Group Disability Insurance

UNDERWRITTEN BY

The Standard
Insurance Company

Evidence of Insurability for
University of Central Florida

ENROLLMENT CONDUCTED BY

Why Do You Need Disability Insurance?

Your most important asset is not your home, your car, your jewelry, or other material possessions. It's your ability to earn a living. All of your plans for the future - buying a home, putting your kids through college, building a retirement nest egg, etc. - are based on the assumption you will continue to earn a paycheck until you retire. What could happen if those paychecks stopped? That's where disability insurance comes in.

Voluntary disability insurance from Standard Insurance Company (The Standard) is designed to assist you and your family in the event that you are unable to work due to a covered illness or injury. The plan is payroll-deducted and available on a guaranteed issue basis (no medical exam or health questions required) to new employees or during open enrollments for your university, administered by Gabor.

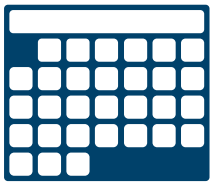
The Risk of Disability

The risk of disability may be greater than you think.

RECENT STATISTICS* HAVE SHOWN:

Just over 1 in 4 of today's 20-year-olds will become disabled before they retire.

The average group long-term disability claim lasts 34.6 months.



1 in 8 workers will be disabled for five years or more during their working careers.

* Disability Statistics can be found via the Council for Disability Awareness at www.disabilitycanhappen.org

What Does Disability Insurance Provide?

The benefits highlights are described below:

- 60% of the first $25,000 of your monthly pre-disability earnings, reduced by deductible income.
- The maximum monthly benefit is $15,000.
- The minimum monthly benefit is the greater of $100, or 10% of your LTD benefit before reduction by deductible income.
- Benefits pay from the end of the elimination period until Social Security Normal Retirement Age (SSNRA), as long as you meet the definition of disability as specified in the policy. If you become disabled after age 65, benefits are paid according to the information found in the "How Long Can LTD Benefits Continue?" section.

What Are Some of the Features of this Coverage?

ANNUITY CONTRIBUTION BENEFIT:
Pays a benefit after 9 months of disability equal to 11% of your pre-disability earnings, not to exceed $2,750 for an annuity. The minimum benefit is $50 per month. Upon qualification for the monthly annuity contribution benefit, a lump-sum payment equal to 9 times the monthly annuity benefit is paid as a catch up.

COST OF LIVING ADJUSTMENT BENEFIT:
After disability benefits have been paid for a year, the benefit will be increased annually up to a maximum of 2% per year for five years.

ASSISTED LIVING BENEFIT:
Paid in addition to the LTD benefit, income replacement is increased to an additional 20% of pre-disability earnings, not to exceed a maximum of $5,000 for employees with severe disabilities. The benefit is available when suffering one of the severe disabilities described below and when the condition is expected to last 90 days or more:

You are unable to safely and completely perform two or more Activities of Daily Living (bathing, continence, dressing, eating, toileting and transferring) without assistance

OR

You require substantial supervision for health or safety due to severe cognitive impairment

The additional benefits paid under the Assisted Living Benefit are not reduced by deductible income.

LIFETIME SECURITY BENEFIT:
Extends disability benefits beyond SSNRA until death. The benefit is available when LTD benefits are payable, when suffering one of the severe disabilities described below and when the condition is expected to last 90 days or more:

You are unable to safely and completely perform two or more Activities of Daily Living (bathing, continence, dressing, eating, toileting and transferring) without assistance

OR

You require substantial supervision for health or safety due to severe cognitive impairment

SURVIVORS DEATH BENEFIT:
If you die while LTD Benefits are payable, and on the date you die you have been continuously disabled for at least 180 days, The Standard will pay a lump sum Survivors Death Benefit equal to 3 times your LTD benefit without reduction by deductible income. However, the Survivors Death Benefit will first be applied to reduce any overpayment of your claim. The benefit is paid at Standard Insurance's option to any one or more of the following: surviving spouse/domestic partner; you and your surviving spouse/ domestic partner 's unmarried children, including adopted children, under age 25; or any person providing the care and support of the spouse/ domestic partner or unmarried children.

No Survivors Death Benefit will be paid if you are not survived by any person listed above.

