Office of the Administrator
P.O. Box 14464
Des Moines, IA 50306-8993

RESERVE STRENGTH
RESERVE LIFE

Dear ,

Military professionals know the true meaning of disability. The ROA Long-Term Disability Income Insurance Plan can help protect your income should you become Totally Disabled. The only question to ask yourself is … how much ROA Long-Term Disability Insurance would you require?

Right now we are making available a disability plan at affordable group rates. It can provide you up to $3,000.00[1] a month in cash benefits if you are Totally Disabled after 90 or 180 days. (The waiting period is your option.) Moreover, this plan can keep on paying your benefit for up to 24 months or up to age 65, whichever is longer.

Why sign up for the ROA Plan? Simply because you may not be able to match the depth of this protection at the price we offer under an individual plan.

There's another issue that is often raised: "I'm careful. I don't take chances. I'm not accident-prone." The trouble with that reasoning is that nobody should count on being lucky.

To qualify for our Long-Term Disability Insurance Plan, you have to be under age 65 … Actively-at-Work for 30 or more hours a week, reside in the U.S. and not on full-time Active Duty in the Armed Forces of any country or international authority. If you are under age 35, acceptance in the plan is guaranteed[2], while members age 35 and older may qualify by answering a few medical questions.

You may choose from coverage options with 90- or 180-day waiting periods and monthly benefits ranging up to $3,000.00, as long as the benefit does not exceed 60% of your Gross Monthly Salary. For particulars of the coverage and rates, please see the enclosed materials.

(Continued...)

I believe you will find that the facts about the ROA Long-Term Disability Plan speak for themselves. I urge you to carefully examine and evaluate the enclosed information (including costs, exclusions, limitations, reduction of benefits and terms of coverage) - soon. Today, if possible. Thank you.

Sincerely,

Anthony A. Baldus, Principal
Mercer Health & Benefits Administration LLC
ROA Insurance Plans Administrator
License #8704140

P.S. Your ROA Insurance Committee thoroughly screened several disability plans before selecting this one. Underwritten by Hartford Life Insurance Company this plan met all of our criteria of protection, price and flexibility. There is a 30-day, no-obligation evaluation period. On all counts, we highly recommend their product and services to our members.

[1]An Insured Person's Monthly Benefit Amount will reduce by 50% to a maximum of $1,500.00 on the premium due date on or next following the date he or she attains Age 60.

[2]This policy is guaranteed acceptance, but it does contain a Pre-Existing Conditions Limitation. Please refer to the enclosed brochure for more information on exclusions and limitations, such as Pre-Existing Conditions.

Disability Form Series includes SRP-1311, or state equivalent.

 ILTD020L-ROA

For Members of the Reserve Officers Association

DISABILITY INCOME INSURANCE APPLICATION

HARTFORD LIFE INSURANCE COMPANY

Hartford, Connecticut 06155

TO APPLY:

1. Complete and sign the application.

2. Send no money with your application.
You will be billed upon approval.

3. Use the postage paid envelope provided to return to:

ROA GROUP INSURANCE PROGRAM
P.O. Box 14464
Des Moines, IA 50306-8993

E-Mail: roa.service@mercer.com
02005-M

Section 1

Association Name: Reserve Officers Association	Policy No.: AGP-5175	Certificate No.: (Leave Blank)

Section 2

Name: (First, Middle Initial, Last)	❑ Male ❑ Female	Height:___ft.___in. Weight:_____lb.	
Street:	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Age Last Birthday:	Place of Birth (State/Country):	
Daytime Phone No.: ( )	Business Telephone: ( )	E-Mail Address: _____	
Business Address: Street:	City:	State:	Zip Code:

Beneficiary - Print full name & relationship to you

Name: _____ Relationship: _____

Section 3

COVERAGE REQUESTED:

Member Coverage:

❑ New Coverage: Monthly Benefit Amount: $ _____
Waiting Period: ❑ 90 days ❑ 180 days

❑ Change in Coverage:
Increase my Monthly Benefit Amount: $ _____

❑ Change in Waiting Period:
Waiting Period: ❑ 90 days ❑ 180 days

Section 4

Do you have any Disability Income Insurance in force or pending in this or any other company? ❑ Yes ❑ No
If yes, give details:

				To be replaced?	
Company	Monthly Benefit	Benefit Period	Waiting Period	Yes	No

Have you been actively engaged in the full-time duties of your occupation (at least 30 hours per week) 90 days before the date of this application? ❑ Yes ❑ No

