Catastrophic Disability Income Insurance Application

The Institute of Electrical and Electronics Engineers, Incorporated

Unimerica Insurance Company
Association Administrative Address:
P.O. Box 17828, Portland, Maine 04112-8828
Group Policy Number: 1122

TO APPLY:
Send this completed form to:
ADMINISTRATOR
IEEE GROUP INSURANCE PROGRAM
P.O. BOX 10374
Des Moines, IA 50306-8812

QUESTIONS?
Call: 1-800-493-IEEE(4333)
ieee.service@mercer.com

Please print in INK. Do not erase or use correction fluid.
To correct, cross out and initial/date changes. Answer all questions, then sign the Agreement and Authorization.

Member of The Institute of Electrical and Electronics Engineers, Incorporated Date of Membership: _____
Member Number: _____

If an Employee: Name and Address of Member/Firm: _____ Employee of Member of IEEE

_____

SECTION 1: APPLICANT INFORMATION

1. Applicant Name: _____
2. Applicant SSN: _____ – _____ – _____ 3. Email Address:_____
4. Billing Address: _____ City:_____State: _____ Zip: _____
5. Home Address: _____ City:_____State: _____ Zip: _____
6. Date of Birth: _____ /_____/_____ 7. Place of Birth*: _____ 8. Citizenship/Country*: _____
9. Sex: ❑ Male ❑ Female 10. Daytime Phone #: _____ – _____ – _____
11. Current Occupation / Profession: _____ 12. How many hours a week do you work? _____
13. Please describe your duties: _____
14. Beneficiary _____ 15. Relationship of Beneficiary to you: _____
16. Application is made for: ❑ New Coverage
    ❑ Increase/Certificate No.: _____ Current Amount of Coverage: _____
    ❑ Reinstatement/Certificate No.: _____ Amount of Coverage: _____

*Residents of MD, please do not answer question 7 or 8 above.

SECTION 2: PLAN SELECTION FOR CATASTROPHIC DISABILITY COVERAGE

1. MAXIMUM MONTHLY BENEFIT: $_____$1,000 to $10,000 per month, in increments of $100, not to exceed 100% of your Annualized Monthly Income. If applying to increase coverage, indicate only the ADDITIONAL amount of Monthly Benefit desired.
2. MAXIMUM BENEFIT PERIOD: (Select one) ❑ 60 Months ❑ 120 Months ❑ To Age 65
3. ELIMINATION PERIOD: (Select one) ❑ 60 days ❑ 90 days ❑ 180 days ❑ 360 days
4. OPTIONAL BENEFIT: ❑ Extended Catastrophic Disability Benefit (Choose an amount between $10,000 to $100,000):
   Applicant Only: _____ Applicant and Spouse: _____ (Complete Spouse Information below.)
   Spouse Information: Name of Spouse _____ Date of Birth: ____/____/_____
   Place of Birth _____ Citizenship/Country _____

Payment Options: ❑ Quarterly Direct Bill ❑ Electronic Funds Transfer
(complete Automatic Monthly Check Withdrawal Form if this option is requested)

BE SURE TO COMPLETE ALL PAGES AND SIGN WHERE REQUIRED ➡

SECTION 3: OTHER COVERAGE

If you have Disability Income Insurance in force or pending with Unimerica Insurance Company ("Unimerica"), or through any other company, provide details below:

Company Name	Type of Coverage	Benefit Amount	Benefit Period	Elimination Period	Will Coverage be Replaced?	Employer Paid	Who is insured by Other Coverage?
					❑ Yes ❑ No	❑ Yes ❑ No	❑ Applicant ❑ Spouse
					❑ Yes ❑ No	❑ Yes ❑ No	❑ Applicant ❑ Spouse
					❑ Yes ❑ No	❑ Yes ❑ No	❑ Applicant ❑ Spouse

