Symetra Financial

Group STD Product Manual

Includes:
Brochure
Product Fact Sheet
Administrative Guide
Specimen Policy
Forms

GIS
GROUP INSURANCE
SERVICES

GROUP SHORT-TERM DISABILITY INCOME INSURANCE

For more information, please contact your Symetra representative.

Minimum Group Size	10 eligible lives.
Participation Requirements	Noncontributory – 100 percent. Contributory – 75 percent with a minimum of 10 enrolled lives.
Partial Income Replacement	Up to 70 percent of pre-disability earnings.
Maximum Weekly Benefit	$2,500, based on underwriting and reduced by other income benefits.
Maximum Payment Duration	Up to 26 weeks.
Elimination Period	If disability is due to an injury or sickness, it is the latter of 14 days, the date salary continuation ends or the date accumulated sick leave ends.
Definition of Disability	Total, partial or residual disability options are available.
Integration Options	Integrates with other income benefits.

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Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004
www.symetra.com

Benefits and provisions may vary depending on the state where the group policy is issued. Group size and participation requirements may vary by state and/or industry. For details, contact your Symetra representative. This provides a brief description of the group short-term disability income insurance insured by Symetra Life Insurance Company located at 777 108th Avenue NE, Suite 1200, Bellevue, WA 98004. For a complete description of benefits, including exclusions, limitations, reductions and termination provisions, refer to the policy or contact your Symetra representative. Product is not available in all U.S. states or any U.S. territory.

SYMETRA GROUP SHORT-TERM DISABILITY INCOME INSURANCE

Definition of Disability

All definitions of disability measure the disabled employee's ability to perform the duties of the employee's own job and a reasonable employment option offered by the employer. These definitions also measure income the employee is able to earn.

The definition of disability may include total, partial or residual disability definitions.

Value

- Encourages claimants to explore return-to-work options.
- Ensures benefits are only payable to someone who is truly disabled due to a medical condition.

Cost-of-Living Freeze

After the first deduction has been taken for Other Income Benefits (OIB), disability payments will not be reduced due to cost-of-living increases to OIB, except for increases in income that an insured earns or receives from any form of employment.

Value

- Allows claimants to benefit from cost-of-living adjustments.
- Helps maximize claimants' benefits.

Accumulation of Elimination Period

A disability will be treated as a continuous condition when disability stops during the elimination period for less than a specific number of days (varies by elimination period) and the employee becomes disabled again from the same original sickness or injury.

This benefit is only included when Symetra short-term disability income insurance is offered along with Symetra long-term disability income insurance.

Value

- Motivates employees to return to work as soon as possible.
- Helps employers manage disability absences.

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OUR SERVICE COMMITMENT TO YOU

We promise to:

- Listen to your concerns
- Respond promptly
- Explain the status of your claim
- Outline what to expect throughout the claims process
- Review all claims in a fair, equitable and timely manner
- Treat our customers the way we want to be treated

If, for any reason, you believe we're not living up to our commitment, please call toll-free at: 1-877-448-1999.

This brochure provides a brief description of some claims policies and procedures that may apply to your group disability income insurance coverage. It is not intended to become a part of your plan provided by Symetra Life Insurance Company. If there is any conflict between the provisions in this brochure and your group disability plan, the plan will prevail. For a complete description of coverage, please contact your human resources representative. Symetra Group Disability Income Insurance is insured by Symetra Life Insurance Company and is not available in all U.S. states or any U.S. territories.

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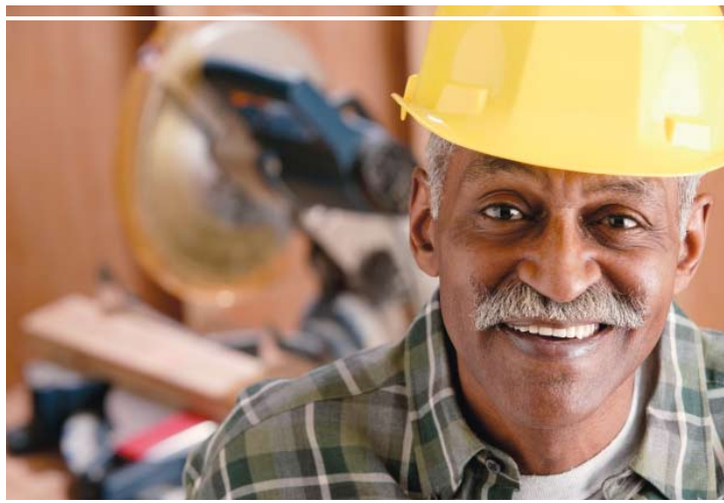
WHAT TO EXPECT WHEN YOU FILE A DISABILITY CLAIM



SYMETRA GROUP DISABILITY INCOME INSURANCE

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FREQUENTLY ASKED QUESTIONS

Q: What is disability income insurance?

A: Disability income insurance is a form of partial income protection, which pays benefits should you be unable to work due to a covered sickness or injury as defined by your plan.

Q: Where do I obtain a copy of my disability income insurance plan?

A: Your employer should supply you with a copy of your long-term disability (LTD) plan.