Is the Monthly Benefit Amount herein applied for equal to or less than 60% of your Basic Monthly Pay minus any Other Income Benefits? ❑ Yes ❑ No

Section 5

PLEASE COMPLETE THE FOLLOWING:		**YES**		**NO**	
All questions are answered to the best of my knowledge and belief:					
1.	In the past 10 years, have you been diagnosed or treated by a member of the medical profession for:				
	A. A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory system?	❑	❑	❑	❑
	B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system?	❑	❑	❑	❑
	C. Colitis, ulcer, kidney disease or disorder or liver disease or disorder, or any disease or disorder of the digestive, urinary or reproductive system?	❑	❑	❑	❑
	D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders?	❑	❑	❑	❑
	E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands?				
	F. Arthritis, impaired sight or hearing, or any disease or disorder of the skin, bones, or joints, including neck or back disorders?	❑	❑	❑	❑
	G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests?	❑	❑	❑	❑
2.	During the past 5 years, have you consulted any physician, surgeon, psychologist, psychiatrist or other practitioner for any reason not previously noted on this application; or been confined or treated in any hospital, sanatorium or similar institution?	❑	❑	❑	❑
3.	Are you now pregnant?	❑	❑	❑	❑
	When is the baby due?_____				
	What was your pre-pregnancy weight?_____				
	Are there any medical complications?	❑	❑	❑	❑

Section 6

If you answered "Yes" to any of the above medical questions, please explain the details below.

Question Number and Condition	Dates	For any question answered "yes" please provide details, your physician's name, full address and phone number. (Required for processing)

(Attach sheet of paper if additional space is needed. Sign and date additional sheet of paper).

Section 7

AUTHORIZATION

I hereby certify that I have read or have had read to me all statements and answers in this application, and in any other application or medical form required by Hartford Life Insurance Company, and that they are full, complete, and true to the best of my knowledge and belief. I also understand that any misrepresentation contained herein or relied on by the Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk. I understand that any intent to defraud or knowingly facilitate a fraud against the Company, by submitting an application or filing a claim containing a false or deceptive statement is insurance fraud. I also agree that a copy of this application shall be attached to and form a part of any certificate issued. I also understand that the Company may request whatever additional evidence of insurability it needs.

Subject to the deferred effective date provision, I understand that coverage will not become effective until the Company grants its underwriting approval. I do not receive temporary or conditional insurance coverage just because I submit an application and pay the first premium.

I authorize any: doctor or counselor; health practitioner; hospital, clinic or medical facility; insurer or reinsurer; Medical Information Bureau, Inc.; or employer; to give Hartford Life Insurance Company or its legal representative information about my physical or mental health, (including history, condition, diagnosis and treatment), drug or alcohol use history, or other insurance coverage.

Hartford Life Insurance Company will use the information to decide if and to what extent I am eligible for insurance coverage or benefits under the policy. This information will be treated as confidential. I understand the Medical Information Bureau, Inc. will release records or information only to Hartford Life Insurance Company.

I authorize Hartford Life Insurance Company to give information about me to: its reinsurer(s), the Medical Information Bureau, Inc., any other insurance company to whom I may apply for Life or Health Insurance, or other persons or organizations handling a claim, underwriting coverage applied for or administering coverage issued as a result of this application or as required by law.

I understand that upon written request I may revoke this authorization except to the extent that action has already been taken in reliance on the authorization. This authorization expires two (2) years from the effective date of my coverage or, if no coverage has been issued one (1) year from the date of this application.

I understand that a photocopy of this form is as valid as the original, and that I have a right to receive a copy of this form upon request.

I certify that I have received the Notice of Insurance Information Practices. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.

PRE-EXISTING CONDITIONS LIMITATION: I understand that any injury or sickness, diagnosed or undiagnosed, for which I have received medical advice or treatment in the 12 month period prior to my effective date of coverage will not be covered until I have gone 12 months ending on or after my effective date of coverage without medical advice or treatment for that condition, or until 1 year after my effective date of coverage, whichever comes first, provided that the condition is not specifically excluded or limited by the policy or by a Health Waiver attached to my certificate. Applications to increase coverage will be subject to a new pre-existing conditions limitation. I further understand that any condition excluded or limited by the Policy or by a Health Waiver attached to my certificate will not be covered under this Policy at any time.

Notice: I understand that California law prohibits an HIV test from being required or used by Health Insurance Companies as a condition of obtaining health insurance coverage.

Section 8

Member's signature (Sign name in full) _____ Date _____

Required Required

SEND NO MONEY NOW!