SECTION 4: FINANCIAL INFORMATION

1. Employment Type (check one): ❑ Non-Owner employee ❑ Proprietorship ❑ Partnership ❑ Corporation ❑ S-Corporation ❑ Limited Liability Partnership ❑ Limited Liability Corporation ❑ Other (specify): _____
   If you have an ownership interest in your business, answer question 2.
   If you do not have an ownership interest in your business, please skip to question 3.
2. Percentage of business owned by you: _____ Number of years owned by you: _____
   Number of years business has been in existence: _____
3. Annual earned income from your personal services as reported to the IRS on your personal and/or business federal tax return:
   Last Calendar Year: $_____ Prior Calendar Year: $_____

SECTION 5: APPLICANT'S/SPOUSE'S STATEMENT OF HEALTH

Applicant

1. a) Height _____ft. _____in. b) Weight _____ lbs.
   c) Weight change last year: _____ lbs.
   d) Reason for weight change: (gain or loss) _____
2. Name of Personal Physician (if none, please indicate):
   _____
   Physician Address: _____
   _____
   Date last seen: _____
   Reason: _____
   Results: _____

Spouse

1. a) Height _____ft. _____in. b) Weight _____ lbs.
   c) Weight change last year: _____ lbs.
   d) Reason for weight change: (gain or loss) _____
2. Name of Personal Physician (if none, please indicate):
   _____
   Physician Address: _____
   _____
   Date last seen: _____
   Reason: _____
   Results: _____

	Applicant	Spouse
3. In the past 180 days have you ever been:		
a) absent from work, or unable to perform any duty of your occupation, because of sickness or injury?	❑ Yes ❑ No	❑ Yes ❑ No
b) homebound or hospitalized because of sickness or injury?	❑ Yes ❑ No	❑ Yes ❑ No
Applicant: If Yes to (a) or (b), for how many days? _____ Date(s):_____		
Reason: _____		
Spouse: If Yes to (a) or (b), for how many days? _____ Date(s):_____		
Reason: _____		
4. Have you used tobacco/nicotine-containing products or smoked any substance in any form or manner in cigarettes, cigars or a pipe within the last 12 months?	❑ Yes ❑ No	❑ Yes ❑ No
5. During the past 10 years (7 years in MD, 5 years in IN, KS and MN), have you engaged in deep sea diving, parachuting/paragliding, rock/mountain climbing, or motorized speed racing? In MN, indicate Yes/No for deep sea diving, parachuting/paragliding, rock/mountain climbing, or organized motorized speed racing	❑ Yes ❑ No	❑ Yes ❑ No
6. During the past 10 years (7 years in MD, 5 years in IN, KS and MN), have you ever been medically diagnosed as having, or been treated for a condition stated below? Indicate Yes/No and give details under Medical Details Except in KS and MD, include conditions for which you have experienced symptoms.		
a) chest pain, high blood pressure, palpitations, or any disease or disorder of the heart or circulatory system? ...	❑ Yes ❑ No	❑ Yes ❑ No
b) shortness of breath, persistent hoarseness or cough, bronchitis, asthma, emphysema, tuberculosis, allergies, chemical sensitivities or any disease or disorder of the lung?	❑ Yes ❑ No	❑ Yes ❑ No
c) diabetes, any glandular, thyroid, or other endocrine disease or disorder?	❑ Yes ❑ No	❑ Yes ❑ No

