



# Voluntary Life

## **Contractors Management Services, LLC** announces Life insurance protection for its employees

Proposed Effective Date: 05/01/2008

Voluntary Group Term Life and Accidental Death and Dismemberment (AD&D) coverage is available to you for purchase through payroll deduction. Voluntary Life insurance can be a way to protect your family in the event of your death, particularly if you have financial obligations such as a mortgage or children in college.

### **The plan your employer has selected includes the following features:**

#### **Eligibility**

- ◆ You are eligible to participate in the plan if you are a full-time employee of the policyholder or an associated company,
  - who is at active work, and
  - who is working in the United States of America, except any temporary or seasonal worker.
  - Any other requirements set by your employer must also be met. "Full-time" means working at least 20 hours per week.
- ◆ Dependent Life insurance is available for eligible dependents, including your lawful spouse (if not disabled or hospital confined on the effective date) and unmarried children (if not hospital confined) from live birth to age 19, or to age 25 if a full-time student. The hospital confinement exception does not apply to a child born while dependent insurance is in effect.
- ◆ If you and your spouse work for the same employer and are both eligible for this insurance as employees, you cannot cover each other as dependents, and only one of you may insure any dependent children.

#### **Voluntary Life Schedule Amounts**

- ◆ Life insurance coverage is available in \$10,000 units from a minimum of \$20,000 to a maximum of \$250,000, not to exceed 5 times your basic annual earnings.
- ◆ At age 70, we will reduce by 33% the original Life insurance amount, rounded to the next higher \$10,000, if not already an exact multiple of \$10,000; at age 75, reduce by 33% of the inforce amount, similarly rounded. The reduced amount will not be less than \$20,000.
- ◆ If you elect coverage for yourself, you can buy up to 50% of that amount for your spouse in \$5,000 units to a maximum of \$125,000. If you elect child coverage, your children are eligible to be covered for \$1,000, \$5,000 or \$10,000 each. The amount of insurance for an eligible dependent cannot be more than 50% of your Life insurance amount.

#### **Accidental Death and Dismemberment Insurance (AD&D)**

- ◆ The AD&D benefit, if elected, equals the employee Life amount, to a maximum of \$250,000. AD&D provides 24-hour coverage and a benefit in the event of your loss of life, limb or eyesight as a direct result of an accident, provided the loss occurs within 365 days of the accident. The coverage includes:
  - A Higher Education Benefit that pays an additional \$3,000 per year for up to 4 consecutive years for eligible dependent students.

**The insurance policy or policies described in this document are underwritten by Union Security Insurance Company, a subsidiary of Assurant, Inc. Assurant Employee Benefits, a business unit of Assurant, Inc., markets life, disability and dental benefits plans as well as related products and services. In this document, the terms, "we", "us", "our", and the like, refer to each as applicable.**

- An Automobile Accident Benefit that pays an additional 20% of the scheduled AD&D benefit, to a maximum of \$50,000, if the covered person dies from an automobile accident injury while wearing a seat belt, provided an AD&D benefit is payable. Limitations and exclusions may apply.
- In the case of AD&D, we will not pay benefits if the loss results directly or indirectly from war; riot or insurrection; service in the armed forces; physical or mental disease; infection (except pyogenic infection that occurs from an accidental wound); assault or felony committed by the covered person; suicide or attempted suicide; intentionally self-inflicted injury; the use of any drug, unless it is used as prescribed by a doctor; or your intoxication, including but not limited to operating a motor vehicle while you are intoxicated.

**Proof of good health requirements**

- ◆ The Guarantee Issue amount for an employee is **\$130,000**; a spouse is **\$50,000**; a child is **\$10,000**.
- ◆ "Guarantee Issue" means the amount of coverage you can purchase without answering proof of good health questions. Guarantee Issue amounts apply to timely eligible applicants. A timely applicant is one who applies for coverage within 31 days from the date that all eligibility requirements are met. If you decline Voluntary Life coverage, you may be required to provide proof of good health to become insured.