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NOTICE OF INSURANCE INFORMATION PRACTICES

To properly underwrite and administer your application for insurance coverage, we must collect certain information concerning your insurability. You are our most important source of information, but we may also contact other sources such as medical professionals and institutions, employers and other insurance companies. While all information regarding your insurability will be treated as confidential, in some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

INVESTIGATIVE CONSUMER REPORTS — NOT APPLICABLE TO RESIDENTS OF NEW YORK

As part of our procedure for processing your application, an investigative consumer report may be prepared by an outside insurance reporting organization. Personal information may be collected from others regarding your general reputation and lifestyle. If an interview is conducted with someone other than you, we will inform you of your right to be interviewed in connection with the preparation of the investigative consumer report. You have the right to send a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

PERSONAL HISTORY INTERVIEW

To provide you, our client, with the best possible service, we may also conduct what we call a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the application information is complete. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to assess your eligibility for insurance.

MEDICAL INFORMATION BUREAU (MIB) PRE-NOTICE

Information regarding your insurability will be treated as confidential. Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, 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 about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of the 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Hartford Life Insurance Company, Hartford Life and Accident Insurance Company, or their reinsurers, may also release information from their files to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

ACCESS, CORRECTION AND DISCLOSURE

You can obtain access to personal information about you contained in our policy files by sending us a written request. You may also request any necessary corrections, amendments or deletion of any information in our files which you believe to be inaccurate or irrelevant. Hartford Life Insurance Company or Hartford Life and Accident Insurance Company or its reinsurer(s) may release information in their 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. Also, please be advised that personal and confidential information collected by us may, in certain circumstances, be disclosed to third parties without authorization. A notice providing further description of the circumstances under which information about you may be disclosed and the types of persons and organizations to whom it may be disclosed will be sent to you upon your written request. If you desire further information or access to your personal information, please send your written request to: Hartford Life Insurance Company or Hartford Life and Accident Insurance Company, 200 Hopmeadow St., Simsbury, CT 06089.

PA-9369

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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.

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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ROA Long-Term Disability Income Insurance Plan Member Benefits Summary

Here Is How The ROA Long-Term Disability Income Insurance Plan Can Work For You

Why the ROA Long-Term Disability Insurance Plan can be so important

The consequences of long-term disability to an ROA member — and his or her family — can be enormous.

While the chances of long-term disability may not be lessened, we can take safeguards. Designed specifically for our membership, ROA's Long-Term Disability Insurance Plan helps protect you with a wide range of benefit amounts.

Available to ROA members in good standing

As an ROA member under age 35, you are guaranteed acceptance* in this Plan. If you are over age 35, certain underwriting requirements are required. Other qualifications include that you are Actively-at-Work at least 30 hours per week, are a resident of the U.S. and are not on full time Active Duty in the Armed Forces of any country or international authority.

Your choice of benefits

Choose a monthly benefit of $1,000.00, $2,000.00 or $3,000.00**. (Monthly benefits for $100.00 are also available upon request. Please contact your Plan Administrator at 1-800-247-7988 for more information.) You can elect a benefit for as much as 60% of your Gross Monthly Salary, exclusive of bonuses, commissions, dividends, or overtime pay at your regular place of employment before your Total Disability occurs.

Here is a general guideline you can use to help determine the monthly ROA Long-Term Disability benefit you can apply for:

If your Annual Income is…	You may apply for a monthly ROA Benefit up to
$20,000 - $29,999	$1,000.00
$30,000.00 - $40,000.00	$1,500.00
$40,001.00 - $59,999.00	$2,000.00
$60,000 and up	$3,000.00

The Benefit Amount will be reduced by Other Income payable in any month in which a benefit is payable under this Policy. Other Income means any benefits payable under: a) any Workers' Compensation Law, statutory disability law, or Federal Social Security Act (Act) or any other similar law or act; and b) any salary continuance or retirement program provided for or sponsored by any employer; and reduction for Federal Social Security benefits will be determined by the benefits payable under that Act at the time benefits under this Policy become payable. There shall be no further reduction for cost of living increases under the Act.
This example is for purposes of illustrating the effect of the benefit reductions and is not intended to reflect the situation of a particular claimant under the policy:

Insured's Gross Monthly Salary	$3,000.00
Long term disability benefits percentage	x 60 %
Unreduced maximum benefit	$1,800.00
Less Social Security disability benefit per month	-$900.00
Less state disability income benefit per month	-$300.00
Total amount of disability benefit per month	$600.00

Total benefits can be payable for years

This Plan pays a disabled member up to age 65 or for two years, whichever period is greater. A 40-year old member who chose the $2,000.00 benefit and then becomes Totally Disabled at that age could receive more than $600,000.00 in disability benefits by the time he or she reached age 65. Benefit payment is contingent upon the claimant remaining Totally Disabled throughout that period.