SECTION 5: APPLICANT'S/SPOUSE'S STATEMENT OF HEALTH *CONTINUED*

	Applicant	Spouse
d) arthritis, gout, neck or back problems, sciatica, carpal tunnel syndrome, disease or disorder of the musculoskeletal system, bones, joints, muscles, connective tissue disease or any chronic pain condition?	❑ Yes ❑ No	❑ Yes ❑ No
e) depression, anxiety, any mental condition, headaches, epilepsy, dizziness, tremor, stroke, Transient Ischemic Attack (TIA) or other brain, nervous or neurological disease?	❑ Yes ❑ No	❑ Yes ❑ No
f) cancer, disease or disorder of the skin, lymph nodes, lesions, cysts, tumors, anemia or immune system? (In ME and WI, excluding HIV)	❑ Yes ❑ No	❑ Yes ❑ No
g) liver, digestive system, either kidney, urinary or reproductive tract, prostate or sexually transmitted diseases (Except for HIV)?	❑ Yes ❑ No	❑ Yes ❑ No
h) dementia, confusion, memory loss, Parkinson's disease, or Alzheimer's disease?	❑ Yes ❑ No	❑ Yes ❑ No
i) loss of hearing or vision, or disease or disorder of the eyes, ears, nose or throat?	❑ Yes ❑ No	❑ Yes ❑ No
j) chronic fatigue, Epstein Barr virus, fibromyalgia?	❑ Yes ❑ No	❑ Yes ❑ No
k) complications of pregnancy?	❑ Yes ❑ No	❑ Yes ❑ No
l) Are you pregnant? If "yes", due date :_____		
7. During the past 10 years (7 years in MD, 5 years in IN, KS and MN), have you had, been told you have, or been treated for a disease or disorder of the blood? (In ME and WI, excluding HIV) ..... A Disease or Disorder of the Blood includes all conditions of the blood presently recognized as disorders, both primary disorders (e.g. disorders of the red blood cells, white cells, platelets and clotting factors, immune disorders whether congenital or acquired) and disorders that reflect other disease processes (e.g. infections, malignancies and sources of blood loss.)	❑ Yes ❑ No	❑ Yes ❑ No
8. During the past 10 years (7 years in MD, 5 years in IN, KS and MN), have you had or been advised to have any surgical operation, hospitalization, medical care, x-ray, EKG, blood test or other diagnostic test? (In Maine, excluding HIV)	❑ Yes ❑ No	❑ Yes ❑ No
9. During the past 10 years (7 years in MD, 5 years in IN, KS and MN), have you consulted, or are you planning to consult, or have you received treatment from any physician, psychiatrist, psychologist, counselor, chiropractor or other practitioner, clinic or hospital? (in ME, excluding HIV)	❑ Yes ❑ No	❑ Yes ❑ No
10. Are you presently under observation or treatment, or presently have any physical impairment or deformity, or within the past 12 months taken medication (prescription or non-prescription) for any reason?	❑ Yes ❑ No	❑ Yes ❑ No
11. During the past 10 years (7 years in MD, 5 years in IN, KS and MN) have you:		
a) Sought, been advised to seek, or received treatment for the use of alcohol, or (except in NC) received counseling for the use of alcohol?	❑ Yes ❑ No	❑ Yes ❑ No
b) Used narcotics, cocaine, heroin, hallucinogens, barbiturates, marijuana, or other habit forming drugs; sought, or been advised to seek, or received treatment for the use of prescribed or non-prescribed drugs, or (except in NC) received counseling for the use of prescribed or non-prescribed drugs; or been arrested for the possession of or use of prescribed or non-prescribed drugs?	❑ Yes ❑ No	❑ Yes ❑ No
c) To the best of your knowledge and belief, been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC); or except for residents of Florida, been treated for AIDS or ARC? (in ME, excluding HIV).	❑ Yes ❑ No	❑ Yes ❑ No
12. **If you are a resident of CA, CO, CT, ME, ND, NJ, NY or WI do not answer question 12.** During the past 10 years (7 years in MD, 5 years in IN, KS and MN) have you tested positive for the presence of the Human Immunodeficiency ("HIV") Virus or HIV antibodies?	❑ Yes ❑ No	❑ Yes ❑ No
13. Do you need human assistance of any kind to perform every day activities such as bathing, continence, dressing, eating, using the toilet or transferring?	❑ Yes ❑ No	❑ Yes ❑ No
14. During the past 10 years (7 years in MD, 5 years in IN, KS and MN) have you used any special medical equipment or appliances such as a walker, cane, wheelchair, catheter, oxygen tank, pacemaker or artificial limb?	❑ Yes ❑ No	❑ Yes ❑ No
15. During the past 10 years (7 years in MD, 5 years in IN, KS and MN) have you had medical or surgical advice or treatment, or been under observation for any disease or disorder, or had a physical impairment or deformity not listed on this application? (In Maine, excluding HIV)	❑ Yes ❑ No	❑ Yes ❑ No

SECTION 6: MEDICAL DETAILS

(Please provide details if you answered YES to any item in the Applicant/Spouse Statement of Health Section). If you need more space, attach separate sheet with additional information.