Q: What should be included when filing my claim?

A: Your claims application should be fully completed and include the following information:

- Employer statement
- Employee statement
- Attending physician statement

We may request additional information if we believe it is needed in order to make an appropriate decision on your claim.

Q: What happens after I submit my disability claim?

A: Once you submit your claim, we contact your employer via telephone to confirm certain information concerning your employment. Also, we will contact you for an initial claims interview* to discuss your claim. As needed, we may also request additional medical, occupational, and financial information. After our initial contact with you, we will send you a status letter, outlining the information we may still need and identifying the date.

Q: What information should I have ready for my initial telephone interview?

A: You should have names, contact information, and office visit dates for all providers (doctors, hospitals, etc.) you have consulted or who have treated you since the onset of your condition that is the basis for your claim. We will also want to know the names and dosages of your medications.

Q: Once my claim has been approved, when will I begin to receive benefits?

A: If you remain disabled as defined by your policy after your elimination period (the period of time that you must remain disabled prior to receiving benefits) your benefits are payable in arrears on a monthly basis.

Q: If benefits are approved, will additional information ever be required?

A: Because every claim is different, there may be some variation from one claim to another in the amount of information we request, and the intervals at which we may request it. Often, though, you will be required to provide ongoing medical information, occupational information, and/or financial information.

Q: What happens if I am receiving other income for the same period during which I am receiving long-term disability benefits?

A: Your plan states that your monthly LTD benefit will be reduced by the amount of these other income benefits, as defined by the plan.

For example:

Let's say your monthly LTD payment is $1,000, and you begin also to receive a monthly Social Security Disability (SSDI) benefit of $500.

Your monthly LTD benefit will then be reduced by $500, so that your total income replacement level is $1,000 (LTD plus SSDI)

Essentially, you will receive the same amount in benefits monthly, but the benefits may end up coming from multiple sources as opposed to just one source.

Q: What happens if and when I return to work?

A: When it is time for you to return to work, you should notify your claims handler; your claims handler will then need to receive a release before you can return to work, signed and dated by your doctor. Your claims handler will contact your employer to confirm your return.

Q: What happens if I return to work part-time, but plan to eventually return full-time?

A: If you are released to return to work part-time, and are earning between 20% and 80% of your predisability earnings—but still meet the definition of disability under your contract—we will require a release to return to work note from your doctor. Depending on your plan, you may still be eligible for a reduced disability benefit to supplement your work earnings.

*A great time to have questions answered is during your initial claims interview.

SYMETRA LIFE INSURANCE COMPANY

GROUP ADMINISTRATIVE GUIDE

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ADMINISTRATION

ENROLLMENT

ENROLLING EMPLOYEES

An Enrollment Form must be completed for each employee. It should contain the benefit amount, beneficiary information, and be signed and dated. **Keep all Enrollment Forms in your office; do not send them to Symetra Life Insurance Company.**

The importance of maintaining current enrollment and beneficiary information cannot be overemphasized. The only record of an employee's selection is that found on the Enrollment Form. In the event of a claim, all forms (or in some cases copies) must be submitted with the claim form. If incorrect or outdated information is shown, unnecessary delay in benefit payment could result.

EFFECTIVE DATE FOR NEW EMPLOYEES

Employees become eligible for coverage after they meet the Eligibility Requirement and complete the Service Waiting Period listed in your contract.

PROVIDING CERTIFICATES

It is important that employees be given a Certificate of Insurance when they are added to your plan so they can be fully aware of all benefits, conditions and reporting requirements.

PARTICIPATION REQUIREMENTS

If the employer pays the entire premium for a particular coverage, all eligible employees must be enrolled. If employees pay part of the cost for contributory coverage they are not required to enroll. Participation requirements on contributory policies must remain at or above the level indicated in the policy or risk termination of the policy or coverage.

LATE ENTRANT

Employees enrolling more than 31 days after they are first eligible for contributory coverage are considered Late Entrants and must submit an Evidence of Insurability form. The form should be fully completed and include the correct policy name, number, and coverage(s) for which application is being made. Symetra will notify you if the applicant has been approved or declined and, if approved, of the date coverage will start.

PROOF OF GOOD HEALTH (Also see Late Entrant section)

Evidence of Insurability forms, if required by your contract, will be included in the Enrollment section of your Administrative Kit. They should be fully completed and include the correct Policyholder Name, Policy Number, and coverage(s) for which application is being made. Symetra will notify you if the applicant has been approved or declined and, if approved, of the effective date coverage will start. You may then add the employee to the plan and begin premium payments.

SELECTING THE BENEFICIARY

It is important that beneficiary selections be kept up to date. The employee can select almost anyone to receive the benefits. In most states, it is unlawful for the Group policyholder to be named as the beneficiary of Group Life Insurance. Please advise employees of this fact when you give them their Enrollment Form.

CHANGES

AGE CHANGE

The contract specifies when benefits change due to a change in age. Enter the change on the back of the Enrollment Form. You may then adjust future self-administered premium payments based on the reduced benefit amount.

