CHECKLIST FOR:
GROUP LIFE WRAP FOR FULLY-INSURED PLANS

General Information

Employer's Full Name: ______________________________

Address: ______________________________

____

Telephone: ______________________________

Employer Identification Number: ______________________________

Plan Sponsor *(if different from Employer)*: ______________________________

Plan Administrator *(if different from Employer)*: ______________________________

Plan Year: ____________________ through ____________________

ERISA Plan Number: ______________________________

Agent for Service of Process: ______________________________

Address: ______________________________

____

Telephone: ______________________________

Trustees *(if any)*: ______________________________

Address: ______________________________

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Telephone: ______________________________

Title or Name of Contact Person for Questions: ______________________________

Telephone: ______________________________
Fax: ______________________________
Email: ______________________________

Effective Date of this Summary Plan Description (month & year): ______________________________

Participating Employer(s):____

____

(Employers whose employees are eligible to participate in this plan – must be affiliated companies – if you are unsure whether the entities meet ERISA's requirements for affiliation, please describe the relationship.)

Does HIPAA apply to the Employer(s)? Yes ______ No ______
(HIPAA applies to group health plans and group health insurance coverage for any plan year if, on the first day of the plan year, the plan has 2 or more participants who are current employees. It does not apply to any plan or coverage providing "excepted benefits," which include limited scope dental or vision benefits if offered separately from any other benefits.)

Does COBRA apply to the Employer(s)? Yes ______ No ______
(COBRA applies to all group health plans maintained by all public and private employers, other than churches; governmental entities of the U.S., the District of Columbia and U.S. territories and possessions; state and local government agencies that are not recipients of PHSA fund; and employers, including related employers, whose total number of employees (full-time and part-time), including leased employees, was less than 20 on at least 50% of the typical business days in the prior calendar year.)

Does FMLA apply to the Employer(s)? Yes ______ No ______
(FMLA applies to private sector employers of 50 or more employees and public agencies.)

Is this a Union Plan (maintained pursuant to a collective bargaining agreement): ____________________
If so, what is the Name of the Union: ____
If so, what is the Local Number: ____
If so, what is the Local Location: ____

Is this a Government Plan: ____
If so, is HIPAA applicable: ____
(A "Government Plan" is any plan established or maintained for its employees by the U.S. Government, the government of any state or political subdivision thereof, or by any agency or instrumentality of the foregoing. It also includes any plan to which the Railroad Retirement Act of 1935 or 1937 applies, and which is financed by contributions required under that Act, and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act.)

Is this a Church Plan: ____
If so, is HIPAA applicable: ____
(A "Church Plan" is a plan established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches which is exempt from tax under §501 of the Internal Revenue Code of 1954 ("IRC"). It does not include a plan where the employees or their beneficiaries are employed in connection with one or more unrelated trades or businesses (as described in IRC §513) or if less than substantially all of the individuals included in the plan are employees or beneficiaries. "Employee" means a duly ordained, commissioned or licensed minister of a church in the exercise of his ministry, regardless of the source of his compensation, or an employee of an organization which is exempt from tax under IRC §501 and which is controlled by or associated with a church or a convention or association of churches.)

Type of Benefit Plan: ***(Please list name of plan (i.e., Prudential, AIG, etc.):***

____

____

Please enclose a copy of your most recent plan information, if possible.

Are employees required to contribute for their coverage? Yes ____ No ____ If so, how are contributions calculated? ____

Are employees required to contribute for dependent coverage? Yes ____ No ____ If so, how are contributions calculated? ____

Eligibility for Participation

Am I eligible to participate in the *Plan*?
As a full-time *employee* regularly scheduled to work at least [__________] hours per week, you are eligible for coverage when you…

	…complete your waiting period of [__________] days of continuous *active employment*.
	…begin *active employment*.
	Other:

Am I eligible if I retire?
You can remain on the *Plan* as a retired *employee* if, when you terminate *active employee* status, you have reached age [__________], completed at least [__________] years of service with your *participating employer*, and your age plus your years of service must total at least [__________] years or more.