Active duty call-up provision

You won't have to pay your premium for your ROA Long-Term Disability Plan if you're called to full-time active duty. Your coverage will temporarily stop during this time, but when your full-time active duty ends, your coverage will begin again. You won't have to complete a new application or reapply for coverage under the Plan.

Group rates make this coverage affordable

The ROA Long-Term Disability Insurance Plan does not allow for excessive sales or administrative costs. Thanks to ROA's high membership numbers, we can offer you affordable group rates.

ROA Long-Term Disability Plan

These are the monthly rates for the two available Plans you may choose from:

(Next page, please)

Plan A - Monthly benefits begin on the 91st day of covered Total Disability

Monthly Rates				
Age	$3,000.00	$2,000.00	$1,500.00	$1,000.00
Under Age 40	$30.00	$20.00	$15.00	$10.00
Ages 40-49	70.50	46.67	35.00	23.33
Ages 50-59	145.00	96.67	72.50	48.33
Ages 60-64†	137.50	91.67	68.75	45.83

Plan B - Monthly benefits begin on the 181st day of covered Total Disability

Monthly Rates				
Age	$3,000.00	$2,000.00	$1,500.00	$1,000.00
Under Age 40	$25.00	$16.67	$12.50	$8.33
Ages 40-49	62.50	41.67	31.25	20.83
Ages 50-59	125.00	83.33	62.50	41.67
Ages 60-64†	115.00	76.67	57.50	38.33

Monthly benefits are available from $100.00 - $3,000.00 in $100.00 increments.

Rates are based on the attained age of the Insured Person and increase as you enter each new age category.

†Monthly benefits reduce by 50% to a minimum of $1,500.00 at age 60.

Rates and/or benefits in this brochure may be changed on a class basis.

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

You sign up by mail and no salesperson will ever call

As military professionals, ROA members are well-known for making the right decision on their own. You are invited to apply for this Long-Term Disability Insurance Plan by mail only. Though there is a toll-free line available to call for questions or clarification, you will not be contacted by a telemarketer.

How do I select my monthly benefit?

Benefits can range up to $3,000.00 per month and, if you have other disability income plans or programs, your monthly ROA Plan benefits will be reduced by the monthly benefits received from other plans.[1]

Thus if you chose the $3,000.00 ROA monthly benefit and also have a company plan that pays $1,000.00, the ROA benefit you receive would be a maximum of $2,000.00 for Total Disability.

Waiver of Premium while Totally Disabled

It can be comforting to know that after you are Totally Disabled for a period of six months, your monthly premiums will be waived while the coverage continues in full force.

What Waiting Period should you select?

Depending upon the Waiting Period selected, your benefits start being paid either 90 or 180 days after the start of the disability. The longer this period, of course, the less the cost.

There is a Survivor Income benefit

In the event of your death while receiving the ROA Disability Benefit, your eligible beneficiary will receive a lump sum payment equal to three times your monthly benefit. (You must have participated in the ROA Plan and been receiving Total Disability benefits for at least 180 days.) This benefit will be paid to your spouse, if living; if no spouse, your children, if living; if no spouse or children, to your estate. Of course, if you'd like to arrange for a different beneficiary, simply notify the plan administrator in writing.

Exclusions

This program does not cover any disability resulting from: Intentionally self-inflicted Injury, suicide or attempted suicide, whether sane or insane; pregnancy or childbirth, except Complications of Pregnancy; war or act of war, whether declared or not; any Injury sustained while riding on, boarding or alighting from, any aircraft: as a pilot, crew member or student pilot; being used for tests, experimental purposes, stunt flying, racing or endurance tests; the commission or attempted commission of a felony by you; Sickness contracted or Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority. Upon request, we will refund the premium paid for coverage during the time you or your spouse were in the armed forces. Written notice must be given within 12 months of the date you enter the Armed Forces. However, orders to active duty for training purposes of two months or less shall not constitute active duty in the armed forces.

Pre-Existing Conditions

During the first two years of coverage, losses incurred for Pre-Existing Conditions are not covered. A Pre-Existing Condition means any Injury or Sickness including pregnancy; diagnosed or undiagnosed, for which you have received medical care within the 12 month period prior to your coverage effective date or the date of an increase in coverage. During that time, benefits for all other accidents or illnesses will be paid under the policy provisions. You are urged to consider this limitation before dropping any coverage you may have until the Waiting Period is over.

