Long-Term Disability Insurance is Paycheck Insurance

3 in 10 men and 1 in 4 women become disabled before retiring.[1]
Are you willing to gamble with those odds?

√ Health Insurance
√ Car Insurance
√ Life Insurance
? Paycheck Insurance

Most people remember to insure their car, their health and their life. However, almost everything you own is based on your ability to earn an income. Disability Insurance is not an "extra". It is a "must".

Your employer is pleased to provide you with the opportunity to purchase Group Voluntary Disability Insurance. Now you can protect your wages by taking advantage of affordable group rates. When you enroll in this coverage, you will be paid a percentage of your salary if you suffer a covered disability.

Nobody wants to think about a tragic long-term illness or injury. If it happened to you, how would you replace your paycheck? Disability benefits can help pay your mortgage, college tuition, health insurance payments or more.

Disability is not only caused by freak accidents. It is often caused by conditions such as arthritis, cancer, pregnancy, heart disease, etc.[2]

- In the U.S., a disabling injury occurs every one second, a fatal injury occurs every four minutes.[3]
- The risk of long-term disability during a worker's career is greater than the risk of premature death. Yet most workers would never think of going without Life Insurance protection for their families.[3]
- Disability can be more disastrous financially than death. If you are disabled, you lose your earning power, but you still have living expenses and medical care costs not covered by Health Insurance.[4]

What about Social Security and Other Insurance Plans?

- Only 36% of the 2.8 million workers who applied for Social Security Disability Insurance benefits in 2011 were approved.[5]
- Workers' Compensation provides benefits ONLY if a disability is a result of an on-the-job accident, injury or occupational disease. Close to 90% of disabling accidents and illnesses are not work related.[6]
- Health Insurance covers medical services and prescriptions. It does not replace income if you cannot work.
- Unemployment Compensation is for those who are physically and mentally able to work.

(over)

Don't Gamble With Your Paycheck. Enroll Today!

This brochure is not the insurance contract. It is a brief description of Long-Term Disability Insurance.

[1] Social Security Fact Sheet #3, October 2010, Consortium for Citizens with Disabilities | [2] Council for Disability Awareness, disabilitycanhappen.org
[3] Guide to Disability Income Insurance, America's Health Insurance Plans, 2009. | [4] "Life and Disability Insurance," usa.gov, October 17, 2012.
[5] Social Security Administration, Office of Chief Actuary , ssa.gov/OACT/STATS/dibStat.html | [6] Council for Disability Awareness, CDA 2012 Long Term Disability Claims Review.

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Are There Any Medical Questions or Tests Needed to Qualify for Disability Insurance?

Individual insurance carriers often require medical questions, blood tests and/or a visit with a nurse or physician. With group insurance, the insurance company's risk is lower because it is based on the claims history of the entire group, rather than your personal health history. Therefore, the insurance company is often able to offer a period of time where you can purchase Voluntary Disability Insurance without medical questions or tests. Certain conditions may apply.

What is an "Elimination Period"?

An Elimination Period is the time between when your disability begins, and the time you are eligible to receive benefits. No benefits are paid during the Elimination Period.

Are Disability Income Benefits Taxed?

If you pay for Disability Insurance with after-tax dollars, your disability benefits will not be subject to income tax. Please see your tax adviser for specific advice.

No Disability Insurance Payments During a Disability

While you are disabled, you don't want to worry about paying for your coverage. The Waiver of Premium feature waives your Disability Insurance payment. This begins as soon as you start receiving disability benefits and continues while you are disabled.

How Is This Plan Different than Short-Term Disability Insurance or Sick-Leave Pay?

Short-Term Disability Insurance and sick-leave plans pay for a specified period of time – typically 6-25 weeks. After the Elimination Period (see above), your Long-Term Disability plan will pay benefits for a specified number of months or years if you are unable to work in your *current* occupation. If you are unable to work in *any* occupation, you will usually receive benefits to age 65 or later (depending upon the age at when you became disabled).

