



**AMERICAN CONFERENCE *of* CANTORS**  
*Sacred music. Spiritual leadership. Jewish life.*

ACC Group Insurance Plans  
Enrollment Kit for New Participants  
March 2018



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Enrollment Kit for New Participants

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Dear ACC Member,

The American Conference of Cantors has partnered with Group Benefit Associates (GBA) to help facilitate enrollment and administration of the group insurance benefits. These include 2 benefits: Voluntary Long Term Disability Insurance and Life and Accidental Death and Dismemberment (AD&D) Insurance Plan, both through The Standard.

**Long-Term Disability Benefit through The Standard**

Voluntary Long Term Disability pays a portion of your earnings if you cannot work due to a disability. After an elimination period of 90 days of disability, you can replace up to 60% of your regular pay, to a maximum monthly benefit of \$ 13,892 in 2018.

**Life Insurance and Accidental Death & Dismemberment Benefit**

You may choose to purchase life insurance in \$10,000 increments up to \$150,000 guarantee issue. You may purchase up to \$500,000 with evidence of insurability. You may also choose to elect up to 50% of the member elected coverage for your spouse. Dependent child coverage may also be elected.

Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable.

Your eligibility begins with your “hire date” otherwise known as the date you become a member of the ACC. To enroll in the program, please read the enclosed material provided, complete the enrollment forms and return to Group Benefit Associates at the address listed below. **Forms must be received no later than 31 days from the start of your eligibility for guarantee issue.** To remain eligible for these benefits, you must be working a minimum of 30 hours per week. Please notify GBA if your eligibility should change in the future.

These programs have been arranged through the ACC as part of its continuing efforts to provide members access to additional benefits. Feel free to contact GBA directly with any questions:

Group Benefit Associates  
1701 W. Lake Avenue, Suite 400  
Glenview, IL 60025

Telephone: 800-450-1271 toll-free  
Fax: 773-427-6875  
Email: [customerservice@groupba.com](mailto:customerservice@groupba.com)

We hope that you will find this coverage a welcome benefit to you and your family.

Sincerely,

ACC Insurance Plan Administrator



## **Group Long Term Disability Insurance**

Group Long Term Disability (LTD) insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a monthly benefit in the event of a covered disability.

The cost of this insurance is paid by you through monthly bank draft or credit card.

### **Eligibility**

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#### **Definition of a Member**

You are a member if you are a member of American Conference of Cantors, actively working at least 30 hours each week, and a citizen or resident of the United States or Canada. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.

#### **Eligibility Waiting Period**

You are eligible on the date you become a member. You will need to provide acceptable evidence of good health if you elect coverage after initially becoming eligible, after the initial open enrollment period ending December 31, 2014.

### **Benefits**

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#### **Monthly Benefit**

60 percent of the following amounts of monthly predisability earnings, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)

Effective January 1, 2015, the first \$20,000	Effective January 1, 2018, the first \$23,153
Effective January 1, 2016, the first \$21,000	Effective January 1, 2019, the first \$24,310
Effective January 1, 2017, the first \$22,050	Effective January 1, 2020, the first \$25,526

#### **Maximum Monthly Benefit**

Effective January 1, 2015, the first \$12,000	Effective January 1, 2018, the first \$13,892
Effective January 1, 2016, the first \$12,600	Effective January 1, 2019, the first \$14,586
Effective January 1, 2017, the first \$13,230	Effective January 1, 2020, the first \$15,315

#### **Minimum Monthly Benefit**

\$100

#### **Benefit Waiting Period**

90 days

### Definition of Disability

For the benefit waiting period and the first 24 months for which LTD benefits are payable, being unable – as a result of physical disease, injury, pregnancy or mental disorder – to perform with reasonable continuity the material duties of your own occupation and suffering a loss of at least 20 percent of predisability earnings when working in your own occupation.

After that, being unable – as a result of physical disease, injury, pregnancy or mental disorder – to perform with reasonable continuity the material duties of any occupation:

- That you are able to perform, due to education, training or experience,
- That is available at one or more locations in the national economy, and
- In which you can be expected to earn at least 60 percent of predisability earnings within 12 months of returning to work, regardless of whether you are working in that, or any other, occupation.