Question #	Person who answered "YES"	Reason /Condition	Diagnosis/Treatment/ Results	Names, Address and Phone Number of Physician and/or Hospital	Date of Onset	Date Last Seen	No. of Days Lost from Work
	❑ Applicant ❑ Spouse						
	❑ Applicant ❑ Spouse						
	❑ Applicant ❑ Spouse						

SECTION 7: FRAUD NOTICE (Please review notice that applies in your state)

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

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.

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.

Florida: 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.

Kansas: 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 may be guilty of 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: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a 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.

New Mexico: 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 civil fines and criminal penalties.

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 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.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: 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 a crime and may be subject to fines and confinement in prison.

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

Tennessee, Virginia 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.

All Other States: 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.

SECTION 8: COLLECTION OF INFORMATION (applies to residents of New Jersey only)

This application is our main source of information. But we may also ask you to have a physical exam, an EKG and/or a blood profile, etc; ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us; obtain information from the Medical Information Bureau (MIB); seek information from other companies you have applied to for insurance; seek information about you from public records. If we require any additional information, we will seek your permission prior to obtaining it through use of a written request.

SECTION 9: AUTHORIZATION AND ACKNOWLEDGEMENT

I declare that all the statements made in this form are, to the best of my knowledge and belief: true and complete; and, that they are the basis on which insurance requested by me may be issued. I understand that: I am completing an insurance application; and, that each response must be: complete; and accurate. I understand all statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me; my personal representative; or, my beneficiary.

I authorize: any licensed physician; medical practitioner; pharmacy benefit manager; hospital; clinic or other medical or medically related facility; other insurer or reinsurer; Medical Information Bureau, Inc. ("MIB"); health care clearinghouse; and, any of their affiliates; representatives; or, business associates; or, other organization; institution or person; that has any records or knowledge of me or my health, (with respect to residents of Maine, the applicant's authorization does not include disclosure from "other organizations; institutions or persons that has knowledge of the applicant") to disclose the information to: the Unimerica Insurance Company; and, its affiliates ("Unimerica"). This information will be used to determine my eligibility for benefits.

I authorize Unimerica to: obtain; use; and disclose; my medical, claim or benefit records. This includes any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities, including health care providers. I authorize Unimerica to disclose the information to the Policy's administrator; or as may be required by law. **I authorize Unimerica, or its reinsurers, to make a brief report of my personal health information to MIB.**

I understand that information I authorize a person or entity to obtain and use may be: re-disclosed; and no longer protected by federal privacy regulations; except as prohibited by state law. I agree that a photocopy of this form shall be as valid as the original. I understand that I have a right to receive a copy of the authorization.

I understand that: this authorization is voluntary; and, I may refuse to sign the authorization. My refusal may, however, affect my ability to: enroll in the Policy; or, receive benefits. I understand I may revoke this authorization at any time by notifying Unimerica in writing. Such revocation will not affect any action taken or information released prior to the revocation; and, will not affect any legal right Unimerica has to contest any insurance or claim under the Policy. This authorization, unless revoked earlier, expires 24 months after the date it is signed. With respect to residents of Minnesota, the authorization is valid as long as the applicant is continually insured with Unimerica Insurance Company. With respect to residents of Maine, in addition, revoking the authorization may be the basis for denying benefits for claims submitted after the revocation. I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected.

I have not given the agent; or, any other persons any health information not included on this form. I understand that Unimerica is not bound by any statements I have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

I understand that any condition which is excluded under the Policy will not be covered at any time. I certify that: I have read; or have had read to me; this completed application; and, that I realize any false statements or misrepresentation in it may result in loss of coverage under the Policy. I understand that, subject to the Deferred Effective Date provisions, coverage will not take effect until Unimerica grants its underwriting approval.