BENEFICIARY CHANGE

When an employee wants to change their beneficiary, have them complete the Change of Beneficiary Designation Form (LG-12008). The Change of Beneficiary Designation Form must include the employee's information as well as all of the new beneficiary information. It must be signed, dated, and **stapled** to the employee's original Enrollment Form. All Enrollment Forms should be retained in your active file of forms. **Do not send the form(s) to Symetra Life Insurance Company.**

BENEFIT CHANGE (Also see Late Entrant section)

To move an employee from one class to another, or to add additional benefits not previously elected, have the employee complete a new Enrollment Form. The new form must include the benefit amount and beneficiary information (if applicable) and must be dated and signed by the employee. Staple the form to the employee's original Enrollment Form and retain them in your active file of forms. **Do not send the form(s) to Symetra Life Insurance Company.** Adjust future premium payments accordingly.

NAME CHANGE

Have the employee complete a new Enrollment Form *IN FULL* when a name change occurs. The new form must include the benefit amount and beneficiary information (if applicable) and it must be

dated and signed by the employee. Staple it to the employee's original Enrollment Form and retain them in your active file of forms. **Do not send the form(s) to Symetra Life Insurance Company.**

CONTINUATION OF COVERAGE

Under certain circumstances, an employee's coverage may be continued for a period of time while the employee is off work due to temporary-layoff or other approved leaves of absence (refer to your policy for specific details). Continuation must be terminated if employment terminates for any reason. Indications that an employee has terminated their employment could include the election of COBRA continuation or the conversion of coverage.

TERMINATION OF EMPLOYEE

In most cases, coverage ends immediately upon termination of employment (refer to your policy for specific details). Those individuals losing coverage may be able to take advantage of Conversion or Portability (again, please refer to your policy for specific details).

Premiums for terminated employees will be required through the month in which termination occurs. **Do not send the employee's Enrollment Form(s) to Symetra Life Insurance Company.**

CONTRACT ADMINISTRATION

SUPPLY ORDERS

If your supply of forms is low, complete the Supply Request Form (LB-219) and mail it to Symetra or fax it to our office at 1-866-348-0058. You may also call your Agent or Symetra Service Representative for assistance.

CERTIFICATE ORDERS

Additional certificates can be ordered by mailing the Supply Request Form (LB-219) to Symetra or by faxing it to our office at (425) 256-5321. You may also contact your Agent or Symetra Service Representative for assistance. When ordering, please include the Policyholder Name, Policy Number, number of certificates needed for each class, **street** mailing address and contact person for delivery. Overnight delivery cannot be made to a Post Office Box.

Certificate orders will be processed as soon as possible. Please allow 2 to 3 weeks for delivery. If your order is urgent, please let your Agent or Symetra Service Representative know and we will do everything we can to accommodate your needs.

CONTRACT CHANGES

Requests for changes to your contract should be sent in writing to your agent or Symetra Service Representative prior to the date the requested change is to occur.

CONTRACT TERMINATION

Symetra must receive written notification of your intent to terminate your policy. Notification must be sent prior to the requested termination date.

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PREMIUM

SELF-ADMINISTERED BILLING STATEMENT

Prior to the first of each month, you will receive a Self Administrated Billing Statement. It provides space for reporting and calculating the monthly premium due for your group's coverages. Preprinted on the statement will be the Policyholder Name, Policy Number, month for which premium is due, and the current rates for each of the coverages you have purchased.

The statement will only include rates for the current month. It will not indicate prior balances due. **If prior premium was not received, the current statement will not reflect that information.**

INFORMATION NEEDED

Since this is a self-administered type of billing statement, we need your help in providing the information necessary to properly compute the premium:

- The number of employees covered for each type of coverage ("# employees");
- The total benefit amount for each type of coverage ("Total Inforce", "Weekly Benefit" or "Covered Monthly Payroll"); and
- Any adjustments you are making to the previous month's payment, such as adding new employees or deleting terminated employees.

GROUP DEPARTMENT
EMPLOYER'S SELF-ADMINISTERED STMT
FOR THE PERIOD OF: JAN 2006

POL NO: 01-012345-00 STMT ID: 1

MAIL TO:

PLEASE REMIT BY: JAN 10, 2006

JOHN DOE MANUFACTURING CO
1234 FICTITIOUS DRIVE
INDUSTRIAL PARK EAST
JACKSONVILLE, FL 32224

ATTN: MR B. JONES, ACCOUNTING

RETURN STATEMENT & PREMIUM TO:
SYMETRA LIFE INSURANCE COMPANY
GROUP ADMINISTRATION
P.O. BOX 1491
MINNEAPOLIS, MN 55480

ADDRESS CHANGE?
COVERAGES OR RATES LISTED INCORRECTLY?
CALL TOLL FREE: 1-800-426-7784

PLEASE COMPLETE THIS STATEMENT; CALCULATE PREMIUMS DUE, AND SUBMIT YOUR CHECK IN THE ENCLOSED ENVELOPE.