### Maximum Benefit Period

If you become disabled before age 62 LTD benefits may continue until age 65 or to the Social Security Normal Retirement Age (SSNRA) or 3 years 6 months, whichever is longest. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins:

Age	Maximum Benefit Period
62	To SSNRA, or 3 years 6 months, whichever is longer
63	To SSNRA, or 3 years, whichever is longer
64	To SSNRA, or 2 years 6 months, whichever is longer
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

### Other Features and Services

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- 24 hour coverage, including coverage for work-related disabilities
- Employee Assistance Program
- Reasonable Accommodation Expense Benefit
- Rehabilitation Incentive Benefit
- Rehabilitation Plan Provision
- Return to Work Incentive
- Return to Work Responsibility
- Survivors Benefit
- Temporary Recovery Provision
- Waiver of Premium while LTD benefits are payable

*This information is only a brief description of the group LTD insurance policy sponsored by American Conference of Cantors. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reductions in benefits, exclusions and when The Standard and American Conference of Cantors may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For costs and more complete details of coverage, contact your human resources representative.*

# What are the costs?

## Voluntary Long-Term Disability Insurance

Coverage amounts are based on earnings. Your cost may change if your earnings change. Your cost will also change when you move into a new age category.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
<b>ACC Admin Fee</b>	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10
<b>Cost</b>	.162	.135	.162	.333	.522	.729	0.981	1.098	1.026	0.99
<b>Calculation Rate</b>	0.262	0.235	0.262	0.433	0.622	0.829	1.081	1.198	1.126	1.09

To calculate your monthly cost, please use the following formula(s):

$$\frac{\text{Your Annual Earnings (includes parsonage) Maximum= \$240,000}}{12} = \frac{\text{Your Monthly Earnings}}{100} = \text{_____} \times \frac{\text{Calculation Rate}}{\text{Rate}} = \$ \text{_____ Monthly Cost}$$



## **Group Voluntary Life and Accidental Death and Dismemberment Insurance**

Voluntary Life Insurance Group from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an insured member's, or his or her dependent's, covered death. Voluntary Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by you through monthly bank draft or credit card.

### **Eligibility**

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#### **Definition of a Member**

You are a member if you are a member of American Conference of Cantors and regularly working at least 30 hours each week. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.

#### **Eligibility Waiting Period**

You are eligible on the date you become a member. You and your dependents will need to provide acceptable evidence of good health if you elect coverage after initially becoming eligible, after the initial open enrollment period ending December 31, 2014.

### **Benefits**

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#### **Voluntary Life Coverage Amount**

Your Voluntary Life coverage amount is available in increments of \$10,000 to a maximum of \$500,000. The minimum amount that can be elected is \$10,000.

Acceptable evidence of good health may be required for the amount of Voluntary Life coverage in excess of \$150,000.

#### **Voluntary AD&D Coverage Amount**

For a covered accidental loss of life, your Voluntary AD&D coverage amount is equal to your Voluntary Life coverage amount. For other covered losses, a percentage of this benefit will be payable.

#### **Age Reductions**

Voluntary Life and AD&D insurance coverage amounts are reduced by 35 percent at age 65 and by 50% at age 70.

#### **Voluntary Dependents Life Coverage Amount**

The Voluntary Dependents Life coverage amount for your spouse/domestic partner is available in increments of 50% of your Voluntary Life coverage amount.

Acceptable evidence of good health may be required from your spouse/domestic partner to become insured for the amount of Voluntary Dependents Life coverage in excess of \$10,000.

The Voluntary Dependents Life coverage amount for each of your eligible children is \$10,000.

### **Other Voluntary Life Features and Services**

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- Accelerated Benefit
- Portability of Insurance Provision
- Repatriation Benefit
- Right to Convert Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

### **Other Voluntary AD&D Features**

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- Air Bag Benefit
- Family Benefits Package
- Seat Belt Benefit

*This information is only a brief description of the group Voluntary Life/AD&D and Voluntary Dependents Life insurance policy sponsored by American Conference of Cantors. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reductions in benefits, exclusions and when The Standard and American Conference of Cantors may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For costs and more complete details of coverage, contact your human resources representative.*



# What are the costs?

## Voluntary Life Insurance and Accidental Death & Dismemberment (AD&D)

### For The Member:

Available in increments of \$10,000 to \$150,000 guarantee issue. Increments above \$150,000 to a maximum of \$500,000 require a Medical History Statement Form and are subject to insurance carrier approval. The minimum amount that can be elected is \$10,000.

Member Rate Per \$1,000											
Age	Under 29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
ACC Admin Fee	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10
Cost	0.09	0.09	0.117	0.171	0.261	0.387	0.567	0.918	1.629	2.46	4.19
Rate Calculation	0.19	0.19	0.217	0.271	0.361	0.487	0.667	1.02	1.729	2.56	4.29

	Age	Rate Per \$1,000	x	Benefit In \$1,000's	=	Monthly Cost
*Example:	35	.217	x	150	=	\$32.55
			x		=	

\*Example is based on a 35 year old electing \$150,000 in coverage.