I certify that I have received the Insurance Information Practices Notice. I acknowledge that I have read the applicable Fraud Warning Notices provided with this application. I understand that the Policy does not cover disability on account of: a disease; or, physical condition; that I now have or have had in the past until the earlier of: the date I have been insured under the policy for 24 months (12 months in MD, MT, SC, SD and UT); or the date I have been free of treatment for such condition for a one year period ending on or after my Effective Date. Except in ID, MN and ND, I understand that this includes any symptoms that I had within the 3 month period prior to my Effective Date.

With respect to residents of Maine, failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims or process applications and may be a basis for denying an application or claim for benefits. **This authorization excludes divulging whether tests for the presence of HIV antibody have been performed and excludes divulging the results of such tests. Such test results shall not be disclosed or published. Nothing in this caveat will prohibit this authorization from divulging the fact that the applicant or any other person to be covered has AIDS/ARC.**

With respect to residents of Minnesota, this authorization excludes information on blood borne pathogens and HIV antibody tests if performed: on criminal offenders or their victims as the result of a crime reported to police; or on any person giving or receiving emergency care including the patient, emergency medical, fire, or police personnel, or any person qualifying for this exemption under Minnesota law, including the Good Samaritan law.

With respect to residents of Virginia, the applicant agrees that a photocopy of this form shall be as valid as the original for the purpose of collecting information in connection with this application. The applicant understands that he, or a person authorized to act on his behalf, is entitled to receive a copy of this authorization form.

X	**X**
Applicant Signature	**Date**
X	**X**
Spouse Signature	**Date**

Retain a photocopy of this application for your records and return the original to: Mercer Consumer.

Printed in U.S.A. 2/15

Form No: ADI-4001-APPA CDE1664

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Unimerica Insurance Company
Insurance Information Practices Notice

Our Underwriting Procedures

For certain types of coverage, we require proof of insurability to determine if you are eligible for the coverage you requested. We review all of the information in your application Form, and, if necessary, confirm or add to this information in the ways described in this notice.

Privacy and Information Practices

Collecting Information

Your application is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us.
- Obtain information from the Medical Information Bureau (MIB). See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with Unimerica Insurance Company or its affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage. Medical information, however, will only be disclosed through the attending licensed physician.

If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone.

We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. Unimerica 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 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 Post Office Box 105, Essex Station, Boston, MA 02112.

Unimerica Insurance Company, or its reinsurers, may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Form AA-2035
Printed in USA

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AUTOMATIC CHECK WITHDRAWAL REQUEST: By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

Checking Account

Routing #: ___ ___ ___ ___ ___ ___ ___ ___ ___ Account #: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____ Date: _____

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Catastrophic Disability Insurance Plan

FOR MEMBERS OF IEEE OR EMPLOYEES OF MEMBERS

A plan that helps if you need assistance with basic needs of living

WHAT IF YOU NEED HELP WITH DAY-TO-DAY LIFE?

A sudden disability that leaves you without a paycheck is devastating enough. But what if you also found you needed help with the activities of daily living we take for granted such as bathing or toilet? The costs of assisted-living care, even for only a short time, can devastate the cash reserves you've been counting on to serve you in retirement.

IEEE's Catastrophic Disability insurance helps you keep control of your life, and your future. It will help pay the burdensome costs of assisted living, whether it's in a facility or your home, so you don't have to sacrifice your future, or your loved ones'.

Disability income insurance you may have from work makes up part of your missing paycheck. But it may not be enough to cover expenses for visiting in-home nurses, or for skilled care in an assisted-living facility. The IEEE Catastrophic Disability Plan can offer a flexible, affordable safety net.

WHAT CATASTROPHIC DISABILITY INSURANCE PROVIDES

Catastrophic Disability insurance pays you a monthly benefit to help cover the cost of assisted-living care, at home or in a facility, if you fall victim to a disabling injury or illness. Benefits are provided regardless of Social Security or Workers' Compensation.

The coverage offers features that will assist you in returning to work, including Rehabilitation Services and Worksite Modification. Use of these programs is optional, but – in most cases – monthly benefits will continue if you remain disabled even though you've returned to work.

