

Short Term Disability Insurance

Wallingford Swarthmore School District



If you were out of work due to an illness or accident, how long would you or your family stay afloat without your paycheck?

The first few months of a disability could be costly. Loss of income during this time may result in a financial hardship that could be difficult to recover. This Short-Term Disability Insurance plan works in coordination with your Long-Term Disability Insurance plan to cover you during the time period before your Long-Term benefits begin.

- If you suffer a disability, this plan would pay up to 60% of your annual salary divided by 52, depending upon your coverage choice, per week.
- Benefits are tax-free if you pay for coverage with after-tax dollars. (If unsure, confirm with your employer.) Please see your tax adviser for further specific advice.
- Benefits for a covered illness or injury continue for 180 days, the date you are no longer disabled or until you are eligible to receive benefits under your Long-Term Disability Insurance plan, whichever comes first.
- Benefits start on the greater of the 14th day or end of accumulated sick pay for a covered disability resulting from an accident or illness.

Summer Coverage

Summer vacation period is included as long as the covered disability would have prevented you from engaging in your normal occupation, if school were in session.

Maternity Coverage

Pregnancy, childbirth and related medical conditions are covered the same as any other illness. Coverage may continue up to 6 weeks for natural childbirth, 8 weeks cesarean delivery or longer if there are complications.

Definition of Disability

Disability and disabled means that the insured person is, as a result of physical disease, injury, pregnancy, substance abuse or mental disorder, unable to perform a majority of the material duties of his or her own occupation.

Medical Questions

The insurance company allows you to purchase this insurance without medical questions if you enroll within 31 days of the date you first became eligible for this coverage.

If you choose not to apply for coverage prior to, or within 31 days of becoming eligible and subsequently wish to obtain coverage, you must fill out the medical questionnaire form and be approved for coverage.

Maximum Weekly Benefit

Your maximum weekly benefit will be \$692.

Participation Requirement

If less than 25% of eligible employees enroll in this Short-Term Disability Insurance plan, this plan will be withdrawn.

Pre-Existing Conditions

This provision applies to all new enrollees. If you received medical treatment, took prescribed drugs, or consulted a physician for an illness or injury in the 3 months before coverage began or increased, that particular sickness or injury or anything related to the condition will not qualify for benefits during the first 12 months of coverage.

General Exclusions

The policy does not cover any disability: caused or contributed to by war, declared or undeclared, or any act of war; that occurs during any military leave for active duty, including training duty, the National Guard or Coast Guard, or any active or reserve component of the military forces; due to your attempted suicide while sane or insane; as a result of your intentionally self inflicted injuries; caused or contributed to by committing of or attempting to commit a crime; while you are imprisoned, confined in a penal or correctional institution or under house arrest; as a result of your participation in a riot; or as a result of your engaging in an illegal activity.

For Questions Contact: Hillendale Associates, Inc., Joe Walsh
610.399.3635

Return Forms To:

Administered by:
NATIONAL INSURANCE SERVICES
Corporate Headquarters
250 South Executive Drive, Suite 300, Brookfield, WI 53005
Offices Nationwide
800.627.3660

Underwritten by:
Madison National Life Insurance Company
Independence Holding Group
PO Box 5008, Madison, WI 53705

This is a brief description of disability insurance. For complete details including all benefits, exclusions and limitations, refer to Certificate form number GSDI-C200-(12/06) as issued to your employer.

Madison National Life Insurance Company, Inc. is a Wisconsin Insurance company and a Member of the IHC Group. The IHC Group is an insurance organization composed of Independence Holding Company (NYSE: IHC) and its operating subsidiaries. The IHC Group has been providing life, health and stop loss insurance solutions for over 30 years. For information on the IHC Group, see www.ihcgroup.com.

Insurance Benefit Enrollment Form

Return to: National Insurance Services, Attn: Billing Department
 250 S. Executive Drive, Suite 300 Brookfield, WI 53005-4273
 Phone 1.800.627.3660 Fax 262.785.9269



Enter your information:					
Employer Name: Wallingford Swarthmore School District				NIS Group Number: 012223	
Full Name (Last name, First name, Middle Initial):				Date of Hire:	
Home Address:			City:		State: Zip:
Social Security Number:		<input type="checkbox"/> Single <input type="checkbox"/> Married	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No*		Date of Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Occupation/Title:				Hours worked per week: Annual Salary:	

*If you are not a U.S. Citizen, please provide a copy of your Visa.

Insurance benefits:					
<input type="checkbox"/> Elect	<input type="checkbox"/> Decline	Short-Term Disability			
		Age	Rate per \$10 of Weekly Benefit	Age	Rate per \$10 of Weekly Benefit
		0-24	\$1.40	45-49	\$0.77
		25-29	\$1.32	50-54	\$0.89
		30-34	\$1.19	55-59	\$1.09
		35-39	\$0.89	60-64	\$1.35
		40-44	\$0.71	65 +	\$1.59
<p>TO CALCULATE YOUR PREMIUM:</p> $\frac{\text{Annual Salary}}{52} = \frac{\text{Weekly Salary}}{52} \times 60\% = \frac{\text{Weekly Benefit}}{52} \times \frac{\text{Rate}}{10} = \text{Monthly Premium}$					

Sign here (required whether electing or declining any coverage):	
<p>I have been given the opportunity to apply for group insurance and agree to accept or decline coverage(s) as noted above. If I am declining coverage(s), I understand that if my dependents or I decide to apply for coverage at a later date, Evidence of Insurability (medical questions) may be required at my own expense and the insurance company must approve coverage. If I have elected any coverage(s) above, I authorize my employer to make any required deductions, if any, from my salary to pay my portion of the insurance premium when my insurance becomes effective.</p> <p>Warning: Any person who knowingly presents false information on an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.</p>	
Signature:	Date:

Instructions for the employee: Complete and return this form to your Benefits Administrator.

Instructions for the Benefits Administrator: Retain a copy of this form for your records and provide employee with a copy. Mail original to National Insurance Services at the address above.