WHAT ARE THE EXCLUSIONS AND LIMITATIONS?
You are not covered for a disability caused or contributed to by:

War or any act of war, whether declared or undeclared; Intentional self-inflicted injury, while sane or insane; Loss of professional or occupational license or certification; Committing or attempt to commit an assault or felony, or your active participation in a violent disorder or riot; A pre-existing condition.

What is the Definition of a Pre-existing Condition?

Pre-existing condition means a mental or physical condition, whether or not diagnosed or misdiagnosed, for which you have done any of the following:

Undergone diagnostic procedures, including self administered procedures;

OR

Received medical treatment, services or advice;

OR

Consulted a physician or other licensed medical professional;

OR

Taken prescribed drugs or medications which, as a result of any medical examination including routine examination, was discovered or suspected at any time during the 90-day period just before your insurance becomes effective.

EXCLUSION:
You are not covered for a disability caused or contributed by a pre-existing condition or medical or surgical treatment of a pre-existing condition unless, on the date you become disabled, you:

Have been continuously insured under the group policy for 12 months; and

Have been actively at work for at least one full day after the end of that 12 months

When am I Considered Disabled?

During the benefit waiting period and the next 26 months (if the 30-day plan is selected) or 24 months (if the 90-day plan is selected) you are considered disabled if, due to injury, physical disease, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation, or you are unable to earn 80% or more of your indexed pre-disability earnings when working in your own occupation.

Thereafter, you are considered disabled if, due to an injury, physical disease, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of Any Occupation. Any Occupation being those that you are able to perform, whether due to education, training, or experience:

- Which is available at one or more locations in the national economy, and
- In which you can be expected to earn at least 80% of your indexed pre-disability earnings within 12 months following your return to work, regardless of whether you are working in that or any other occupation.

When Do the Benefits Become Payable?

If your LTD claim is approved by The Standard, LTD benefits become payable at the end of the 30 or 90 day benefit waiting period, depending on the plan selected.

How Long Can LTD Benefits Continue?

If you become continuously disabled before age 62, LTD benefits can continue during disability until age 65, or to SSNRA*, or 3 years and 6 months, whichever is longest. If you become continuously disabled at age 62 or older, LTD benefits can continue during disability for a limited time.

AGE:

61 or younger: To age 65, or to SSNRA* or 3 years and 6 months, whichever is longer

62: To SSNRA*, or 3 years and 6 months, whichever is longer

63: To SSNRA*, or 3 years, whichever is longer

64: To SSNRA*, or 2 years and 6 months, whichever is longer

65: 2 years

66: 1 year and 9 months

67: 1 year and 6 months

68: 1 year and 3 months

69 or older: 1 year

*Social Security Normal Retirement Age (SSNRA) means your normal retirement age under the Federal Social Security Act.

Group Insurance Certificate

If you become insured, you can go online to download and print a group insurance certificate containing a detailed description of the insurance coverage. The information presented above is controlled by the group policy and does not modify it in any way. The controlling provisions are in the group policy issued by The Standard. Your coverage will become effective on the first day of the calendar month following the date of your application, provided the required premium contribution has been made for that month and you are actively at work. Actively at work will include regularly scheduled days off, holidays, or vacation days, so long as you are capable of active work on those days.

Under this plan you may choose one of two options:

30

The 30-day Plan

The 30–day plan begins paying benefits after 30 days. The first 60 days of benefits are paid on a weekly basis. Following 60 days of benefits, beginning on day 90, benefits are paid on a monthly basis.

90

The 90-day Plan

The 90–day plan begins paying benefits on a monthly basis after 90 days.

*The disability benefit is based on your earnings from your employer. The group insurance policy refers to these earnings as pre-disability earnings.
The group policy has an Active Work requirement which you must meet before your insurance will become effective.