### For The Spouse/Domestic Partner:

Spouse/domestic partner coverage amounts are available at 50% of the Member's coverage amount. The minimum amount that can be elected is \$5,000. Any coverage elected above \$10,000 requires a Medical History Statement Form and is subject to insurance carrier approval. The spouse/domestic partner rate is based on the Member's age.

Spouse/Domestic Partner Rate Per \$1,000											
Member Age	Under 29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
ACC Admin Fee	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10	0.10
Cost	0.09	0.09	0.117	0.171	0.261	0.387	0.567	0.918	1.629	2.46	4.19
Rate Calculation	0.19	0.19	0.217	0.271	0.361	0.487	0.667	1.02	1.729	2.56	4.29

	Member Age	Rate Per \$1,000	x	Benefit In \$1,000's	=	Monthly Cost
*Example:	35	.217	x	75	=	\$16.28
			x		=	

\*Example is based on the member's age of 35 and electing \$75,000 in coverage.

### For The Dependent Child:

- Dependent child(ren) coverage includes unmarried child(ren) from live birth through age 20, or through age 24 if the child is a full-time registered student.
- The coverage for dependent child(ren) is a flat \$10,000 per child.
- Monthly Cost= \$2.10. The cost of coverage includes the premium plus a small allowance of \$0.10 for administrative costs. Premium covers all dependent children regardless of the number of children.

### Your Total Monthly Cost

$$\frac{\text{Member's Monthly Cost}}{\text{Member's Monthly Cost}} + \frac{\text{Spouse/Domestic Partner Monthly Cost}}{\text{Spouse/Domestic Partner Monthly Cost}} + \frac{\text{Child(ren)}}{\text{Child(ren)}} = \frac{\text{Total Monthly Cost}}{\text{Total Monthly Cost}}$$

# Eligibility

As a plan participant you must notify Group Benefit Associates of the following:

- Within 30 days of any layoff
- Within 30 days of your subsequent return to work
- Immediately when your bank account or credit card information changes for the purpose of premium collection
- Immediately when your annual salary changes
- Within 1 year of your date of disability if you become disabled
- You must be actively working at time of enrollment into the plan

**Failure to notify Group Benefit Associates in a timely manner of any of the above listed changes can affect your participation in the plan or the benefits you are eligible to receive under the plan**

## Cancellation Requests

Cancellation requests must be received by GBA in writing by mail, fax, or e-mail. Cancellations will become effective on the last day of the month in which they are received.

## Premium Waived if Disabled

Premium is waived if you are receiving a disability benefit. Please contact us within 30 days of your disability so that we may waive your premium while you are not working.

## Premium Payments

Your initial premium will be collected within 5 business days of your enrollment. Subsequent premiums will be collected automatically from a Visa, MasterCard or direct debit from a checking account on the 15th of each month. If the 15th falls on a weekend or holiday, the charge will occur on the next business day.

Group Number <b>159034</b>	Division N/A	Billing Category N/A	Date of Employment
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**To Be Completed By Applicant**    Apply for Coverage    Beneficiary Change *Complete Beneficiary Section below.*    Name Change  
 Add or  Delete Dependent   Date of add/delete \_\_\_\_\_

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Your Address		City	State	ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>			Phone Number	
Employer Name <b>American Conference of Cantors</b>			Job Title/Occupation	
Hours Worked Per Week	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input checked="" type="checkbox"/> Year		

**Coverage**

**Life Insurance**

Voluntary Life with AD&D requested amount \$ \_\_\_\_\_

**Dependents Life Insurance**

Spouse Life with AD&D requested amount \$ \_\_\_\_\_

Spouse Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Child(ren) Life with AD&D requested amount \$ 10,000

**Long Term Disability**    Voluntary LTD

**Beneficiary** *This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.*

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

**Signature** I wish to make the choices indicated on this form. If electing coverage, 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.

Member/Employee Signature Required \_\_\_\_\_ Date (Mo/Day/Yr) \_\_\_\_\_

## Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated \_\_\_\_\_."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

REQUIRED FORM to enroll

YOUR INFORMATION
Last Name, First Name:
Annual Salary (includes parsonage):
Social Security Number:

Home Address:
City, State Zip:
Phone:
Email:

PAYMENT OPTIONS (select one)		
<input type="checkbox"/> Checking Account	Name as it appears on check:	
	Bank Name:	
	Routing Number (9 digits):	
	Account Number:	

<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard  <i>**We do not accept Amex or Discover</i>	Name as it appears on card:	
	Credit Card Number:	
	Expiration (MM/YY):	
	Card Security Code (last 3 digits on back of card):	

Signature of premium payer \_\_\_\_\_

Date \_\_\_\_\_

The premiums for this program are collected in advance of the month that they are due. Premium must be paid via automatic collection by credit card or bank draft. Your initial premium due will be collected within 5 business days of the application. Subsequent premiums will be collected on the 15th of the month prior to the start of the next month. **There will be no invoicing of premium; premium will ONLY be collected electronically.** You are authorizing Babbitt Municipalities, Inc. (d.b.a. Group Benefit Associates) to draft a checking account or charge a credit card for the purpose of collecting premiums for the supplemental benefits.

