LONG TERM DISABILITY INSURANCE

901 East 78th Street | Minneapolis, MN 55420-1300
800.995.5357 | Fax 952.853.8474 | benefits@fcmmbenefits.org

FORM 101: ENROLLMENT INSTRUCTIONS

FCMM Long Term Disability Insurance
with Life and Accidental Death and Dismemberment Insurance

Complete and return the following pages from the enrollment packet:
Page 1 (Enrollment form) – Enter the "Total Salary" from Worksheet Line 3 in the appropriate space
Page 2 (Limitations and Exclusions notice)
Page 3 (Beneficiary form)
Page 4 (Salary worksheet)
Insurer requires that original signed forms be filed with FCMM.

To: FCMM Benefits and Retirement
901 East 78th Street
Minneapolis, MN 55420

Please note:

- **Payroll Deduction:** If you receive this insurance with premiums submitted by your employer from amounts deducted from your salary, it is required by the insurance company that FCMM receive the enrollment forms within 10 days from the completion date of your waiting period, if any (normally 30 days, but may be established by your church as a different length). If you miss this window of opportunity you can enroll during open enrollment in December each year.

- **Employee Benefit:** If you receive this insurance as a benefit with premiums paid by your employer, you will begin coverage on the first of the month following the completion of your waiting period, if any (normally 30 days, but may be established by your church as a different length).

Prompt return of forms to FCMM Benefits and Retirement is important to meet insurance guidelines. Please contact FCMM if you have any questions regarding the return of forms.

Contact: benefits@fcmmbenefits.org or call (800) 995-5357

Underwritten by:
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

Evangelical Free Church of America

Administered by: **FCMM Benefits & Retirement**
Mail to: 901 East 78th Street, Minneapolis, MN 55420

Group Long Term Disability Insurance & Term Life/AD&D
Enrollment Form
Policy #930391/Div #001

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

Employee Social Security Number	**Gender**	**Date of Birth (mm/dd/yyyy)**	**Hours Worked Per Week**
- -	M F	/ /	

Employee First Name	**M.I.**	**Last Name**

Employee Home Street Address	**City**	**State**	**Zip Code**

Original Full-Time Date of Hire	**Annual Salary From Worksheet**	**Occupation / Job Title**
	$,	

Phone Number: ☐ **Salaried** ~OR~ ☐ **Hourly** **Email Address:**

To calculate the per-paycheck cost for this coverage, complete the calculations below.
Note: *If your annual salary exceeds $120,000, use $120,000 as your annual salary in the calculation.*

____	X	$0.0082	=	____	÷	____	=	____
Annual Salary **(from above)**		Your Rate		Annual Cost		# Paychecks per Year		**Cost per Paycheck***

* Final cost may vary slightly due to rounding.

(1) ☐ My Employer pays 100% of the cost of the premiums for this plan. (Benefits during disability will be taxable to me.)

~ OR ~

(2) ☐ I pay 100% of the premium cost for my coverage under this plan, if I elect to participate (Benefits during disability will NOT be taxable to me).

☐ **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 limitations & exclusions and benefit amounts and offsets.**

☐ **No,** I do not wish to participate. I understand that I can't enroll again until the Annual Open Enrollment, if I wish to elect this coverage in the future.

Employee Signature: ____________________ Date: __ __/__ __/__ __ __ __

Return Forms To: ____________________ By: __ __/__ __/__ __ __ __

This section to be completed by your employer:

Coverage Effective Date: __ __/__ __/__ __ __ __ **Authorized Signature: ____________________**

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

Please be aware that your coverage may be impacted by certain limitations and exclusions including, but not limited to, the following:

Limitations and Exclusions

Delayed Effective Date:

Employee: Insurance will be delayed for employees not in active employment until the first of the month, coincident with or next, following the date they return to work. Regularly scheduled vacation time is considered active employment.
Dependents: Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer disabled. This delay does not apply to newborn children while dependent insurance is in effect. "Totally disabled" means that, as a result of injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; is receiving or is entitled to receive any disability income from any source due to any sickness or injury; is receiving chemotherapy radiation therapy or dialysis treatment; or has a life threatening condition. Disabled children over the maximum child age may be eligible for benefits, please see your plan administer for more details.

Exclusion for Suicide:

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

This Suicide Exclusion does not apply to Washington residents.

AD&D Benefit Exclusions

AD&D Benefits would not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders;
- Suicide, self-destruction while sane, or self-inflicted injury;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Attempt to commit or commission of a crime;
- The voluntary use of any prescription or non-prescription drug, poison, fume or any other chemical substance unless used according to the prescription or direction of the individual's doctor. This exclusion does not apply to the individual if the chemical substance is ethanol; or
- Intoxication. ("Intoxicated" means that the individual's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.)

Please see your Plan Administrator [or your Policy] for a complete listing of applicable limitations and exclusions.

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Enrollment Form
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FORM 102: BENEFICIARY DESIGNATION - EFCA Term Life and AD&D Insurance

Please print legibly and 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)** / / ____________

Employee First Name ____________ **M.I.** ___ **Last Name** ____________

Amount of Employee coverage selected: $10,000 of Life and AD&D
(Amount may vary based on Benefit cutbacks due to age of the insured)

Beneficiary Information: Please complete the beneficiary information on this form. If you wish to change your beneficiary at any time please complete a new form. The form with the most recent signature date will replace all other elections or directions.