Calculate your Monthly Premium

30–DAY DISABILITY INCOME PROTECTION FORMULA

1. Enter your monthly salary (maximum $25,000) $ ____
2. DIVIDE by 100 / ____
3. MULTIPLY the amount in Line 2 by $0.85 to get your **monthly premium** $ ____

EXAMPLE
$4,000 / 100 x $.85 =
(monthly salary) (per 100 salary rate based)

$34.00 Monthly Premium

90–DAY DISABILITY INCOME PROTECTION FORMULA

1. Enter your monthly salary (maximum $25,000) $ ____
2. DIVIDE by 100 / ____
3. MULTIPLY the amount in Line 2 by $0.59 to get your **monthly premium** $ ____

EXAMPLE
$4,000 / 100 x $.59 =
(monthly salary) (per 100 salary rate based)

$23.60 Monthly Premium

CONTACT GABOR NOW
(800) 330-6115

1410 Piedmont Drive East
Tallahassee, FL 32308
(800) 330-6115
info@gaborfs.com
www.gaborfs.com

GABOR FINANCIAL SOLUTIONS

To Be Completed By Applicant ☐ Apply for Coverage ☐ Change in Coverage ☐ Name Change

Employer Name	Group Number	Date of Employment	Job Title/Occupation
University of Central Florida	**648962**		

Your Name (Last, First, Middle)

Employee ID	Your Social Security Number	Birth Date	☐ Male ☐ Female

Your Address	City	State	ZIP

Hours Worked Per Week	Annual Earnings $_____	Choose one: I am employed on a ☐ 9 ☐ 10 ☐ 12 month contract

Coverage

Short Term Disability (STD) and Long Term Disability (LTD) Insurance

☐ 30 Day Plan (Voluntary STD and Voluntary LTD)

Long Term Disability Insurance

☐ 90 Day Plan (Voluntary LTD)

The 30 Day (STD and LTD) and 90 Day (LTD) Disability Plans have a pre-existing condition limitation. If I have received medical or surgical treatment, services or advice, undergone diagnostic procedures, including self administered procedures, taken prescribed drugs or medicines, or consulted with a physician or other licensed medical professional, for any mental or physical condition which was discovered or suspected as a result of any routine or other medical examination at any time within the 90 days prior to my effective date of coverage, these conditions will not be covered unless the disability begins more than twelve (12) consecutive months after my effective date of coverage. Review your booklet for additional information about the effective date of your coverage and the pre-existing condition exclusion.

I understand that I need to provide proof of good health to obtain this coverage. I also understand that should I be declined for coverage because of the proof of good health provided, I may be excluded from participating in future open enrollments.

Signature: I wish to make the choices indicated on this form. I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. The deductions are to be continued until (a) I request in writing that this authorization be cancelled; or (b) termination of employment.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____

Return completed form and Medical History to your local Gabor Representative.

Standard Insurance Company
Medical Underwriting, 900 SW Fifth Avenue Portland OR 97204

Medical History Statement
For Residents of: Florida

DIRECTIONS FOR APPLYING FOR COVERAGE

Read the Information Practices Notice(s) on page 3. Complete all items, date and sign in the space at the bottom of page 2. Keep a copy for your records and give the original to your local Gabor Representative.

MEMBER/EMPLOYEE INFORMATION

Name of Group **University of Central Florida**		Group Number **648962**	
Member/Employee Name		Birthdate (Mo/Day/Year)	Date Hired (Mo/Day/Year)
Occupation	Salary	Social Security Number	Member/Employee Identification No.

APPLICANT INFORMATION

Applicant's Name (Person to be insured)			Email Address		
Street Address	City		State	Zip	Residency ☐ USA ☐ Other
Sex ☐ M ☐ F	Birthdate (Mo/Day/Year)	Birthplace	Social Security Number	Work Phone ( ) Home Phone ( )	

APPLICATION INFORMATION

Type of Application *(check one)* ☐ Initial ☐ Increase in Coverage ☐ Late Application

Check the type and provide details on the amount of coverage you are requesting.

☐ 30 Day Plan (Short Term Disability and Long Term Disability)

☐ 90 Day Plan (Long Term Disability) _____ + _____ = _____
Current Amount In Force, if any — Additional Amount Requested — Total Amount Requested

MEDICAL HISTORY STATEMENT QUESTIONS

Check yes or no for each of these questions, and give details for any "yes" answers. Attach a separate sheet if necessary.

NOTE: Medical questions do not relate to Disability products for amounts over the Guaranteed Issue.