May I cover anyone else?
You may cover your spouse and unmarried children who are under [__________] years of age.

Any other unmarried children under age [__________] who go to school on a regular basis and depend solely on you for support will also be covered as a dependent.

Your children include:

	…your biological children
	…your adopted children
	…your stepchildren
	…any other child you support who lives with you in a parent-child relationship
	Other:

No person may be covered both as an *employee* and dependent, and no person may be covered as a dependent of more than one *employee*.
OPTIONAL – KEEP or REMOVE

What if I do not enroll during my original eligibility period and later decide to apply for coverage?

<u>Late Enrollees</u>
Forms are available from the *employees'*...

	…personnel office
	…human resources office
	Other:

If a late enrollee application is approved, the *effective date* of coverage will be the first day of the month following the date coincident with the date of the *insurance company*'s approval.
OPTIONAL – KEEP or REMOVE

Life Insurance Benefits

How much is an *employee* insured for?
An *employee's* life insurance amount is calculated by doubling his annual salary and rounding the result up to the next higher thousand.
OPTIONAL – KEEP or REMOVE

The minimum amount of life insurance under the *Plan* for *employees* is $[__________] and the maximum amount is $[__________], regardless of salary.

If an *employee* has a change in salary, the amount of life insurance coverage will also change. Any change in the amount of the *employee's* life insurance will be effective on the first day of the month following the salary change.
OPTIONAL – KEEP or REMOVE

What is the cost of coverage to *employees*?

	The employer pays 100% of the coverage and there is no cost to the *employee*.
	The *employee* shares in the cost of the life insurance premium with the employer. The *employee* pays [__________]% and the employer pays [__________]%.
	The premiums for life insurance coverage are paid through payroll deductions.

What is the cost of coverage for retirees?
A retiree must pay [__________]% of the cost for his coverage.

The employer will bill the retiree directly, on a monthly basis, for the premiums for life insurance coverage for the retiree.
OPTIONAL – KEEP or REMOVE

What is the cost of coverage for dependents?
An *employee* must pay [__________]% of the cost for his dependents' coverage.

	The premiums for life insurance coverage for dependent's are paid through payroll deductions.
	The employer will bill the *employee* directly, on a monthly basis, for the premiums for life insurance coverage for dependents.

Totally Disabled Employees
If you become permanently and totally disabled, your insurance may be extended. You will not have to make any further contributions while you are disabled.
OPTIONAL – KEEP or REMOVE

	This extended insurance will be for the exact amount that you were insured for on the date your permanent and total disability began.
	The *insurance company* may require you to go for an examination. If you do not have the examination completed within [__________] days, this benefit will cease.
	The *insurance company* will require proof that you are still permanently and totally disabled. If proof is not provided within [_____] days of that date, this benefit will cease.

However, if you become eligible for life insurance under any group policy within [__________] days after the end of the extension period, this privilege is not allowed.

Extended death benefit
If the *insurance company* receives proof, at its office, that all of the following apply, the *insurance company* will pay your beneficiary the amount of life insurance which may be extended under the permanent and total disability provision:

	Premium payments for your life insurance cease while you are permanently and totally disabled by disease or injury which stops you from working in any reasonable job;
	You die during the uninterrupted continuance of the permanent and total disability;
	Death occurs no later than 12 months after premium payments from your employer cease; and
	You would have qualified for extended insurance except that
	o Your permanent and total disability had not lasted at least nine months; or
	o The required proof has not yet been received or approved by the *insurance company*.

Written notice of your death must be provided to the *insurance company* at its home office within 12 months of your death. If it is not provided, the *insurance company* will not have to pay this benefit.
OPTIONAL – KEEP or REMOVE

When the *insurance company* approves a claim for any benefit under this feature, the benefit will be in full settlement and satisfaction of the *insurance company's* obligations.
OPTIONAL – KEEP or REMOVE

If any individual policy has been issued to you under the Conversion Privilege, your rights under this section may be restored. In order to restore those rights, you must give up all such policies without claim, except for the return of the premiums you paid.
OPTIONAL – KEEP or REMOVE