PLAN FEATURES

Optional Extended Disability Benefit

The optional Extended Disability Benefit rider offers an additional lump sum benefit (ranging from 10,000 to $100,000) for catastrophic disabilities after satisfying the elimination period. This optional benefit is available to eligible members, employees of members and member's spouses under age 55. See policy for details.

Maximum Benefit

Choose a maximum benefit from $1,000 to $10,000 in $100 increments.

Survivor Benefit

A lump sum benefit equaling 3 months of disability benefit is payable to your beneficiary (or your estate) if you die after having receiving six continuous months of disability benefits under this plan.

Waiver of Premium

If you remain catastrophically disabled and unable or incapable of performing the material and substantial duties of your occupation and have satisfied your elimination period, premiums will be waived for a period of up to 24 months.

Rehabilitation Services

Rehabilitation services are available to assist you in returning to work. Participation in this program is voluntary.

Transplant Benefit

This plan provides coverage for catastrophic disabilities which result from organ transplant procedures. This benefit is available only once in a lifetime and has a maximum benefit period of 12 months.

When is Benefit Payable?

The benefit is payable when you suffer a catastrophic disability as defined in the policy. The period of disability must satisfy the elimination period first.

Eligibility

Catastrophic Disability insurance is available to IEEE members or employees of members under age 55 and who are actively at work; reside in the United States, and earning a minimum of $12,000 per year.

This plan is not currently available in all states, for details, call 1-800-493-IEEE(4333).

Waiting Period Options

Choose from four waiting period options:
60 days, 90 days, 180 days and 360 days.

[1]Inforce disability insurance is taken into consideration at time of application.

Benefit Period Options

Choose from three benefit period options, with benefits payable as follows:

To Age 65 Benefit Period

If Disability begins	Benefits are Paid
• Prior to age 64	To Age 65
• On or after age 64	12 months

10-Year Benefit Period

If Disability begins	Benefits are Paid
• Prior to age 60	120 months
• On or after age 60, but before age 64	To Age 65
• On or after age 64	12 months

5-Year Benefit Period

If Disability begins	Benefits are Paid
• Prior to age 60	60 months
• On or after age 60, but before age 64	To Age 65
• On or after age 64	12 months

Mental Illness Limitation: If you are Disabled due to Mental Illness, the Maximum Benefit Period for Catastrophic Disability Benefits will reduce to the lesser of the Maximum Benefit Period shown in your Schedule; or 24 months during your lifetime.

The Maximum Benefit Period may be reduced in accordance with the Mental Illness and Substance Abuse Limitation or Subjective Symptoms Limitation as specified in the General Limitations section of the Certificate.

PRE-EXISTING CONDITION PROVISION

The Catastrophic Disability policy will not cover any sickness or injury caused by, contributed to by, or resulting from a pre-existing condition that begins in the first 24 months after your coverage is effective, unless you have been treatment-free for 12 consecutive months after the effective date of coverage.

A Pre-Existing Condition is any Injury or Sickness, or Subjective Symptoms for which You: were diagnosed by or received Treatment from a Physician or other licensed practitioner of the healing arts; took any drugs or medications; or had symptoms for which an ordinarily prudent person would have sought Treatment; within the 6 month period prior to Your effective date of insurance, or with respect to increases in coverage, within the 6 month period prior to the effective date of the increase.

QUARTERLY PREMIUMS

BASE RATES PER $100 OF MONTHLY BENEFIT

To Age 65 Benefit Period

Age Band	60 Day Waiting Period	90 Day Waiting Period	180 Day Waiting Period	360 Day Waiting Period
Under 30	$ .71	$ .66	$ .62	$ .58
30–34	.75	.70	.66	.61
35–39	.88	.82	.77	.72
40–44	1.01	.93	.86	.79
45–49	1.26	1.16	1.08	.99
50–54	1.49	1.37	1.27	1.15
55–59*	1.84	1.68	1.53	1.37
60–64*	3.06	2.76	2.49	2.16
65–69*	8.05	7.21	6.46	5.52

Note: The premiums will increase on the renewal date coinciding with or next following the date you enter a new age bracket.