(I) Primary Beneficiary Information

Name *(last name, first, middle initial)*:	**Relation to You:**	**Benefit %:**
(1)		
(2)		
(II) CONTINGENT BENEFICIARIES: If the beneficiary(ies) named above are not living, then pay: (1)		
(2)		
(3)		
(4)		

Request for Signature and Certification: *I have read and understand the "Limitations and Exclusions" included with this enrollment form.* I certify that all statements that I have provided are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

________________________ __ __/__ __/__ __ __ __ ____________ ____________
Employee Signature *Date* *Work Phone* *Home Phone*

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Mail to: 901 East 78th Street, Minneapolis, MN 55420
(800) 995-5357 benefits@fcmmbenefits.org

Group Long Term Disability Insurance & Term Life/AD&D
Enrollment/Update Form
Policy # 930391/Div #001

FORM 103: SALARY WORKSHEET & INFORMATION/CHANGE

Payroll deduction premium payment **employees are only eligible to enroll for coverage during the eligibility period** established by employer, or they must then wait until a future open enrollment period, usually in December each year, to apply for coverage.
If the *premium is paid by the employer as a staff benefit,* then new eligible employees are enrolled the first of the month following the eligibility period and premiums are paid beginning on that date.

Prompt completion of enrollment forms to FCMM Benefits and Retirement enables timely coverage. Accurate and current **salary information** is necessary for our carrier. Salary changes as well as other updates should be reported on Form 103: Salary Worksheet & Information/Change, which may be downloaded from fcmmbenefits.org. Up-to-date salary information is essential to be on file for full benefits in the event of a claim. Verification will occur at the time of any claim filed.

(PLEASE PRINT)

EMPLOYEE'S NAME ______________________________ **EMAIL** ____________________

EMPLOYEE'S ADDRESS ____

EFCA CHURCH OR ORGANIZATION ______________________________________

EMPLOYER ADDRESS ____

PERSON PROVIDING THIS INFORMATION _________________________________

DATE INFORMATION WAS PROVIDED ___________________________________

Combined total of salary and housing allowance is considered when figuring a pastor's "salary" for premium and benefit:

1. **Annual Base Salary** **$**____________________

   Line 1 should report the employee's annual salary which does include:
   - Salary added for clergy Social Security offset
   - Salary added in lieu of health insurance
   - Employee payroll-deducted contribution to Health Savings Account or Flexible Spending Account
   - Employee payroll-deducted salary deferral for retirement contribution

   Line 1 should not include:
   - Housing Allowance and/or Fair Rental Value for Parsonage (enter this amount in Line 2)
   - Reimbursement for business expenses
   - Employer retirement contributions
   - Other employer-paid nontaxable benefits (example: dental insurance)

2. **Housing Allowance and/or Fair Rental Value** **$**____________________

   (For qualified pastoral staff only)

   Line 2 should indicate the employee's approved designated Pastoral Staff housing allowance and/or fair rental value of housing provided by the church (if applicable).

3. **TOTAL SALARY** (add lines 1 and 2)* **$**____________________

   With initial enrollment, enter this amount on page 1 of enrollment form.

I participate in an employer-sponsored retirement plan. ☐ Yes ☐ No

Submit pages 1-4 for initial enrollment to FCMM. Please note: The participating church must have a board minute or resolution stating participation in the plan and type of premium payment on file with the FCMM Benefits office. That form must be in agreement with what the employee has checked on the enrollment form for the method of payment.

FCMM FORM 138: Coverage Overview for Evangelical Free Church of America

GROUP LONG TERM DISABILITY PLAN HIGHLIGHTS

Employee Disability Insurance
- Pays 60% of your monthly earnings to a maximum monthly benefit of $6,000
- 90 Day Elimination Period before disability benefit payments begin
- Maximum Benefit Duration lasts up to your Social Security Normal Retirement Age
- Definition of Disability is based on your inability to perform the duties of your own- occupation for the first 3 years of a disability
- Additional disability benefits of up to $1,000/month may be available to you for up to 2 years if you are cognitively disabled or unable to perform two or more Activities of Daily Living (ADLs)
- All employees working at least 25 hours per week are eligible for the plan

Spouse Long Term Disability Rider
- Pays a benefit if your spouse is cognitively disabled or unable to perform two or more Activities of Daily Living (ADLs)
- Pays a $1,500 monthly benefit after a 60-day elimination period
- 2 year lifetime maximum payment period

Additional Plan Features
- **Conversion** – you may convert your coverage to an individual policy and take it with you if your employment ends
- **Survivor Benefit** – if you pass away while receiving a long term disability benefit, Unum will pay your eligible survivor a lump sum benefit equal to 3 months of your gross disability payment
- **Rehabilitation and Return to Work Assistance Program** – depending on your disability, Unum may create a program tailored to your needs that could assist you in returning to work. This program pays an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month. You may also qualify for child care reimbursement of $250 per child, per month, not to exceed $1,000 per month while participating in this program

GROUP LIFE PLAN HIGHLIGHTS

Employee Life and AD&D Insurance
- All employees working at least 25 hours per week are eligible for the plan
- For those who currently have the Unum LTD Insurance; $10,000 for all employees under age 70, $6,500 for those ages 70 – 75 or $5,000 for those ages 75+.
- Guarantee Issue coverage – you will not have to answer any medical questions

Additional Plan Features:
- **Waiver of Premium** - If you become disabled (as defined by your plan) and are no longer able to work, your premium payments will be waived during this period of disability.
- **Survivor Support** counsel included
- **Portability** - If you retire, reduce your hours or leave your Employer, you can take this coverage with you according to the terms of the contract.

VALUE ADD SERVICES ~ Additional Information Available at: fcmmbenefits.org

Travel Assistance Benefit

Employees and family are covered while traveling (100 or more miles from home), with crisis management, guaranteed hospital admissions, critical care monitoring, emergency medical evacuation, etc. Services provided by Assist America.

Employee Assistance Program

Unum's Life Balance program is there to assist employees with everyday home, personal and family issues. They provide full access to counseling, information, resources for wellness and free will preparation services. Services provided by Ceridian.