Zurich American Life Insurance Company of New York

Enrollment or Termination Form
Employee-Paid Short-Term and Long-Term Disability Coverage

Section 1—Employee Information

Legal Name

First _____ MI _____

Last _____

Mailing Address

Street _____

City _____

State _____ Zip Code _____

Country _____

Home Phone _____

Mobile Phone _____

Personal Email _____

Social Security # / TIN _____

Date of Birth _____

Gender ☐ Male ☐ Female

Is employee actively at work? ☐ Yes ☐ No

Does employee work in the US? ☐ Yes ☐ No

Work Location _____

Work Phone _____

Scheduled number of work hours per week _____

Section 2—Employer Information

Employer Name _____

Client Number _____

Mailing/Billing Address

Street _____

City _____

State _____ Zip Code _____

Country _____

Phone _____

Diocese _____

List Bill _____

Section 3— Enrollment, Coverage Change or Termination

Transaction Type

☐ New Hire
☐ Late Enrollee
☐ Newly Eligible
☐ Employee Termination of Coverage* (proceed to Section 4B)
☐ Annual Enrollment

Effective Date of Change _____

Short-Term Disability Coverage

Policy Selected**

☐ STD 26 Weeks 60%
☐ STD 26 Weeks 66.67%
☐ STD 13 Weeks 60%
☐ STD 13 Weeks 66.67%

Long-Term Disability Coverage

Policy Selected**

☐ LTD 180 Days 50%
☐ LTD 90 Days 50%

Enrollment deadline:

Enrollments in a Short-Term and/or Long-Term Disability plan must be made within 31 days of the employee's hire date. The plans do not allow for waiting periods.

* Terminated employees who have been enrolled in either of the Employee-Paid (Voluntary) Long- Term Disability Plans for 12 or more consecutive months can convert their LTD coverage if they apply directly through Zurich American Life Insurance Company of New York within 31 days of their termination date. Forms are available at cpg.org.

** Coverage subject to elimination period and maximum amount.

Section 4A—Acknowledgment, Signatures, and Notices (Do not complete if selected Employee Termination of Coverage)

Employee Signature

The employee and employer organization must sign this form. By signing below, I certify that:

- I accept the insurance coverage(s) chosen above.
- I authorize my employer to deduct the required contribution in advance from wages due me.
- I understand that my insurance will not go into effect unless I am actively at work on the effective date.
- I understand the conditions for the requested insurance to be effective are described in the Benefit Summary and the Certificate of Coverage. Approval of this request by Zurich American Life Insurance Company of New York is one of those conditions.
- I hereby certify that to the best of my knowledge and belief, all written statements I have given are true and complete.

Employee Signature _____ Date _____

Employer Signature

By signing below, the employer certifies the employee is eligible for all coverages applied for, that the employer agrees to deduct and timely remit the required contribution from the employee's wages and, to the best of the employer's knowledge, all information provided above is correct.

Employer Signature _____ Date _____

Section 4B—Acknowledgment, Signatures, and Notices for Termination

Employee Signature	By signing below, I certify my desire to terminate and end my Disability Coverage enrollment. Employee Signature _____ Date _____
Employer Signature	By signing below, the employer certifies and agrees not to deduct and remit the required contribution from the employee's wages and, to the best of the employer's knowledge, all information provided above is correct. Employer Signature _____ Date _____
Submit the completed and signed form to:	The Episcopal Church Clergy and Employees' Benefit Trust, 19 East 34th Street, New York, NY 10016, Attn: Client Services or email to admin-assist@cpg.org. If you have any questions, call us at (866) 802-6333, Monday to Friday, 8:30AM to 8:00PM ET.

Please note that this material is provided for informational purposes only and should not be viewed as investment, tax, or other advice. It does not constitute a contract or an offer for any products or services. In the event of a conflict between this material and the official plan documents or insurance policies, the official plan documents or insurance policies will govern.

In New York, the terms and conditions for the Group Short-Term and Long-Term Disability Income Insurance policies are set forth in policy form number 1000-ZAGP-DS-NY-01. The policies are issued by Zurich American Life Insurance Company of New York, domestic life insurance company, located at its registered home address of 150 Greenwich Street, Four World Trade Center, 54th Floor, New York, NY 10007-2366.

This notice is only applicable for Accidental Death and Dismemberment and Long- and Short-Term Disability coverage. 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

CHURCH PENSION GROUP
Passionate About Our Purpose

2020–2022 Disability Insurance Rates

All Rates Are Per $100 of Covered Monthly Payroll

MLPS Coverage Code	Plan Name	Age Bracket	Monthly Rate to be Paid by Employee
GSEE3	STD 26 weeks 60% EE Paid (Maximum covered compensation is $130,000)	<30	$ 0.779
		31-40	$ 0.625
		41-50	$ 0.458
		51>	$ 0.696
GSEE4	STD 26 weeks 66.67% EE Paid (Maximum covered compensation is $117,000)	<30	$ 0.894
		31-40	$ 0.738
		41-50	$ 0.553
		51>	$ 0.812
GSEE1	STD 13 weeks 60% EE Paid (Maximum covered compensation is $130,000)	<30	$ 0.215
		31-40	$ 0.175
		41-50	$ 0.124
		51>	$ 0.186
GSEE2	STD 13 weeks 66.67% EE Paid (Maximum covered compensation is $117,000)	<30	$ 0.301
		31-40	$ 0.259
		41-50	$ 0.166
		51>	$ 0.240

MLPS Coverage Code	Plan Name	Age Bracket	Monthly Rate to be Paid by Employees
GLEE2	LTD 180 days 50% EE Paid (Maximum covered compensation is $120,000)	<30	$ 0.233
		31-40	$ 0.466
		41-50	$ 0.837
		51>	$ 1.696
GLEE1	LTD 90 days 50% EE Paid (Maximum covered compensation is $120,000)	<30	$ 0.413
		31-40	$ 0.806
		41-50	$ 1.081
		51>	$ 2.131

Sample Calculation		
	A Annual Covered Compensation*	$42,000
	B Divide by 12	12
	C Monthly Compensation	(A/B) $3,500
	D STD Coverage Rate (STD 26 weeks 66.67% age 31-40)	$0.738
	E Multiply Monthly Compensation and Rate	(C*D) $2,583
	F Divide by 100	100
	G Monthly Premium	(E/F) $25.83

** Compensation should be capped at the maximum covered compensation (e.g., $117,000)*