10 Year Benefit Period

Age Band	60 Day Waiting Period	90 Day Waiting Period	180 Day Waiting Period	360 Day Waiting Period
Under 30	$ .53	$ .50	$ .47	$ .44
30–34	.56	.53	.50	.47
35–39	.66	.62	.58	.54
40–44	.77	.71	.66	.61
45–49	1.02	.94	.87	.80
50–54	1.35	1.24	1.14	1.03
55–59*	2.01	1.84	1.68	1.51
60–64*	3.06	2.76	2.49	2.16
65–69*	8.05	7.21	6.46	5.52

Note: The premiums will increase on the renewal date coinciding with or next following the date you enter a new age bracket.

QUARTERLY PREMIUMS *continued*

BASE RATES PER $100 OF MONTHLY BENEFIT

5 Year Benefit Period

Age Band	60 Day Waiting Period	90 Day Waiting Period	180 Day Waiting Period	360 Day Waiting Period
Under 30	$ .34	$ .32	$ .30	$ .28
30–34	.37	.34	.32	.30
35–39	.42	.39	.37	.34
40–44	.51	.47	.44	.40
45–49	.69	.64	.60	.53
50–54	.97	.89	.81	.72
55–59*	1.47	1.33	1.21	1.07
60–64*	3.06	2.76	2.49	2.16
65–69*	8.05	7.21	6.46	5.52

Note: The premiums will increase on the renewal date coinciding with or next following the date you enter a new age bracket.

Option Extended Disability Benefits Per $1,000 Benefit Quarterly Mode

Attained Age of Applicant	180 Day Waiting Period
Under 30	$ .10
30–34	.10
35–39	.12
40–44	.17
45–49	.22
50–54	.32
55–59*	.50
60–64*	1.27
65–69*	1.27

Note: The premiums for you and your spouse will increase on the renewal date coinciding with or next following the date you or your spouse enters a new age bracket.

*Renewal premiums only.

CATASTROPHIC DISABILITY RATES

Use the following example to calculate your quarterly premium.
Divide the monthly benefit by 100 and multiply by the base rate (listed in the tables).

Example: Male, Age 42

5 Year Plan/90 Day Waiting Period/$5,000 Monthly Benefit

$5,000 divided by 100 = 50 X .47 = $23.50

WHEN DOES COVERAGE TERMINATE?

Coverage ceases if:

- You are no longer a member of IEEE, or an employee of a member.
- With respect to Your Covered Dependent Spouse, the date You are divorced or legally separated.
- You attain age 70.
- You do not pay the required premium when due.
- The date the policy ends.
- You retire.
- The 1st day of the month following a 60 day continuous period during which you are no longer actively at work except to due a disability covered by this policy or due to a layoff that meets the conditions stated in this policy.
- The date the Enrolling Group ceases to participate with the Policyholder.
- The date we or the Policyholder cancel coverage for a class of persons to which you belong.

WHEN DO BENEFITS TERMINATE?

Benefits will cease on the first to occur of the date:

- benefits have been payable for the maximum payment period you elected;
- you die,
- you are no longer disabled in accordance with the terms of the insurance policy;
- you refuse to be examined by a Physician, if we request such an exam or the date you refuse to be interviewed by one of the insurance carrier's representatives.

If your maximum benefit period is more than 12 months, benefits will cease after 6 months if you reside outside of the United States or Canada for 12 months or more.

EXCLUSIONS

The following exclusions apply to all benefits of the Policy.

Exclusions: The policy does not cover, and will not pay a benefit for any Loss or Disability:

- Due to an act or accident of war or act of war, declared or undeclared, whether civil or international, or due to any substantial armed conflict between organized forces of a military nature;
- Due to suicide or intentionally self-inflicted injury;
- Due to active participation in a riot;
- Due to committing or attempting to commit a felony;
- Due to your being engaged in an illegal occupation;
- Due to pregnancy (except that Complications of Pregnancy are covered);
- Due to injury sustained during travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on:
- A scheduled route; or
- A charter flight seating 15 or more people;
- While you are in the armed forces of any country or international authority for a period greater than 30 days (in such event the pro rata unearned premium shall be returned to you for any period of full-time active duty for more than 30 days provided you notify us within 12 months of entering the armed forces); or
- While incarcerated or under any house arrest that places restrictions on your movement outside your home by a court of competent jurisdiction, including restrictions that are monitored by electronic means or other means.