BASIC LIFE:	# EMPLOYEES	TOTAL INFORCE		RATE/1,000		PREMIUM
000	_____	$ _____,___,___	X	0.14	=	$ _____,___,___

REMARKS AND ADJUSTMENT EXPLANATION:

TOTAL CURRENT MONTH: $ ____,___,___

**COVERAGE IS STEP RATED BY AGE BAND; SEE ADMIN KIT OR CALL ABOVE TOLL FREE NUMBER

ADJUSTMENTS: O $ ____,___,___

TOTAL PREMIUM DUE: $ ____,___,___

PREPARED BY: DATE:

MAKE CHECK PAYABLE TO: SYMETRA

STEP RATES

For coverages with step rates (i.e., rates that are based on the insured's age), determine each insured's age at each policy anniversary. Use the age for the entire policy year to determine the appropriate rate. New insureds should use their age as of the date insurance becomes effective.

ADJUSTMENTS

Adjustments must be submitted in a timely manner and an explanation must be given for any adjustments made.

COMPUTING TOTAL PREMIUM DUE

Once the information has been filled in, you should compute your premium. Multiply across for each coverage line and then add all premium amounts to arrive at "Total Current Month" premium. Add or subtract any adjustments for the "Total Premium Due."

SENDING IN PAYMENT

After computing your premium due, if you submit your premium directly to Symetra, place your check and the statement in the return window envelope included with your statement. Make sure the return address is showing and **mail it to Symetra Life Insurance Company by the 10th of the month** in which the premium is due.

GRACE PERIOD

The contract provides for a 31 day grace period, after which all coverage terminates. You will be required to pay for coverage provided during this period.

QUESTIONS

If you have any questions regarding your Billing Statement, call our toll free number at 1-800-426-7784.

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PREMIUM

SHORT TERM DISABILITY INSURANCE

SUMMARY BILLING STATEMENT

The Summary Billing Statement that you receive each month from Symetra provides space for reporting and calculating the monthly premium due. The Short Term Disability portion of the statement looks like this:

Short Term Disability	# Employees	Weekly Benefit		Rate	Premium
100	_____	$___,_____.___	X	(xx.xx)	$___,_____.___

EMPLOYEES

List the number of employees covered under the Short Term Disability Insurance.

WEEKLY BENEFIT

If the Weekly Benefit is a **flat dollar amount** for each covered employee, total the benefit amounts for all employees and enter the total.

If benefits are based on a percentage of the employee's salary:

- List each covered employee and their total weekly salary. If you need to convert monthly salary to a weekly figure, divide the monthly amount by 4.333.
- Reduce each weekly salary by any amount that exceeds the maximum covered salary (Excess Salaries).

  If the benefit amount in the contract states "60% of basic weekly earnings to a maximum of $250" the maximum amount any covered employee will receive when disabled is $250 per week. If you divide $250 by .6 (% of Salary Payable) you will find that $416.67 per week is the Maximum Salary. Any amount in excess of $416.67 should not be included when calculating the premium due.
- Total the adjusted weekly salaries for all employees.
- Since rates are calculated based on "per $10 of benefit", you will need to divide the result of the above total by 10. Insert this information under "Weekly Benefit".

RATE

Symetra will preprint the Rate for your convenience.

PREMIUM

Multiply the Weekly Benefit by the preprinted Rate to arrive at the monthly Premium amount due.

EXAMPLE

Following is an example of how to calculate the Short Term Disability Insurance monthly premium if the Rate is ".63% (.0063) per $10 of benefit" and the benefit amount is "60% of basic weekly earnings to a maximum benefit of $250".

Employee:	Total Weekly Salary	Less	Maximum Salary	Equals	Excess Salary
Smith	$1,000.00	-	$416.67	=	$583.33
Jones	520.00	-	416.67	=	103.33
Allen	680.00	-	416.67	=	263.33
Anderson	320.00	-			
Johnson	200.00				
Black	225.00				
White	185.00	-			
Green	820.00	-	416.67	=	403.33
	$3,950.00				$1,353.32

Total Weekly Salaries		$3,950.00
Less: Excess Salaries	-	1,353.32
		2,596.68
Multiplied by: % of salary payable	x	.60
		1,558.01
Divided by:	÷	10
Weekly Benefit		155.80
Multiplied by: Rate per $10 of benefits	x	. 63
Monthly Premium Due Symetra		$ 98.15

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BENEFITS

EMPLOYEE SHORT TERM DISABILITY INCOME INSURANCE

Disability income benefits may be payable if the employee becomes disabled while insured under this policy. In order to assure prompt claims service, it is essential that all requested information be supplied when a claim is first submitted. Missing information requires additional time-consuming correspondence.

To apply for this benefit the **EMPLOYER** must:

- Complete all questions, sign and date Section 3 of the Group Disability Claim Application (LB-1065).
- Have the **Employee** complete all questions, sign and date Sections 1 and 2 of the Group Disability Claim Application (LB-1065). Then have the physician complete, sign and date the statement in Section 4.
- Submit copies of all Enrollment Forms (keep the originals).

DISABILITY CONTINUANCE VERIFICATION

Verification of the continuance of disability may require completion of additional forms.