**Additional Features**

- ◆ If you become disabled, your premiums may be waived to the earliest of age 65, recovery or retirement if disabled prior to age 60. If you become disabled at age 60 through 64, the waiver of premium will be to the earliest of one year, age 65 or retirement. You may be considered disabled for Life insurance if you are considered disabled under our Long-Term Disability policy. Any time Life insurance is continued under the Waiver of Premium, AD&D insurance will also be continued (and the premium waived) for up to 1 year from the date of disability. Limitations and exclusions apply.
- ◆ An Accelerated Benefit pays up to 80% of the Life benefit to a maximum of \$200,000 in the event of a life-threatening medical condition where there is a life expectancy of 12 months or less. An Accelerated Benefit may also be available for an insured spouse. Limitations and exclusions apply.
- ◆ Plan portability allows you to continue coverage for up to 3 years after terminating current employment. Limitations and exclusions apply.
- ◆ A Conversion Privilege allows you to convert to an individual policy if any or all of your Life insurance ends while you are insured under our group Life policy. AD&D coverage is not eligible for conversion. Limitations and exclusions apply.

For insureds or dependents who commit suicide within the first year after the effective date of their coverage, the only benefit amount payable is a refund of the amount of the insured's contributions. This coverage has limitations and exclusions. Not all plan provisions or options are available in all states. In addition, some states require modifications to the benefits described here. For complete details, please contact your company's benefits representative or refer to your benefit booklet. This highlight sheet provides a brief description of coverage. In the event that a discrepancy exists, the policy provisions will prevail. We can cancel the policy after giving the policyholder 45 days written notice.





**ISSUE**

Employee name		Employer <b>Contractors Management Services, LLC</b>
Group policy/participant no. <b>5211018</b>	Account no.	Cert. no.

**MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:**

(1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company. (3) Authorize any required deductions from my earnings. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

**Any person who knowingly and with intent to defraud any insurance company or other person files an application 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.**

Employee's signature \_\_\_\_\_ Date \_\_\_\_\_



# Employee Health Statement

Employee name (last, first, initial)			Employer <b>Contractors Management Services, LLC</b>	
Group policy/participant no. <b>5211018</b>	Account no.	Cert. no.	Employee SSN	Employee birthdate

New Enrollee     Annual Enrollment     Life Event-Type/Date \_\_\_\_\_

Please answer the following questions. If you are applying for dependent coverage, please answer all questions for your eligible dependents. Applicant's Height \_\_\_\_\_ Weight \_\_\_\_\_ Spouse's Height \_\_\_\_\_ Weight \_\_\_\_\_

- |   |                          | YES                      | NO                       |
|---|--------------------------|--------------------------|--------------------------|
| 1. Have you or your dependents gained or lost 10 or more pounds in the past 12 months?<br>If yes, how much _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you or your dependents within the past 5 years:   |                          |                          |                          |
| a) Received or been advised to receive any medication, treatment, surgery, therapy, testing, observation or consultation by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium, health resort or any other health related facility?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Used any illegal drug?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 5 years, have you or your dependents ever had, been treated for or been advised to seek treatment for persistent cough, fatigue or swollen glands, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, patches in mouth, skin lesions, prolonged night sweats, visual disturbance or recurring diarrhea, fever or infection?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you or your dependents pregnant?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you or your dependents used tobacco, in any form in the past 12 months?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you or your dependents ever had, been medically diagnosed, treated or been advised to seek treatment for: arthritis; back, neck or joint disorder; asthma; emphysema or lung disorder; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental, nervous or eating disorder; seizures; acquired immunodeficiency syndrome (AIDS) within the past 5 years or immune system disorder?<br>"Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Name, address and telephone number of personal physician \_\_\_\_\_

Employee's address \_\_\_\_\_ Daytime phone ( \_\_\_\_\_ ) \_\_\_\_\_

**If you answered "YES" to any questions, please provide details in REMARKS below.  
Elections are not valid without a signature at the end of this application.**

### REMARKS

If you answered "Yes" to any medical questions above, please provide details below:

Question no.	First name	Description of illness injury or pregnancy, medication and treatment	Duration (dates) & no. of episodes	Residual effects	Name and address of attending physician or hospital (including zip)

Employee name		Employer <b>Contractors Management Services, LLC</b>	
Group policy/participant no. <b>5211018</b>	Account no.	Cert. no.	

**IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY**

To properly underwrite applications and issue insurance policies on an equitable basis, we must obtain information about our proposed insured. The nature of the information we seek includes age, occupation, physical condition, health history, habits, avocations and other personal characteristics and information. This information will be collected from you and various sources, including health professionals and health facilities. Information regarding factors affecting insurability will be treated as confidential.

The information which we collect may, under certain circumstances, be disclosed to third parties without your specific authorization. However, be assured that disclosure will be strictly limited to that which is reasonably required.