POLICY DEFINITIONS

1. Disability:

Catastrophically Disabled: It is determined that, due to Disability as a result of an injury or sickness that begins while you are covered under this benefit you have lost the ability to safely and completely perform two or more activities of daily living without another person's active assistance or verbal cueing; or are cognitively impaired and need another person's assistance or verbal cueing for your protection or for the protection of others. The suspension, revocation or surrender of a professional or occupational licenses or certificate does not constitute Catastrophic Disability.

2. Cognitive Impairment:

Cognitively Impaired means a deficiency in short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness. The impairment must be measurable according to generally accepted medical standards.

3. Activities of Daily Living (ADLs)

Bathing: The ability to wash oneself in the tub, shower, or by sponge bath with or without equipment or adaptive devices.

Dressing: The ability to put on and take off all garments, medically necessary braces, or artificial limbs, and to fasten and unfasten them.

Toileting: The ability to get to and from and on/off the toilet, maintaining a reasonable level of personal hygiene and caring for clothing.

Transferring: The ability to move into and out of a chair or bed, with or without equipment such as canes, quad canes, walkers, crutches, grab bars, or other support devices, including mechanical or motorized devices.

Continence: The ability to voluntarily control bowel and bladder function, or in the case of incontinence, the ability to maintain a reasonable level of personal hygiene.

Eating: The ability to get nourishment into the body by any means after it has been prepared and made available.

PAYMENTS AND CLAIMS

Once you are accepted into these plans, you will have a 31-day grace period for your payment of renewal premiums. When you want to submit claims, write the Administrator for claim forms or call 1-800-493-IEEE(4333).

CERTIFICATE OF INSURANCE

When you become insured, you will be sent a Certificate of Insurance summarizing the provisions of the Plan under which you are insured.

YOUR EFFECTIVE DATE

All eligible members' or employees of members' effective date will be established by the insurance company. Members or employees of members must meet all eligibility conditions on the effective date.

30-DAY FREE LOOK

If you are not completely satisfied with the terms of your Certificate of Insurance you may return it, without claim, within 30 days. Your insurance will then be voided and your premium refunded.

HOW TO APPLY FOR COVERAGE

1. Complete and sign the Application.
2. Do not send any money until Unimerica Insurance Company has approved your Application and notifies you of the premium contribution due, based on the information you have provided.
3. Mail your completed Application to:
   IEEE Group Insurance Program
   P.O. Box 10374
   Des Moines, IA 50306-8812

ABOUT THIS BROCHURE

This information is not intended to be a complete description of the insurance coverage available and some coverage options may not be available in all states. For complete details of coverage, please refer to your association's Master Policy and your Certificate of Insurance. In the event of a conflict between the coverage terms included in this Brochure and in the Master Policy and/or Certificate of Insurance, the Master Policy and/or Certificate of Insurance will govern.

This plan is subject to rate changes on any policy anniversary or premium renewal date and on any date on which benefits are changed. Changes in coverage or other plan provisions can be made by Unimerica Insurance Company or Plan Trustee.

This is a limited policy. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. Coverage described in this brochure is underwritten on Form Number ADI-4001-A (UIC) by Unimerica Insurance Company.

The Group Insurance Program is Administered by:

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
IEEE Group Insurance Program
P.O. Box 10374
Des Moines, IA 50306-8812

Toll-free 1-800-493-IEEE(4333)
www.ieeeinsurance.com

AR Insurance License #100102691
CA Insurance License #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC

The Catastrophic Disability Income Plan is Underwritten by:
Unimerica Insurance Company
(in California, dba Unimerica Life Insurance Company)
Association Administrative Address:
P.O. Box 17828
Portland, ME 04112-8828
Home Office:
10701 West Research Drive, Milwaukee, WI 5322

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