PAYMENT AND TAX REPORTING

Benefit Payments will be sent directly to the employee unless the employer directs otherwise. Short Term Disability Income benefits are paid weekly in arrears. Custom Disability Solutions, on behalf of Symetra Life Insurance Company, will withhold employee taxes if the benefit is taxable. The employer is responsible for matching FICA taxes and preparing W-2s. W-2s should always be prepared for sickpay.

FICA taxes are applicable only for the first six calendar months from the last day worked and only if the benefit is taxable. The benefit is taxable if the employer paid the entire premium or if the employee paid the premium with pre-tax dollars (considered employer paid). If the employee paid all the premiums with post-tax dollars, then the benefit is non-taxable. If the premium payments are shared, then the benefit is taxable for the percentage that the employer paid the premium.

SUBMITTING CLAIMS

Complete forms fully and accurately and submit them with all required documents to:

Custom Disability Solutions (CDS)
P.O. Box 9461
Portland, ME 04104
Fax: 1-800-293-4781

CLAIM INQUIRIES

If your employees have questions regarding claim submissions, have them call CDS toll free at 1-888-234-2641.

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BENEFITS

EMPLOYEE SHORT AND LONG TERM DISABILITY INCOME INSURANCE

Disability income benefits may be payable if the employee becomes disabled while insured under this policy. In order to assure prompt claims service, it is essential that all requested information be supplied when a claim is first submitted. Missing information requires additional time-consuming correspondence.

To apply for this benefit the **EMPLOYER** must:

- Complete all questions, sign and date Section 3 of the Group Disability Claim Application (LB-1065).
- Have the **Employee** complete all questions, sign and date Sections 1 and 2 of the Group Disability Claim Application (LB-1065). Then have the physician complete, sign and date the statement in Section 4.
- Also have the **Employee** provide copies of all correspondence received from the Social Security Administration and Workers' Compensation/State Disability.
- Submit a detailed job description and copies of all Enrollment Forms (keep the originals).

DISABILITY CONTINUANCE VERIFICATION

Verification of the continuance of disability may require completion of additional forms.

PAYMENT AND TAX REPORTING

LTD: Benefit Payments will be sent directly to the employee unless the employer directs otherwise. Long Term Disability Income benefits are paid monthly in arrears. Custom Disability Solutions, on behalf of Symetra Life Insurance Company, will withhold employee taxes, pay in the employer matching FICA and prepare W-2s.

STD: Benefit Payments will be sent directly to the employee unless the employer directs otherwise. Short Term Disability Income benefits are paid weekly in arrears. Custom Disability Solutions, on behalf of Symetra Life Insurance Company, will withhold employee taxes if the benefit is taxable. The employer is responsible for matching FICA taxes and preparing W-2s. W-2s should always be prepared for sickpay.

FICA taxes are applicable only for the first six calendar months from the last day worked and only if the benefit is taxable. The benefit is taxable if the employer paid the entire premium or if the employee paid the premium with pre-tax dollars (considered employer paid). If the employee paid all the premiums with post-tax dollars, then the benefit is non-taxable. If the premium payments are shared, then the benefit is taxable for the percentage that the employer paid the premium.

SUBMITTING CLAIMS

Complete forms fully and accurately and submit them with all required documents to:

Custom Disability Solutions (CDS)
P.O. Box 9461
Portland, ME 04104
Short Term Disability Fax: 1-800-293-4781
Long Term Disability Fax: (207) 883-8641

CLAIM INQUIRIES

If your employees have questions regarding claim submissions, please have them contact CDS at:

Short Term Disability: 1-888-234-2641 or Long Term Disability: 1-877-448-1999

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EMPLOYEE ASSISTANCE PROGRAM (EAP)

We provide Employee Assistance Program (EAP) services through a relationship with Resources For Living (RFL). RFL is a behavioral wellness organization that was established in 1988. Our EAP provides services for assisting employees and their family members with personal and work related problems as well as issues they may experience from time to time. Our EAP includes confidential assessment and counseling services for employees and their family, on both personal and professional issues. EAP also offers support for employers with managing the workplace issues you face.

ACCESS TO EAP

You and your employees can access EAP via a toll-free number or visit RLF's Website to create a secure account. Included in your kit is a supply of our EAP brochures for distribution to your employees. Please contact your local Symetra sales representative should your supply of brochures become depleted.

Toll free: 1-866-656-5831

TTY: 1-800-827-3707

Online: www.rfl.com

SERVICES INCLUDED

Your EAP includes the following services:

Access:

- 24 hours per day, 365 days per year – professional EAP counselors provide live, immediate telephone crisis counseling
- Toll free number Immediate
- Unlimited telephonic assistance
- Access to masters-level counselors
- Web-based information, resources and tools
- Confidentiality strictly maintained

Counseling - Immediate access to help for issues such as:

- Emotional, anxiety, depression
- Family, relationships

- Substance abuse
- Grief, loss
- Dealing with change
- Individual coaching
- Suicide, crisis situations
- Emergency intervention and critical incident stress management (CISM) assistance
- Referral support, tracking, and follow-up
- Our Substance Abuse Counselors have specific knowledge, training, and experience in the assessment and treatment of chemical dependency and other addictions