(Next page, please)

Definitions

Total Disability means disability which: a) during the Waiting Period and the first 24 months during which Total Disability Benefits are payable, wholly and continuously prevents you from performing the substantial and material duties of your usual occupation; and b) after that, wholly and continuously prevents you from engaging in any and every occupation or employment for which you are reasonably suited by training, education or experience.

Gross Monthly Salary means your regular monthly rate of pay, not counting commissions, bonuses, overtime pay or any other fringe benefit or extra compensation, in effect on the last day of Active employment prior to becoming Disabled. With respect to an Insured Person who is self-employed, Gross Monthly Salary means the Insured's average net monthly income (gross revenues less business expenses) from the personal practice of his profession or personal conduct of his main business. This average is based on net income for the 12 months or 24 months, whichever produces the higher average before the determination is made. If a member has been self-employed for less than 12 months, it is based on the whole time he was self-employed. If a member's practice is incorporated, earned income includes the cost to his company of fringe benefits and his share of total surplus. Income does not include investment returns, rents, royalties and the like income which is not directly produced from the member's current work.

Hartford Life Insurance Company is the Plan Underwriter

After careful review by the ROA Insurance Committee, a plan developed by Hartford Life Insurance Company was selected.

Acceptance into this plan is subject to medical evidence of insurability as determined by The Hartford. Depending on your age, the amount of coverage you request, and your answers on the application, a medical examination, medical test(s) or other evidence of good health may be required. Any exams/tests requested by the company will be conducted at your convenience and at no expense to you.

A 30-day "think-it-over" period

Once you receive your certificate of coverage, if anything doesn't strike you right about the Plan just write "cancel" on your Certificate and return it within the 30 days. There will be no obligation.

When will your coverage begin?

Your coverage will be effective on the first day of the month after your application has been approved, your first premium payment has been received and you are Actively-at-Work.

If on the date you are to become covered under the Policy you are not Actively-at-Work, you will not be covered until the date you are Actively-at-Work and performing, in your customary manner, all of the regular duties of your employment or occupation.

Termination

Your coverage will end if the Master Group Policy terminates, you fail to pay your premiums when due, you reach age 65, retire, cease to be Actively-at-Work except due to disability covered by the Policy, or if you enter full-time duty in the armed services.

Limitations

If you are Totally Disabled due to Mental or Nervous Disorders, alcoholism or drug abuse, the Maximum Payment Period will be reduced to 24 months during your lifetime unless you are Confined in a Hospital or other institution licensed to provide care and treatment for that disability.
Periods of Disability due to the same or related medical causes; and separated by less than 6 months during which you are Actively-at-Work; will be considered one Period of Disability.

Benefits during any Period of Disability as the result of: more than one Sickness; or more than one accident; or both Sickness and accident; will be considered the same as if the disability resulted from only one cause.

[1]Other disability plans or programs include Social Security, workers' compensation, salary continuance on retirement programs provided by or sponsored by any employer and other group insurance plans. This plan does not include military retirement benefits or any benefits received from the Veteran's Administration. (See your Certificate of Insurance for details.)

*Under age 35, this policy is guaranteed acceptance, but it does contain a Pre-Existing Conditions Limitation.

** An Insured Person's Monthly Benefit Amount will reduce by 50% to a maximum of $1,500.00 on the premium due date on or next following the date he or she attains Age 60.

(Next page, please)

Administered by:

MERCER

Mercer Consumer,
a service of Mercer Health & Benefits Administration LLC
P.O. Box 14464
Des Moines, IA 50306-8993

QUESTIONS?
Call: 1-800-247-7988
Web: www.roainsure.com

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

Underwritten by:

THE HARTFORD

Hartford Life Insurance Company
Hartford, CT 06155

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life Insurance Company.

This brochure explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this brochure and the policy, the terms of the policy apply. All benefits are subject to the terms and conditions of the policy. Policies underwritten by Hartford Life Insurance Company detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in full or discontinued. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy issued to the policyholder. This program may vary and may not be available to residents of all states.

This coverage is available only for residents of the United States excluding ID, MN, MT, NC, NM, OR, SC, SC and WV.

Your association shares a financial interest in this plan, which benefits the entire membership.

This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York Department of Financial Services.

ILTD020P - ROA

Disability Form Series includes SRP-1311, or state equivalent.