Are there accelerated death benefits?
If, while covered under this *Plan* for life insurance you become terminally ill, you may request that the *insurance company* pay an *accelerated death benefit*. Upon the *insurance company*'s approval of any such request, the *insurance company* will pay to you the amount of *accelerated death benefits*.
OPTIONAL – KEEP or REMOVE

You may request an *accelerated death benefit* at any time by completing a Request for Accelerated Death Benefit Form and submitting it to the *insurance company*. The request must include the statement of a currently licensed United States physician that you are terminally ill.
OPTIONAL – KEEP or REMOVE

The physician's statement must include:

	All medical test results
	Laboratory reports
	Any other information on which the statement is based, including the generally accepted prognostic protocol used by the physician to determine your expected remaining life span.

Your request for an *accelerated death benefit* must state the amount of the benefit requested. You may request as an *accelerated death benefit* up to [__________]% of the amount of life insurance in force for you at the time of diagnosis, but in no event may the requested amount of the *accelerated death benefit* be more than the *accelerated death benefit* maximum. The minimum amount you may request is $[__________].
OPTIONAL – KEEP or REMOVE

You may request an *accelerated death benefit* under this *Plan* only once.
OPTIONAL – KEEP or REMOVE

If, by assignment or otherwise, someone other than you is the owner of your life insurance coverage, an *accelerated death benefit* will not be available under this *Plan* for you.
OPTIONAL – KEEP or REMOVE

If, during the months following the date of your request for an *accelerated death benefit*, the amount of your life insurance would reduce due to the attainment of a specified age or retirement, the *accelerated death benefit* amount will be calculated by multiplying the percentage that you have requested by the amount of life insurance that would remain in effect after any reduction.
OPTIONAL – KEEP or REMOVE

When your request for an *accelerated death benefit* has been approved, the amount of life insurance then in force for you will be reduced by the amount of the *accelerated death benefit*. If your amount of life insurance has been so reduced, you will not be entitled to the Conversion of Life Insurance for the amount of life insurance that ceases because of the reduction by the amount of the *accelerated death benefit*.
OPTIONAL – KEEP or REMOVE

In considering your request for an *accelerated death benefit*, the *insurance company* may require you, at the *insurance company*'s expense, to submit to an independent medical examination by a physician chosen by the *insurance company*. The *insurance company* may suspend its review of a request for an *accelerated death benefit* until the examination has been completed and the results submitted to the *insurance company*.
OPTIONAL – KEEP or REMOVE

The *insurance company* may refuse your request for an *accelerated death benefit* if:

	Prior to the *insurance company*'s receipt of approval of the request: o The group contract terminates as to your eligible class (even though all or part of your life insurance coverage continues for any reason); or o The entire amount of life insurance of the person for whom the request is made ceases under the group contract for any reason; or
	Prior to payment of the *accelerated death benefit*, you die.

Upon approval by the *insurance company*, the amount of the *accelerated death benefit* will be paid to you in a lump sum.
OPTIONAL – KEEP or REMOVE

To the extent allowed by law:

	Any *accelerated death benefit* paid to you is exempt from any legal or equitable process for your debts; and
	You will not be required to request an *accelerated death benefit* in order to satisfy claims of creditors.

All of the following terms of this *accelerated death benefit* section will apply to any *accelerated death benefit* requested while your life insurance is being extended under the terms of the permanent and total disability feature. You may apply for an *accelerated death benefit* if:

	The *insurance company* has extended your life insurance under the terms of the permanent and total disability feature; and
	You have not previously requested and received an *accelerated death benefit*.

Additional Benefits

Can I convert my policy to a private policy?
An *employee* may convert some or all of his group term life insurance to an individual policy with the *insurance company* if:

	The *employee* ceases employment with the *participating employer*;
	The *employee* retires; or
	The group term policy terminates and the *employee* has been covered for at least five years.

Application to convert coverage must be made within [__________] days of the loss or benefit reduction of group term coverage.
OPTIONAL – KEEP or REMOVE

Benefits and provisions under the converted policy may not be the same as the group term life insurance. The *insurance company* should be contacted for full details on the coverage available under conversion and how to apply for it.