Work/Life and Information Referral:

- Financial, credit, debt issues
- Legal information
- Child and elder care
- Home ownership

Immediate Help for Managers and Supervisors:

- EAP orientation for all employers and employees
- Dealing with employee conflicts
- Violence in the workplace
- Substance abuse in the workplace
- Sexual harassment
- Employee behavioral issues
- Supervisory leadership training is available

Legal Services:

- Free 30-minute, telephonic consultation with a network legal provider — One per legal issue, per year- unlimited issues per year
- Free 30-minute telephonic consultation with a network mediator and 25% rate discount for subsequent hours
- Simple will preparation
- 10% discount for telephonic and online assistance with legal documents

Financial Services:

- Free 30-minute, telephonic or face-to-face initial consultation with a financial counselor on: credit counseling, debt and budgeting assistance, retirement planning, and tax questions
- Local referrals
- Web access

OPTIONAL SERVICES

The following optional services are available as part of your EAP offering at an additional cost:

- Onsite workplace intervention
- Standard on-site critical incident management services
- Immediate on-site critical incident management services
- Training and orientation seminars on topics including stress and time management, as well as work/life balance
- Manager/supervisor training seminars

To learn more about these optional services, please contact RFL directly at 1-866-656-5831.

REPORTING

You have access to the RFL Return On People Scorecard® (ROP Scorecard®) for utilization reporting. The reports are produced at a frequency and in the format you request. Reports will be sent electronically to a designated person of your choice. Please contact your local Symetra sales representative with assistance in setting up your customized report.

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E.R.I.S.A. REQUIREMENTS

The Employee Retirement Income Security Act of 1974 (E.R.I.S.A.) requires that non-exempt employers:

- Meet specified reporting requirements,
- Furnish employees with certain documents, and
- Provide other information as may be required.

We suggest that you review the E.R.I.S.A. requirements with your tax advisor to determine how it affects your plan, and whether you are in compliance.

REPORTING REQUIREMENTS

Symetra generates reports for employers of 100 or more employees to assist them with their E.R.I.S.A. 5500-Schedule A reporting requirements. Shortly after your policy anniversary, Symetra will send you some of the information necessary to complete your report: the agent's name and address, total premium and commissions paid. If you have two coverages with Symetra and they renew at different times of the year you will receive two separate reports. In addition, yearly you may receive a letter which discloses compensation cost allocations made to your agent by Symetra.

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E.R.I.S.A. REQUIREMENTS

The Employee Retirement Income Security Act of 1974 (E.R.I.S.A.) requires that non-exempt employers:

- Meet specified reporting requirements,
- Furnish employees with certain documents, and
- Provide other information as may be required.

We suggest that you review E.R.I.S.A. requirements with your tax advisor to determine how it affects your plan, and whether you are in compliance.

REPORTING REQUIREMENTS

Symetra generates reports for employers of 100 or more employees to assist them with their E.R.I.S.A. 5500-Schedule A reporting requirements. In addition, you may receive a letter which discloses compensation cost allocations made to your agent by Symetra. Occasionally this information goes out to smaller employers. Please disregard the information if it is not applicable to your E.R.I.S.A. plan requirements.

GROUP SHORT TERM AND LONG TERM DISABILITY INSURANCE

Policyholder: [ABC COMPANY]

Policy Number: [100000]

Policy Effective Date: [January 1, 2006]

Policy Anniversary Date: [January 1, 2007]

State of Policy Issue: [Insert state of issue]

Policy Insured By: [Insert Insurance Company Name], referred to as "the Company", "we", "us", and "our".

We will provide the benefits under this policy in consideration of the application and premium. We make this promise subject to all of the provisions of this policy.

Read this policy carefully and contact us promptly if you have questions. This policy is delivered and is governed by the laws of the state of policy issue and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

This policy consists of:

- all policy provisions and any amendments and/or attachments issued
- the policyholder's application
- employees' signed applications, if any
- the certificate of coverage.

This policy may be changed in whole or in part. Only an officer of ours can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including any agent, may change this policy or waive any part of it.

Signed for us at [Insert City and State] on the policy effective date.

Secretary President

Licensed Resident Agent

ER-1 rev 10/05

INTRODUCTION

This policy is divided into two sections:

- the employer section
- the employee section

Both sections together form the policy and include all of the benefits available under a plan.

Whenever we use the terms "you or your" in the employer section, we mean the employer.

ER-2

SHORT TERM DISABILITY
POLICY DETAILS

These are details concerning your policy:

Plan Effective Date:

January 1, 2006

Divisions, Subsidiaries or Affiliated Companies Include:

Name	Location (City and State)
None	

Initial Rate:

[X.XX] per $10 of weekly benefit.

Rate Guarantee:

A change in the premium rate will not take effect prior to 1/1/2007 , or 12 months following the policy effective date, whichever is later. However, the premium rate may change prior to this time for reasons that affect the insured risk, which includes:

- a change occurs in a plan of benefits
- a division, subsidiary, or affiliated company is added or deleted
- the number of employees insured by a plan changes by 25% or more
- a new law or a change in any existing law is enacted which applies to a plan.