What about Maternity Coverage?

If you become pregnant while covered, Disability Insurance will protect you if you experience unexpected complications that prevent you from doing your job. Pregnancy, child-birth and related medical conditions are covered the same as any illness.

NATIONAL INSURANCE SERVICES

Corporate Headquarters:
250 South Executive Drive, Suite 300, Brookfield, WI 53005
Offices Nationwide:
800.627.3660

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

NATIONAL INSURANCE SERVICES

Enter your information:

Employer Name: Escambia County – City Commissioners Board			NIS Group Number: 033420	
Full Name (Last name, First name, Middle Initial):			Date of Hire:	
Home Address:	City:	State:	Zip:	
Social Security Number:	☐ Single ☐ Married	U.S. Citizen? ☐ Yes ☐ No*	Date of Birth:	☐ Male ☐ 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:

Voluntary Disability Insurance - Choose one option

☐ Option 1	40% of covered salary	180-days Elimination	.00158
☐ Option 2	50% of covered salary	180-days Elimination	.00199
☐ Option 3	50% of covered salary	90-days Elimination	.00235
☐ Option 4	60% of covered salary	180-days Elimination	.00266

$_____ x _____ = $_____

Monthly Salary (max monthly salary is $5,000) | Rate | Monthly Cost

Sign here (required whether electing or declining any coverage):

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.

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.

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.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601
Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717

Return application to:
National Insurance Services
250 South Executive Drive, Suite 300
Brookfield, WI 53005-4273
Attention: Billing Department

Evidence of Insurability

(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es): ☐ Life: $ _____ ☐ Life/AD&D ☐ Supp. Life:$ _____ ☐ Long Term Disability ☐ AD&D:$ _____ ☐ Short Term Disability ☐ AD&D:$	**Reason for Applying:** ☐ New Hire ☐ Late Enrollee ☐ Increase in Coverage amount ☐ Reinstatement ☐ Adding Dependent(s) ☐ Applying for coverage over GI ☐ Other:

APPLICANT INFORMATION

Applicant's Name: Last, First, MI	**Sex:** ☐ M ☐ F	**Age:**	**Date of Birth:** / /
Height:	**Weight:**	**Applicant's Social Security No.** - -	**Already Enrolled?** ☐ Yes ☐ No
Applicant's Home Address: (Street, City, State, Zip)			**Applicant's Daytime Phone No.** ( )
Applicant's Current Physician's Name:		**Date Last Visited:** / /	**Reason for Visit:**
Physician's Address: (Street, City, State, Zip)			**Physician's Phone No.**
Employee Member Name: (if different than Applicant)		**Employee's Job Title:**	
Employee's Date of Hire:	**No. of Hours Employee Works Per Week:**		**Employee's Annual Salary:** $
Employer Name:	**Employer's Address:** (Street, City, State, Zip)		

HEALTH QUESTIONS

Check Yes or No, circle all applicable "Yes" disorders or procedures and give details below.

I. Are you currently pregnant? ☐ Yes ☐ No **If "Yes", what is your expected due date:**

II. In the past 5 years have you been diagnosed or treated by a medical professional for any of the following conditions?