OPTIONAL – KEEP or REMOVE

Is there an accidental death benefit?
The following Accidental Death Benefit will be payable if, while insured, an *employee* suffers a bodily injury caused by an accident and if, within 365 days after the accident, he suffers a loss of life solely and as a direct result of the accident.
OPTIONAL – KEEP or REMOVE

Is there a passenger restraint and airbag benefit?
A Passenger Restraint Benefit will be payable if a covered loss of life occurs solely and as a direct result of an accident involving a motor vehicle while the *employee*:

	Is an occupant of a motor vehicle; and
	At the time of the accident, it was determined that the *employee* was using a passenger restraint; and
	If the driver has, at the time of the accident, a valid driver's license.

If an airbag is also activated as a result of the same accident, an Airbag Benefit will be payable if the motor vehicle's airbag system is not effective in helping to save the *employee's* life. Verification of the actual use of the passenger restraint and activation of the airbag system, if applicable, at the time of the loss must be part of an official report of the accident or certified, in writing, by investigating officer(s).
OPTIONAL – KEEP or REMOVE

No Airbag Benefit will be payable unless a Passenger Restraint Benefit is paid.
OPTIONAL – KEEP or REMOVE

Is there an education benefit for my *dependent child(ren)*?
If you suffer a loss of life solely and as a direct result of an accident, an Education Benefit is payable on behalf of each *dependent child*, as defined below. The Education Benefit will be payable in annual installments until the earliest to occur of:

	Four years from the date of your death;
	The date no dependent qualifies as a *dependent child*, as defined below;
	The date that satisfactory proof of dependent eligibility status is not provided to the *insurance company* within [__________]days of a request for it; or
	The group policy is discontinued.

The first Education Benefit will be paid when:

	Your Principal Sum becomes payable; and
	The *insurance company* receives written proof that the *dependent child*, as defined below, is attending school on a regular basis.

Education Benefits will be paid on each anniversary of the first Education Benefit, provided the *insurance company* receives written proof that the *dependent child*, as defined below, is attending school on a regular basis.
OPTIONAL – KEEP or REMOVE

The Education Benefit will be payable to the *dependent child*, as defined below, if that child has attained the age of majority. Otherwise, the Education Benefit will be payable to the guardian of the estate of the minor, or to the Custodian under the Uniform Transfer to Minors Act, or an adult caretaker, when permitted under applicable state law. If on your death there is no surviving *dependent child*, as defined below, an Education Benefit will be payable in a lump sum to your named beneficiary.
OPTIONAL – KEEP or REMOVE

Is there an education benefit for my spouse?
An Education Benefit will be paid to your surviving spouse for costs incurred, as a result of your death, towards employment training if your spouse has enrolled for the purpose of obtaining or supplementing an independent source of income. Written proof of your spouse's enrollment in an employment training program must be received within 365 days of your death.
OPTIONAL – KEEP or REMOVE

The Education Benefit will be payable in annual installments until the earliest to occur of:

	Four years from the date of your death; or

	The date that satisfactory proof of dependent eligibility status is not provided to the *insurance company* within [__________] days of a request for it; or
	The group policy is discontinued.

The first Education Benefit will be paid when:

	Your Principal Sum becomes payable; and
	The *insurance company* receives written proof that your spouse is enrolled in an employment training program.

Education Benefits will be paid on each anniversary of the first Education Benefit provided the *insurance company* receives written proof that your dependent spouse is enrolled in an employment training program.
OPTIONAL – KEEP or REMOVE

The Education Benefit will be payable to your surviving spouse, regardless of beneficiary for your life insurance amount. If you do not have a surviving spouse, an Education Benefit will be payable in a lump sum to your named beneficiary.
OPTIONAL – KEEP or REMOVE

Is there a child care benefit?
If you suffer a loss of life solely and as a direct result of an accident, a Child Care Benefit may be payable with respect to any *dependent child*, as defined below. If the *dependent child*, as defined below, is enrolled in a **legally licensed child care center**, the Child Care Benefit is payable in annual installments until the earliest to occur of:

	Four years from the date of your death; or
	The date no dependent qualifies as a *dependent child*, as defined below; or
	The date that satisfactory proof of dependent eligibility status is not provided to the *insurance company* within [__________] days of a request for it; or
	The group policy is discontinued.