We will notify you in writing at least 31 days before a premium rate change is effective. A change may take effect on an earlier date if you agree to it.

ER-3S Rev 3/99

When do you need to pay premium?

Premium payments are due on the plan effective date, and the first day of each calendar month after the plan effective date.

We must receive all premiums on or before the date the premium is due. You must pay premium in United States dollars.

Premium payments for this coverage must continue for any employee receiving payments under this plan.

ER-4S Rev 3/99

WHEN DO YOU MAKE PREMIUM CHANGES?

If employee status changes occur during a policy month then you must report the changes on the next premium due date following the change. Any premium increase or decrease will be adjusted and will become due at this same time, but will not be pro-rated daily.

If you pay premium on other than a monthly basis, changes in premiums will result in a monthly pro-rated adjustment on the next premium due date.

We will adjust premiums for the current policy year and the prior policy year unless changes are the result of fraudulent information.

WHAT INFORMATION DO WE REQUIRE OF YOU?

You must give us the following on a regular basis:

- information about your employees
  - who are eligible to become insured
  - whose amounts of coverage changed, including salary increase and decrease information
  - whose coverage ends
- occupational information and any other information that we may reasonably require.

Your records that we believe have a bearing on coverage under this plan are open for our review at any reasonable time.

Clerical error or omission will not:
- prevent an employee from receiving coverage;
- affect the amount of an insured's coverage;

OR
- effect or continue an insured's coverage if it should not be in effect or continue in effect.

ER-5

WHEN CAN THIS POLICY OR A PLAN UNDER THIS POLICY BE CANCELED?

This policy or a plan under this policy can be canceled:
- by us; or
- by you.

We may cancel or offer to modify this policy or a plan, with at least 31 days written notice, when:
- the employees pay all or a part of the cost of their coverage and less than 75% of the employees eligible for coverage are participating in a plan
- you are paying the full cost of coverage and less than 100% of the employees eligible for coverage are participating in a plan
- you do not promptly provide us with information that we need
- this policy has been in effect more than 12 months
- you fail to perform any of your obligations that relate to this policy
- fewer than 10 employees are insured for coverage under this policy or a plan
- you fail to pay any premium within the 31 day grace period

Plan means a line of coverage under this policy.

Grace period means the period of time following the premium due date, except for the first premium, during which premium payment may be made.

If you do not pay the premium during the grace period, this policy or plan will terminate automatically on the last day for which premium was paid. You are responsible for paying premium for coverage in effect during the grace period. You must pay us all premium due for the full period each plan is in effect.

We reserve the right to review and terminate all classes covered under a plan if any class(es) cease(s) to be covered.

You may cancel this policy or a plan by giving us written notice at least 31 days before you intend the policy or plan to end. Cancellation can occur on an earlier date, if we agree. If this policy or a plan is canceled, the cancellation will not affect a payable claim.

Payable claim means a claim for which we are liable under the terms of this policy.

If this policy or a plan is canceled, coverage will end at 12:01 a.m. on the last day of coverage.

CAN A PLAN BE CHANGED?

You must give us advance notice of a request to change a plan.

WHAT IF STATUTES IN THE STATE OF POLICY ISSUE CHANGE?

Any provision of this policy which, on or after the policy effective date, conflicts with the statutes of the state of policy issue or any federal statutes, is hereby amended to comply with the minimum requirements of such statute.

CAN THE VALIDITY OF THIS POLICY BE DISPUTED?

The validity of this policy shall not be disputed after the policy has been in effect for two years from the policy effective date, except in situations when:

- premium has not been paid;

OR

- for fraudulent misrepresentations.

Disputing the validity of this policy shall be prohibited if statements made by the applicant in applying for this policy do not appear in a written document signed by the person making the statement. A copy of the written document must be given to the person making the statement.

ER-7

GROUP SHORT TERM AND LONG TERM DISABILITY INSURANCE

CERTIFICATE OF COVERAGE

Policy Number: [100000]

[The Insurance Company Name] (referred to as “the Company”, "we", "us", or "our") welcomes your employer as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Your certificate of coverage is written in plain English. There are a few terms and provisions written as required by insurance law. If you have any questions about any of the terms and provisions, please consult our claims paying office. We will assist you in understanding your benefits.

If the terms and provisions of the certificate of coverage (issued to you) differ from the policy (issued to the Policyholder), the policy will govern. Your coverage may be canceled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of [Insert policy situs state] and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, we have discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:00 midnight and end at 12:01 a.m. at the policyholder's address.

C-1

TABLE OF CONTENTS

Your certificate is divided into the following sections:

For your ease in finding information in your certificate, we:

- Start each section with a summary of the contents and the terms we define in the section.
- Shade all of the defined terms within a section.

SECTION 1: HIGHLIGHTS OF YOUR STD PLAN

This is a brief overview of your plan of benefits. We refer to these terms often throughout this certificate. Whenever we use these terms in the certificate they have the following meaning, unless we advise you otherwise.

Eligible Class = All full-time employees.

You must be working at least 30 hours per week.