1. Are you now unable to maintain full time employment as defined by a licensed medical professional because of any physical or mental condition, or injury? . . . . . ☐ Yes ☐ No
2. Has a licensed member of the medical profession ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
   A. Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal ailment, or any disease of the digestive system? . . . . . ☐ Yes ☐ No
   B. Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, blindness, deafness, or any other neurological or muscle disorder? . . . . . ☐ Yes ☐ No
   C. Cancer, tumor, lesions, leukemia, lymphoma, blood clotting or other malignancy or growth? . . . . . ☐ Yes ☐ No
   D. Cardiovascular disease, heart ailment, arteriosclerosis, abnormal pulse, high blood pressure, heart murmur, valve, circulatory, or vascular disease? . . . . . ☐ Yes ☐ No
   E. Emphysema, asthma, bronchitis, sleep apnea, or other respiratory or lung disease? . . . . . ☐ Yes ☐ No
   F. Lupus, scleroderma, vasculitis, connective tissue disease, or an immune system disorder not related to Human Immunodeficiency Virus (HIV)? . . . . . ☐ Yes ☐ No
   G. Osteoarthritis, rheumatoid arthritis, osteoporosis, pain in the joints, amputations, or other disease or disorder of the bones, joints, back, or spine, arthritic or disc conditions? . . . . . ☐ Yes ☐ No
   H. Diabetes, thyroid, gland, spleen, or nephritis? . . . . . ☐ Yes ☐ No
   I. Drug or alcohol abuse, or have you used alcohol, drugs or nicotine in a manner that has resulted in medical treatment? . . . . ☐ Yes ☐ No
   J. Psychiatric or mental condition, depression, Adjustment Disorder (AD), Generalized Anxiety Disorder (GAD), or Obsessive Compulsive Disorder (OCD)? . . . . . ☐ Yes ☐ No
3. In the past 7 years have you had any illness or injury not listed above which resulted in the use of prescribed medication or visits to a licensed member of the medical profession? . . . . . ☐ Yes ☐ No
4. Have you tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or AIDS caused by the HIV infection or other sickness or condition derived from such infection? . . . . . ☐ Yes ☐ No
5. Have you been advised by a licensed medical professional to have any operation or to schedule an appointment for an existing physical or mental condition, or injury? . . . . . ☐ Yes ☐ No
6. Have you been diagnosed by a licensed medical professional as currently being pregnant? . . . . . ☐ Yes ☐ No

Height	Weight	Physician Name or Medical Facility with Applicant's Complete Medical Records (provide name and full mailing address)

Applicant Name	Social Security Number

Describe any "yes" answers below. (Please provide the entire question number.)

Question Number	*Description of Injuries, Disorders and Operations*	*Month/Year*	*Duration*	*Final Result*	*Physicians Consulted, City & State*

ACKNOWLEDGMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION *(Please read carefully.)*

- I represent that the statements contained herein, including those made in response to the Medical History Statement questions and any attachments, are true and complete, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, The Standard's liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, and the MIB, Inc. (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to The Standard or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information to determine my eligibility for group insurance coverage. I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I understand The Standard may release information it has about me to MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid six months from the date of the signature below. A photocopy or facsimile of this authorization shall be as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it has been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), and my coverage will be subject to all terms and conditions of the Group Policy(ies) and state limitations.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation on file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designation(s) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and I have kept a copy of this Medical History Statement.

FRAUD NOTICE

Any person who 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 is guilty of a felony of the third degree.

Signature of Applicant	**Date**

Note: Declinations do not affect either Guarantee Issue Amounts not subject to Evidence Of Insurability or other coverages already in force with Standard Insurance Company.

Applicant Name	Social Security Number

INFORMATION PRACTICES NOTICE

- To help us determine your eligibility for group insurance we may request information about you from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (MIB), formerly known as Medical Information Bureau. We will use the authorization you signed on this form when we seek this information.
- MIB – Information regarding your insurability will be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health (including short and long term disability) insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

  Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

  Standard Insurance Company may release information in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may release information in its file to other insurance companies to whom you may apply for life or health (including short and long term disability) insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.
- DISCLOSURE TO OTHERS – The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS – You have a right to know what information we have about you in our underwriting file. You also have a right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon 97204 or call 1-800-843-7979.