A. HEART		**D. PAIN & DISCOMFORT**	
1. Heart ailment?	☐ Yes ☐ No	1. Arthritis, bursitis or gout?	☐ Yes ☐ No
2. Chest pain, angina or shortness of breath?	☐ Yes ☐ No	2. Recurrent back pain or slipped disk?	☐ Yes ☐ No
3. Irregular heart beat or heart murmur?	☐ Yes ☐ No	3. Disorder of the back, neck or spine?	☐ Yes ☐ No
4. Rheumatic fever?	☐ Yes ☐ No	4. Disorder of the muscles, bones or joints?	☐ Yes ☐ No
5. Disease or abnormality of heart muscle, nerves or vessels?	☐ Yes ☐ No	5. Temporomandibular joint (TMJ) Disorder?	☐ Yes ☐ No
6. Stress test; electrocardiogram or echocardiogram?	☐ Yes ☐ No	6. Recurrent abdominal pain?	☐ Yes ☐ No
B. TUMORS/CYSTS		**E. OTHER**	
1. Cancer of any type?	☐ Yes ☐ No	1. Stroke, seizure disorder or epilepsy?	☐ Yes ☐ No
2. Tumors, cysts, or polyps?	☐ Yes ☐ No	2. Migraine or persistent headaches?	☐ Yes ☐ No
C. BLOOD AND URINE		3. Nervous/mental disorder, depression or anxiety?	☐ Yes ☐ No
1. High or low blood pressure or hypertension?	☐ Yes ☐ No	4. Dizziness or paralysis?	☐ Yes ☐ No
2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes?	☐ Yes ☐ No	5. Asthma, emphysema, breathing or lung disorder?	☐ Yes ☐ No
3. Disorder of kidneys or bladder or kidney stones?	☐ Yes ☐ No	6. Indigestion, ulcers or irritable bowel?	☐ Yes ☐ No
4. Diabetes, high or low blood sugar?	☐ Yes ☐ No	7. Chronic fatigue?	☐ Yes ☐ No
5. Protein, blood or sugar in urine?	☐ Yes ☐ No	8. Has been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No	
6. Night sweats, persistent swollen glands or diarrhea?	☐ Yes ☐ No		

HEALTH QUESTIONS *continued….*

Check all applicable disorders and give details below.

III. In the past 5 years have you been diagnosed or treated by a medical professional for a disease or disorder of the:

A. Brain or nervous system?	□ Yes □ No	D. Prostate, ovaries or uterus?	□ Yes □ No
B. Eyes, ears, nose or throat?	□ Yes □ No	E. Stomach, intestine, gallbladder or liver?	□ Yes □ No
C. Skin or lymph nodes?	□ Yes □ No	F. Thyroid, spleen or any gland?	□ Yes □ No

IV. In the past 5 years, have you:

A. Sought or received advice for the use of alcohol or other chemicals or drugs in which you can provide to us the diagnosis and treatment by a licensed member of the medical profession?	□ Yes □ No	C. Been treated or evaluated in a hospital or medical or psychiatric facility?	□ Yes □ No
B. Scheduled or undergone any surgery?	□ Yes □ No	D. Sustained illness requiring medical care or hospitalization?	□ Yes □ No

V. In the last 12 months, have you used tobacco of any kind? □ Yes □ No

VI. Please list all prescribed and non-prescribed medications you currently take:

If you answered "Yes" to any Health Questions in this form, please explain below. (Please use another sheet of paper if necessary.)

Dates	Conditions	Doctor Names and Addresses	Results

ACKNOWLEDGEMENTS, AUTHORIZATIONS & SIGNATURE

I understand all statements and answers I have given are to be relied upon and form the basis of any coverage issued to me and/or my dependents under the Group Policy. 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 Madison National Life Insurance Company, Inc. of any change in my medical condition while my enrollment is pending. I agree that if my enrollment is approved by Madison National Life Insurance Company, Inc., the effective date of any coverage will be determined in accordance with the terms of the Group Policy, including any Actively at Work requirement.

I acknowledge this Evidence of Insurability form (when approved), the Group Policy, Certificate of Insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of Madison National Life Insurance Company, Inc., can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related facility, state or local government agency, insurance or reinsurance company, consumer reporting agency, or employer, to give to Madison National Life Insurance Company, Inc., its legal representative or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization, in connection with this form, shall be valid for 24 months from my signature date and that I have the right to revoke this authorization at any time. I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.

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

Applicant's Signature	**Date**
Parent/Guardian Signature (for Dependent enrollees under age 18)	**Date**

FOR INSURER USE ONLY:	Decision: □ Approved □ Postponed □ Declined	Effective Date:
Underwriter's Signature:		Date: