Short Term Disability Income Protection Insurance Plan Highlights

CBR Management Services
Policy # 121141

Please read carefully the following description of your Short Term Disability Income Protection insurance plan, underwritten by Unum Life Insurance Company of America.

Your Plan

Eligibility

You are eligible for coverage if you are an active employee working a minimum of 32 hours per week.

Guarantee Issue

You may apply for coverage without answering any medical questions or providing evidence of insurability if you apply for coverage within 31 days after your eligibility date. If you apply more than 31 days after your eligibility date, your coverage will be medically underwritten, and you will be required to qualify based on information you provide on your overall medical health including routine, planned, unplanned or ongoing medical care or consultation. This review may result in a declination of coverage.

Please see your Plan Administrator for your eligibility date.

Weekly Benefit Amount

If you meet the definition of disability, you would be eligible to receive a weekly benefit if you are disabled equal to 60% of your weekly earnings, to a maximum of $1,000 per week.

Your disability benefit may be reduced by deductible sources of income and any earnings you have while disabled. Deductible sources of income may include such items as disability income or other amounts you receive or are entitled to receive under: workers compensation or similar occupational benefit laws; state compulsory benefit laws; automobile liability and no fault insurance; legal judgments and settlements; certain retirement plans; salary continuation or sick leave plans; other group or association disability programs or insurance; and amounts you or your family receive or are entitled to receive from Social Security or similar governmental programs.

Definition of Disability

You are disabled when Unum determines that:

- you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
- you have a 20% or more loss in weekly earnings due to the same sickness or injury.

You must be under the regular care of a physician in order to be considered disabled.

Elimination Period

The Elimination Period is the length of time of continuous disability which must be satisfied before you are eligible to receive benefits. If your disability is the result of an injury that occurs while you are covered under the plan, your Elimination Period is 14 days.

If your disability is due to a sickness, your Elimination Period is 14 days.

Benefit Duration

If you meet the definition of disability you may receive a benefit for 11 weeks.

Federal Income Taxation

The taxability of benefits depends on how premium was taxed during the plan year in which you become disabled. Whether you pay 100% of the premium or you and your Employer share in the cost, if premium for the plan year is paid with **post-tax** dollars, your benefits **will not** be taxed. If premium for the plan year is paid with **pre-tax** dollars, your benefits **will** be taxed. If premium for the plan year is paid partially with post-tax dollars and partially with pre-tax dollars, then a portion of your benefits will be taxed.

Additional Benefits

Rehabilitation and Return to Work Assistance

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will make the final determination of your eligibility for participation in the program, and will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you. This program may include, but is not limited to the following benefits:

- coordination with your Employer to assist your return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

If you are participating in a Rehabilitation and Return to Work Assistance program, we will also pay an additional disability benefit of 10% of your gross disability payment to a maximum of $250 per week. In addition, we will make weekly payments to you for 3 weeks following the date your disability ends, if we determine you are no longer disabled while:

- you are participating in a Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

Limitations/Exclusions/ Termination of Coverage

Pre-existing Condition Exclusion

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and

- the disability begins in the 12 months after your effective date of coverage.

Instances When Benefits Would Not Be Paid

Benefits would not be paid for loss resulting from:

- war, declared or undeclared, or any act of war;
- active participation in a riot;
- intentionally self-inflicted injuries;
- loss of a professional license, occupational license or certification;
- commission of a crime for which you have been convicted;
- any period of disability during which you are incarcerated;
- an **occupational injury or sickness**,*(this will not apply to a partner or sole proprietor who cannot be covered by law under Workers' Compensation or any similar law);*
- pre-existing condition.

Termination of Coverage

Your coverage under the policy ends on the earliest of the following:

- The date the policy or plan is cancelled;
- The date you no longer are in an eligible group;
- The date your eligible group is no longer covered;
- The last day of the period for which you made any required contributions;
- The last day you are in active employment except as provided under the covered layoff or leave of absence provision. Please see your Plan Administrator for further information on these provisions.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

Next Steps

How to Apply

To apply for coverage, complete your enrollment form within 31 days of your eligibility date. After that date you will be required to provide evidence of insurability in order to qualify for coverage. This will include a review of your overall medical health including routine, planned, unplanned or ongoing medical care or consultation, and may result in a declination of coverage.

Effective Date of Coverage

Please see your Plan Administrator for your effective date.

Delayed Effective Date of Coverage

Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Questions

If you should have any questions about your coverage or how to enroll, please contact your Plan Administrator.

This plan highlight is a summary provided to help you understand your insurance coverage from Unum. Some provisions may vary or not be available in all states. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern. For complete details of coverage, please refer to policy form number C.FP-1, et al.

Underwritten by:
Unum Life Insurance Company of America 2211 Congress Street, Portland, Maine 04122, www.unum.com
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Underwritten by:
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

CBR Management Services

Short Term Disability Insurance Enrollment Form

Policy #121141/Div #003

Please complete this form in its entirety. Blank fields will cause significant delays in processing.

Employee Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Gender M ☐ F ☐

Date of Birth (mm/dd/yyyy) ☐☐ / ☐☐ / ☐☐☐☐

Hours Worked Per Week ☐☐

Employee First Name

M.I.

Last Name

Employee Street Address

City

State

Zip Code

Original Date of Hire ☐☐ / ☐☐ / ☐☐☐☐

Annual Salary ☐ , ☐☐☐ , ☐☐☐

☐ **Exempt** ☐ **Non-Exempt**

Occupation

☐ **Date entered into an eligible class (*ex: part time to full time*) *or***
☐ **Rehire Date *or***
☐ **Date of promotion to an eligible class**

☐☐ / ☐☐ / ☐☐☐☐ **(If unknown, consult with your Plan Administrator to complete.)**

Rates* per $10 of Weekly Benefit			
Age	**Rate**	**Age**	**Rate**
<25	$.62	50 – 54	$.64
25 – 29	$.68	55 – 59	$.81
30 – 34	$.59	60 – 64	$.98
35 – 39	$.52	65 – 69	$1.10
40 – 44	$.53	70+	$1.10
45 – 49	$.54		
**STD rates are based on five-year increments. Rates increase as you age.*			

STD Cost Calculation: To calculate your per-paycheck cost for this coverage, complete the calculations below. *Final Cost may vary slightly due to rounding.

NOTE: *If your weekly salary exceeds 87,000, use 87,000 as your weekly salary in the calculation.*

________ Annual Salary ÷ 52 = ________ Weekly Salary X ________ Benefit % = ________ **Your Weekly Benefit**

________ Your Weekly Benefit ÷ 10 = ________ X ________ Your Rate = ________ **Your Monthly Cost**

________ Your Monthly Cost X 12 = ________ Annual Cost ÷ ________ # Paychecks per Year = ________ **Cost per Paycheck***

☐ **Yes,** I would like to participate. I authorize my employer to deduct from my salary or wages the necessary premium for this coverage. My signature verifies the accuracy of information contained on this form.

I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective. **I have also read and understand the information in the Plan Highlights, including all statements regarding exclusions and benefit amounts and offsets.**

☐ **No,** I do not wish to participate. I understand that evidence of insurability will be required, at my own expense, if I decide to elect this coverage in the future.

Employee Signature: ________________ Date: __ __/__ __/__ __ __ __

Return Forms To: ________________ By: __ __/__ __/__ __ __ __