Long Term Disability Conversion Insurance Enrollment Form

Zurich American Life Insurance Company

A member company of Zurich Insurance Group

Home Office
1299 Zurich Way
Schaumburg, IL 60196

Conversion Unit:
62024 Collection Center Drive
Chicago, IL 60693-0620

Toll Free: 800.206.8826

Employer Instructions:

1. Complete Part A below.
2. Maintain a copy for your records
3. Provide to Applicant

Applicant Instructions:

1. To elect this plan, you must have been enrolled in your employer's long term disability plan for a minimum of 12 months.
2. Review Part A for accuracy.
3. Complete Part B and select a plan option. The option selected may not exceed the benefit maximum under your former plan.
4. Mail a copy of this form along with the first premium payable to Zurich American Life Insurance Company at the Conversion Unit address.
5. Maintain a copy for your records.

Part A - To Be Provided By The Employer

1. Employer Name *(please print)*
2. Group Number
3. Division/Department
4. Applicant's Name *(first, middle, last - please print)*
5. Social Security Number
6. Date of Birth
7. Age
8. Gender: ☐ Male ☐ Female
9. Applicant's Coverage Termination Date
10. Date of Notice (when conversion option was provided)
11. Monthly Earnings at Coverage Termination
12. Reason for Coverage Termination
13. Applicant's Mailing Address | City | State | Zip
14. Telephone Number
15. Date Applicant's LTD Coverage became effective
16. Was the Applicant actively at work on the date of coverage termination? ☐ Yes ☐ No
17. Eligibility Period: ☐ 31 days ☐ 60 days
18. Applicant's Occupation and Job Duties
19. Scheduled benefit percent under the prior group LTD plan (e.g., 50%, 60%, 66⅔%)
20. Maximum monthly benefit $
21. Was Employee covered under the prior LTD plan for 12 months or more? ☐ Yes ☐ No
22. Employee effective date of prior plan

The information provided is correct and complete to the best of my knowledge and belief.

Signature of Policyholder's duly authorized representative ______ Date ______

Name of Policyholder ______

Address ______ City ______ State ______ Zip ______ Telephone Number ______ Ext ______

Part B: To Be Completed by Applicant

Enrollment Eligibility Period: You must apply for Conversion coverage within the time frame specified in Box 17. This period starts on the date your prior group long term disability plan was terminated.

Are you eligible for coverage under any other Group Long Term Disability Plan? ☐ Yes ☐ No

Are you enrolled for coverage under any other Group Long Term Disability Plan? ☐ Yes ☐ No

Plan Options (check one):

☐ **Plan A:** **Standard Maximum:** 60% of your monthly earnings as of the date your LTD coverage terminated under the Group Plan, to a monthly maximum benefit of $4,000.*

☐ **Plan B:** **High Maximum:** 60% of your monthly earnings as of the date your LTD coverage terminated under the Group Plan, to a monthly maximum benefit of $8,000.* To enroll for this option, you are required to submit medical evidence of insurability. The amount in excess of $4,000 will not become effective until you are notified of acceptance by Zurich American Life Insurance Company.

* If your Scheduled Benefit and/or the Maximum Monthly Benefit under the prior Plan you are converting was less than the amount under the option you have selected, the conversion plan issued to you will include the lesser amounts.

Direct Billing Mode will be: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

The first Premium must be submitted with application.

To determine the first amount of premium due, see attached LTD conversion rates.

Note: All coverage amounts are subject to applicable state laws.

Amount of premium enclosed: $ ________________ **(Refer to the premium calculation page).**

All forms and the first premium payment must be received by Zurich before the end of your eligibility period.

Comments:

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Important Notices

Notice of *10 Day Right to Examine Coverage Under the Master Policy

You may cancel coverage under the Master Policy no later than 10 days after the Certificate has been received by you. You may cancel it by returning the Certificate, with a written request to cancel at our Conversion Unit address. Upon our receipt of the Certificate, and request to cancel, your coverage will be void from the inception. We will refund all premiums paid less any indebtedness and it shall be as if no Certificate was issued.

* In Utah you have 30 days to examine and return the Certificate.

* In North Dakota you have 20 days to examine and return the Certificate.

Authorization And Agreements

I, the undersigned applicant, wish to become a participating member in the Zurich Corporate Life Americas Trust, a discretionary group trust established in Delaware ("Trust"). The Trustee and Policyholder is Wilmington Trust Company and the Trust Administrator is Zurich American Life Insurance Company. The Insurer is Zurich American Life Insurance Company. This enrollment form also serves as my application ("Application") to become a participating member in the Trust and to receive insurance coverage under the group master insurance policy ("Master Policy") issued to the Trustee. I am acquainted with the rules of eligibility. I understand that the effective date of the insurance for which I am applying is subject to the approval of the Trust Administrator, acting on behalf of the Insurer. I understand that the benefits provided by the Insurer are subject to the terms of the Master Policy issued to the Trustee, as amended from time to time, and the certificate of coverage ("Certificate") to be issued to me evidencing my coverage under the Master Policy. I understand that the Master Policy may be terminated by the Insurer or the Policyholder following due written notice. I agree to remit to the Trust Administrator regularly in advance the required premium due for insurance benefits. I understand that failure to pay billed premiums will result in automatic termination of insurance coverage at the end of the grace period. In that case I will owe and agree to pay the premium due for the grace period. I represent that all information contained in this Application is true and complete to the best of my knowledge and belief.

Nevada Residents: Failure to pay billed premiums during the grace period will result in automatic termination of coverage retroactive back to the day prior to the date the grace period began.

I understand and agree that:

- This Enrollment Form will be part of the Master Policy that provides insurance coverage. A copy of this Enrollment Form will be attached to my Certificate when issued.
- The Master Policy permits the Trustee to change, reduce, restrict or terminate my rights or benefits under the Master Policy without my consent upon 60 days, written notice.
- Plans are underwritten by Zurich American Life Insurance Company, and
- The maximum coverage provided under this LTD Conversion Plan is limited to the lesser of coverage provided under my prior plan and the coverage enrolled for under this plan.

☐ I agree to accept electronic delivery of my certificate of coverage and any notices as it relates to my Plan.

☐ I request delivery of my certificate of coverage and any notices by U.S. Mail.

Written Signature

I have read, or have had read to me, this completed Enrollment Form. I understand that coverage is voluntary and I may cancel this insurance plan at any time upon written notice to Zurich at the Conversion Unit address. I represent that all information provided by me is true and correct to the best of my knowledge and belief.

The Fraud Statement for your state of residence should be reviewed prior to signing and submitting the application.

Print Name of Applicant

on ______________________ Mo/Day/Yr

Signature of Applicant

at ______________________ City and State

Email Address

Please retain a copy of the fully-completed form for your records and return the original to:
Zurich American Life Insurance Company
62024 Collection Center Drive • Chicago, IL 60693-0620 • Toll Free 800.206.8826

State Fraud Notice

Alabama, Arkansas, District of Columbia, New Mexico, Louisiana, Oregon, Rhode Island, West Virginia and all other states except as listed below: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 a 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.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company, or other person files an application for insurance 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.

Maine, Tennessee, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Ohio and Texas: Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

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.

LTD Conversion Rates

QUARTERLY Rates* Per $100 of Maximum Monthly Benefit

*Rates are subject to change based on rate increases implemented on all converted business in accordance with state laws and regulations.

Attained Age	Quarterly Premium Per $100 of The Maximum Monthly Benefit Amount Plan A: $4000 Plan B: $8000
<25	$1.027
25 - 29	$1.260
30 - 34	$2.200
35 - 39	$3.477
40 - 44	$5.042
45 - 49	$6.965
50 - 54	$9.004
55 - 59	$10.127
60 - 64	$10.073
65 - 69	$9.190
70+	$8.331

Example Calculation of Quarterly Premium Based on Age (45 Year)

$6.965 (Age 45 Rate per $100 of Scheduled Benefit)

Plan A Calculation:
$4,000 (Amount of Maximum Monthly Benefit)
$4000 (Amount of Benefit ÷ 100 = 40) X $6.965 = $278.60

Plan B Calculation:
$8,000 (Amount of Maximum Monthly Benefit)
$8000 (Amount of Benefit ÷ 100 = 80) X $6.965 = $557.20

Contact Zurich American Life Insurance Company for premium information
if you are requesting additional coverages.