You have the right to gain access to and request correction of information contained in our files. However, we will not disclose information which relates to a claim or to a civil or criminal proceeding. If you wish to receive a more detailed explanation of our information practices, including a description of access and correction rights as well as circumstances under which non-authorized disclosures or personal information may be made, please contact Senior Vice-President, Underwriting and Administration, 2323 Grand Boulevard, Kansas City, Missouri 64108.

**AUTHORIZATION TO RELEASE INFORMATION:** For underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, consumer reporting agency, employer or any other organization to give UNION SECURITY INSURANCE COMPANY or its reinsurers ALL INFORMATION on my behalf, including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be insured. I give my permission to UNION SECURITY INSURANCE COMPANY or its reinsurers to release any information to other life insurance companies as I may come in contact with. I know that I have a right to a copy of this authorization. A photocopy of this authorization will be as valid as the original. This authorization will be valid for two and one half years from the date shown below. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

**MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:**

(1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company. (3) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (4) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

**This will certify that I HAVE read and understand the above important notice.**

**Any person who knowingly and with intent to defraud any insurance company or other person files an application 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.**

Employee's signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's signature (if spouse coverage elected) \_\_\_\_\_ Date \_\_\_\_\_



# Assurant Employee Benefits

6302 Fairview Road, Suite 209

Charlotte, NC 28210

T 704.553.7609 800.772.6809 F 704.553.7821

## VOLUNTARY LIFE WEEKLY (52) PREMIUM DEDUCTION SCHEDULES FOR: Contractors Management Services, LLC

BENEFIT IN 000'S	EMPLOYEE LIFE PREMIUMS													AD&D				
	AGE													AGE				
	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	<30	30-39	40-49	50-64	65+
\$20	0.36	0.48	0.60	0.72	0.96	1.32	2.16	3.84	7.20	10.80	17.40	32.76	105.48	0.12	0.24	0.24	0.24	0.36
\$30	0.54	0.72	0.90	1.08	1.44	1.98	3.24	5.76	10.80	16.20	26.10	49.14	158.22	0.18	0.36	0.36	0.36	0.54
\$40	0.72	0.96	1.20	1.44	1.92	2.64	4.32	7.68	14.40	21.60	34.80	65.52	210.96	0.24	0.48	0.48	0.48	0.72
\$50	0.90	1.20	1.50	1.80	2.40	3.30	5.40	9.60	18.00	27.00	43.50	81.90	263.70	0.30	0.60	0.60	0.60	0.90
\$60	1.08	1.44	1.80	2.16	2.88	3.96	6.48	11.52	21.60	32.40	52.20	98.28	316.44	0.36	0.72	0.72	0.72	1.08
\$70	1.26	1.68	2.10	2.52	3.36	4.62	7.56	13.44	25.20	37.80	60.90	114.66	369.18	0.42	0.84	0.84	0.84	1.26
\$80	1.44	1.92	2.40	2.88	3.84	5.28	8.64	15.36	28.80	43.20	69.60	131.04	421.92	0.48	0.96	0.96	0.96	1.44
\$90	1.62	2.16	2.70	3.24	4.32	5.94	9.72	17.28	32.40	48.60	78.30	147.42	474.66	0.54	1.08	1.08	1.08	1.62
\$100	1.80	2.40	3.00	3.60	4.80	6.60	10.80	19.20	36.00	54.00	87.00	163.80	527.40	0.60	1.20	1.20	1.20	1.80
\$110	1.98	2.64	3.30	3.96	5.28	7.26	11.88	21.12	39.60	59.40	95.70	180.18	580.14	0.66	1.32	1.32	1.32	1.98
\$120	2.16	2.88	3.60	4.32	5.76	7.92	12.96	23.04	43.20	64.80	104.40	196.56	632.88	0.72	1.44	1.44	1.44	2.16
\$130	2.34	3.12	3.90	4.68	6.24	8.58	14.04	24.96	46.80	70.20	113.10	212.94	685.62	0.78	1.56	1.56	1.56	2.34
\$140	2.52	3.36	4.20	5.04	6.72	9.24	15.12	26.88	50.40	75.60	121.80	229.32	738.36	0.84	1.68	1.68	1.68	2.52
\$150	2.70	3.60	4.50	5.40	7.20	9.90	16.20	28.80	54.00	81.00	130.50	245.70	791.10	0.90	1.80	1.80	1.80	2.70
\$160	2.88	3.84	4.80	5.76	7.68	10.56	17.28	30.72	57.60	86.40	139.20	262.08	843.84	0.96	1.92	1.92	1.92	2.88
\$170	3.06	4.08	5.10	6.12	8.16	11.22	18.36	32.64	61.20	91.80	147.90	278.46	896.58	1.02	2.04	2.04	2.04	3.06
\$180	3.24	4.32	5.40	6.48	8.64	11.88	19.44	34.56	64.80	97.20	156.60	294.84	949.32	1.08	2.16	2.16	2.16	3.24
\$190	3.42	4.56	5.70	6.84	9.12	12.54	20.52	36.48	68.40	102.60	165.30	311.22	1002.06	1.14	2.28	2.28	2.28	3.42
\$200	3.60	4.80	6.00	7.20	9.60	13.20	21.60	38.40	72.00	108.00	174.00	327.60	1054.80	1.20	2.40	2.40	2.40	3.60
\$210	3.78	5.04	6.30	7.56	10.08	13.86	22.68	40.32	75.60	113.40	182.70	343.98	1107.54	1.26	2.52	2.52	2.52	3.78
\$220	3.96	5.28	6.60	7.92	10.56	14.52	23.76	42.24	79.20	118.80	191.40	360.36	1160.28	1.32	2.64	2.64	2.64	3.96
\$230	4.14	5.52	6.90	8.28	11.04	15.18	24.84	44.16	82.80	124.20	200.10	376.74	1213.02	1.38	2.76	2.76	2.76	4.14
\$240	4.32	5.76	7.20	8.64	11.52	15.84	25.92	46.08	86.40	129.60	208.80	393.12	1265.76	1.44	2.88	2.88	2.88	4.32
\$250	4.50	6.00	7.50	9.00	12.00	16.50	27.00	48.00	90.00	135.00	217.50	409.50	1318.50	1.50	3.00	3.00	3.00	4.50