**DIRECTIONS FOR APPLYING FOR COVERAGE**

Read the Information Practices Notice(s) on page 3. A separate form must be submitted for each applicant (Employee/Member, Spouse and/or Child) when Evidence Of Insurability or Proof of Good Health is required to apply for coverage. Complete all items, date and sign in the space at the bottom of page 2. Keep a copy for your records, and send the original to Standard Insurance Company at the address given above.

**MEMBER/EMPLOYEE INFORMATION**

Name of Group American Conference of Cantors		Group Number 159034	Check who is Applying (One per form) <input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	
Member/Employee Name		Birthdate (Mo/Day/Year)	Date Hired (Mo/Day/Year)	
Occupation	Salary (annual)	Social Security Number		

**APPLICANT INFORMATION**

Applicant's Name (Person to be insured)				
Street Address		City	State	Zip
Sex <input type="checkbox"/> M <input type="checkbox"/> 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.**

<input type="checkbox"/> Long Term Disability	_____ +	60% of annual salary Additional Amount Requested	=	60% of annual salary Total Amount Requested
<input type="checkbox"/> Life	_____ +	_____ Additional Amount Requested	=	_____ Total Amount Requested
<input type="checkbox"/> Dependents Life	_____ +	_____ 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.**
- Are you now unable to work full-time because of any physical or mental condition, or injury?  Yes  No
  - Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following:
    - Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal ailment, or digestive system disorder?  Yes  No
    - Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, blindness, deafness, or any other neurological or muscle disorder?  Yes  No
    - Cancer, tumor, lesions, leukemia, lymphoma, blood clotting or other malignancy or growth?  Yes  No
    - Cardiovascular disease, heart ailment, arteriosclerosis, abnormal pulse, high blood pressure, heart murmur, valve, circulatory, or vascular disorders?  Yes  No
    - Emphysema, asthma, bronchitis, sleep apnea, or other respiratory or lung disease?  Yes  No
    - Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Virus (HIV)?  Yes  No
    - 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
    - Diabetes, thyroid, gland, spleen, or nephritis?  Yes  No
    - Drug or alcohol abuse, or have you used alcohol, drugs or nicotine in a manner that has resulted in medical treatment?  Yes  No
    - Psychiatric or mental condition, depression, adjustment disorder, affective disorder, anxiety disorder, or obsessive-compulsive disorder?  Yes  No
  - In the past 7 years have you had any illness or injury not listed above which resulted in the use of prescribed medication or physician visits?  Yes  No
  - Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?  Yes  No
  - Do you plan any operation or visit to a doctor or practitioner for an existing physical or mental condition, or injury?  Yes  No
  - Are you currently 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
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**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.

<b>Signature of Applicant</b> (or Member/Employee for Dependent Child)	<b>Date</b>
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**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](http://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.

**FRAUD NOTICE**

- FOR RESIDENTS OF ARKANSAS, LOUISIANA, OHIO, WASHINGTON: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.
- FOR RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
- FOR RESIDENTS OF DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- FOR RESIDENTS OF NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- FOR RESIDENTS OF PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.



## Insurance Resources

For specific information regarding policy benefits, enrollment, and premiums, contact the ACC's third party insurance administrator, Group Benefit Associates. All enrollment forms are to be returned to Group Benefit Associates for processing:

Group Benefit Associates (GBA)

1701 E. Lake Avenue, Suite 400  
Glenview, IL 60025

Telephone: 800-450-1271

Fax: 773-427-6875

[CustomerService@groupba.com](mailto:CustomerService@groupba.com)

Hours: Mon-Fri 9am-5pm Central



For general information about the ACC's group insurance offerings:

Laura Majeski

American Conference of Cantors

Telephone: 847-781-7800, Ext 302

[retirement@accantors.org](mailto:retirement@accantors.org)

For more about the American Conference of Cantors' Long Term Disability and Life insurance carrier, The Standard Insurance Company:

[www.standard.com](http://www.standard.com)