The first Child Care Benefit will be paid when:

	Your Principal Sum becomes payable; and
	The *insurance company* receives written proof that the *dependent child*, as defined below, is enrolled in a legally licensed child care center.

Child Care Benefits will be paid on each anniversary of the first Child Care Benefit, provided the *insurance company* receives written proof that the *dependent child*, as defined below, is attending a legally licensed child care center.
OPTIONAL – KEEP or REMOVE

For purposes of this benefit, **"*dependent child*"** means a child who is under age 13 and is enrolled in a legally licensed child care center on the date of the accident or subsequently enrolled in a legally licensed child care center within 90 calendar days from the date of the accident and is either:

	…your biological child
	…your adopted child
	…your stepchild
	…any other child you support who lives with you in a parent-child relationship
	Other:

OPTIONAL – KEEP or REMOVE

The Child Care Benefit will be payable to the guardian of the estate of the minor, or to the Custodian under the Uniform Transfer to Minors Act, or an adult caretaker, when permitted under applicable state law. If on your death there is no surviving *dependent child*, a Child Care Benefit will be payable in a lump sum to your named beneficiary.
OPTIONAL – KEEP or REMOVE

Is there a repatriation remains benefit?
This Plan pays a Repatriation of Remains Benefit for the preparation and transportation of a person's body to a mortuary if, as a direct result of an accident for which a benefit is payable under this section, he suffers loss of life while outside a 200 mile radius from his principal place of residence.
OPTIONAL – KEEP or REMOVE

Limitations

Limitations for a loss caused or contributed to by:

	A bodily or mental infirmity;
	A disease or bacterial infection*;
	Medical or surgical treatment*;
	Suicide or attempted suicide;
	An intentionally self-inflicted injury;
	A war or any act of war (declared or not declared);
	Commission of or attempt to commit a felony;
	Use of alcohol, intoxicants, or drugs, except as prescribed by a physician. An accident in which the blood alcohol level of the operator of a motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol; and
	Air or space travel. This does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo).

* These limitations do not apply if the loss is caused by:

	An infection which results directly from the injury;
	Surgery needed because of the injury; or
	Medical malpractice.

The injury must not be one which is excluded by the terms of this section
OPTIONAL – KEEP or REMOVE

Claim Procedures

How is a claim for benefits filed?

	A claim must be submitted to the *insurance company* in writing and must be submitted with a certified copy of the *employee's* death certificate.
	A claim may be submitted to the employer's… [ ] ...personnel… [ ] …human resources… [ ] Other: …office by submitting a certified copy of the *employee's* death certificate. The employer will then complete a Proof of Death form to be submitted to the *insurance company*.

Definitions

"*<u>Accelerated death benefit</u>*" or "*<u>ADB</u>*" means a benefit that will allow the *employee* to receive an advance on the amount of his death benefit once he has been diagnosed as terminally ill. [A person is terminally ill if the person:

- Suffers from an incurable, progressive, and medically recognized disease or condition; and
- To a reasonable medical probability and based on a generally accepted prognostic protocol, will not survive more than [__________] months beyond the date of the request for the *accelerated death benefit*.

"*<u>Employee</u>*" means a person who is a regular full-time *employee* of the *participating employer*, regularly scheduled to work for the *participating employer* in an employer-*employee* relationship. Such person must be scheduled to work at least [__________] hours per week in order to be considered "full-time." An *employee* is not a seasonal, temporary, or leased employee, or an independent contractor.

Plan Administration

What are the duties of the *insurance company*?
Benefits are provided under the terms the *Plan* through a contract, agreement, or policy of insurance issued by the *insurance company*:

Name of Carrier: ______________________________

Address: ______________________________

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HIPAA Privacy Rights

Please list the TITLES ONLY of those persons who will have access to PHI:

____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________