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# Assurant Employee Benefits

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SPOUSE LIFE PREMIUMS													
BENEFIT IN	AGE												
	000's	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
\$5	0.03	0.06	0.06	0.09	0.12	0.24	0.30	0.60	1.14	1.62	2.85	4.95	19.56
\$10	0.06	0.12	0.12	0.18	0.24	0.48	0.60	1.20	2.28	3.24	5.70	9.90	39.12
\$15	0.09	0.18	0.18	0.27	0.36	0.72	0.90	1.80	3.42	4.86	8.55	14.85	58.68
\$20	0.12	0.24	0.24	0.36	0.48	0.96	1.20	2.40	4.56	6.48	11.40	19.80	78.24
\$25	0.15	0.30	0.30	0.45	0.60	1.20	1.50	3.00	5.70	8.10	14.25	24.75	97.80
\$30	0.18	0.36	0.36	0.54	0.72	1.44	1.80	3.60	6.84	9.72	17.10	29.70	117.36
\$35	0.21	0.42	0.42	0.63	0.84	1.68	2.10	4.20	7.98	11.34	19.95	34.65	136.92
\$40	0.24	0.48	0.48	0.72	0.96	1.92	2.40	4.80	9.12	12.96	22.80	39.60	156.48
\$45	0.27	0.54	0.54	0.81	1.08	2.16	2.70	5.40	10.26	14.58	25.65	44.55	176.04
\$50	0.30	0.60	0.60	0.90	1.20	2.40	3.00	6.00	11.40	16.20	28.50	49.50	195.60
\$60	0.36	0.72	0.72	1.08	1.44	2.88	3.60	7.20	13.68	19.44	34.20	59.40	234.72
\$70	0.42	0.84	0.84	1.26	1.68	3.36	4.20	8.40	15.96	22.68	39.90	69.30	273.84
\$80	0.48	0.96	0.96	1.44	1.92	3.84	4.80	9.60	18.24	25.92	45.60	79.20	312.96
\$90	0.54	1.08	1.08	1.62	2.16	4.32	5.40	10.80	20.52	29.16	51.30	89.10	352.08
\$100	0.60	1.20	1.20	1.80	2.40	4.80	6.00	12.00	22.80	32.40	57.00	99.00	391.20
\$110	0.66	1.32	1.32	1.98	2.64	5.28	6.60	13.20	25.08	35.64	62.70	108.90	430.32
\$120	0.72	1.44	1.44	2.16	2.88	5.76	7.20	14.40	27.36	38.88	68.40	118.80	469.44

CHILD AMOUNT	\$1,000	\$5,000	\$10,000
CHILD PREMIUM	0.04	0.21	0.42

Premiums shown are approximate.

