. Your payment will be increased by [_____]% beginning on the first anniversary of payments and each following anniversary while you continue to receive payments for your disability. In no event will your monthly benefit exceed the monthly limited benefit of $[_____]. |

## ADDITIONAL BENEFITS

**Can I continue this *Plan* if I end my employment with the *participating employer*?**

_____ No

_____ Yes. If "yes," please complete the following:

You may be eligible to purchase insurance under the *insurance company's* conversion policy. To be eligible you must have been insured under your *participating employer's* group plan for at least [_____] consecutive months.

You are not eligible to apply for conversion coverage if: you are or become insured under another group long term disability plan within [_____] days after your employment ends.

**Will the *insurance company* contribute to my retirement plan if I am disabled?**

| | |
|---|---|
| | No. |
| | Yes. If you are receiving disability payments and are a participant in your *participating employer's* retirement plan, and you are receiving matching contributions under that *Plan*, the *insurance company* will pay an extra benefit into that plan on your behalf. |

**What benefits will be provided to my family if I die?**

| | |
|---|---|
| | No. |
| | When the *insurance company* receives proof that you have died, the *insurance company* will pay your eligible survivor a lump sum benefit equal to [_____] months of your gross disability payment, if on the date of your death: |

| | |
|---|---|
| | Your disability has continued for [_____] or more consecutive days; and |
| | You were receiving or were entitled to receive payments under the *Plan.* |

## *HIPAA* PRIVACY

Please list the TITLES ONLY of those persons who will have access to PHI. ***This list is REQUIRED, and must be in the Plan (reference to a website is not acceptable):***

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____