Benefit Percentage = 60% of predisability earnings

Maximum Payment Amount = $1,000 *

*We may reduce the amount we pay you by other income amounts and any income you earn or receive from any form of employment. Some disabilities may not be covered under this plan. A pre-existing conditions exclusion and other limitations may apply to the STD plan.

Elimination Period = if disability is due to an injury or sickness: the later of 14 days, the date your salary continuation ends, or the date accumulated sick leave ends.

Pre-disability earnings means your gross weekly rate of earnings from the employer in effect just prior to the date disability begins. It includes earnings from commissions, but not bonuses, overtime pay or other extra compensation. Commissions received will be averaged for the lesser of:
1. the 52 week period of employment just prior to the date disability begins;
OR
2. the period of employment.

If your disability begins while you are on a covered layoff or leave of absence, we will use your pre-disability earnings from the employer in effect just before the date your absence begins.

Our payments to you will be based on the amount of your pre-disability earnings covered by this plan and for which premium has been paid.

EE-1S-1 Rev 10/05

SECTION 1: HIGHLIGHTS OF YOUR STD PLAN (continued)

Maximum Payment Duration = 26 weeks

Waiting Period:

If you are in an eligible class on or before the plan effective date: None
If you are entering an eligible class after the plan effective date: 30 days

If your employment ends and you are rehired by the same employer within 1 year, we will apply your previous employment in an eligible class toward completing the waiting period. All other provisions of this plan apply.

Cost of Coverage:

The employer pays the cost of your coverage.

The cost of your coverage must be paid for any period of time during which you are disabled under this plan.

SUMMARY OF THE GENERAL INFORMATION SECTION 2

What will you find in this section?

- information we have access to
- how we use statements made in applying for coverage
- insurance fraud
- time limits for legal proceedings

What terms do we define in this section?

- you
- we
- us
- our
- employee
- employer
- insured
- plan

EE-2-Summary

SECTION 2: GENERAL INFORMATION

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by us and may include attachments. It tells you:

- the coverage to which you may be entitled
- to whom we make payments

AND

- the limitations, exclusions and requirements applying to a plan.

You means an employee who is eligible for the coverage of this plan.

We, us and our means the Insurance Company named on the first page of your Certificate of Coverage.

Employee means a person who is a citizen or permanent resident of the United States or Canada in active employment with the employer unless we advise you otherwise. This plan excludes temporary and seasonal workers from coverage.

Employer means individual, company or corporation where you are in active employment, and includes any division, subsidiary or affiliated company named in the policy.

Insured means a person covered under this plan.

Plan means a line of coverage under the policy.

EE-2-1 Rev 5/98

TO WHAT INFORMATION DO WE HAVE ACCESS?

The employer will give us information about you including:

- if you are eligible for coverage
- if your amount of coverage changes, including salary change information
- if your coverage terminates
- other information we may reasonably require.

The employer's records that we believe have a bearing on coverage under this plan are open for our inspection at any reasonable time.

Clerical error or omission will not:

- prevent you from receiving coverage
- affect the amount of your coverage

OR

- effect or continue your coverage if it should not be in effect or continue in effect.

HOW CAN WE USE STATEMENTS YOU OR THE EMPLOYER MADE IN APPLYING FOR COVERAGE?

We consider any statements you or the employer made in a signed application for coverage a representation and not a warranty. If any of the statements you or the employer made are not complete and/or not true at the time they were made, we can:

- reduce or deny any claim

OR

- cancel your coverage back to the date your coverage became effective.

We will use only statements made in a signed application as a basis for doing this. You will receive a copy of the signed application.

SECTION 2: GENERAL INFORMATION
(Continued)

HOW WILL WE HANDLE INSURANCE FRAUD?

We promise to focus on all means necessary to support fraud detection, investigation, and prosecution. It is a crime if you or the employer knowingly, and with intent to injure, defraud or deceive us, file a claim containing any false, incomplete or misleading information. These actions, as well as submission of false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

WHAT IF FACTS ABOUT YOU ARE NOT ACCURATE?

If relevant facts about you were not accurate, then we will use accurate information to decide if your coverage should be in effect and what your amount of coverage should be. If the cost of your coverage is affected, we will make a fair adjustment in the cost.

DOES THE EMPLOYER ACT AS YOUR AGENT?

For all purposes of the policy, the employer acts on its own behalf or as your agent. The employer is not our agent.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You can start legal action regarding your claim 60 days after the date you sent us proof of claim. You have up to three years after the date you sent us proof of claim to start legal action, unless otherwise provided by law.

DOES THIS PLAN REPLACE OR AFFECT ANY REQUIREMENT FOR WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The plan does not replace or affect requirements for coverage by Workers' Compensation Insurance or state disability insurance.

EE-2-3

SUMMARY OF THE ELIGIBILITY FOR COVERAGE SECTION 3

What will you find in this section?

- eligibility for coverage
- waiting period
- when coverage becomes effective
- evidence of insurability requirements
- what happens to coverage during a lay-off, leave of absence or a family or medical leave of absence
- when coverage under this plan ends

What terms do we define in this section?

- waiting period
- active employment
- work site
- evidence of insurability
- layoff
- leave of absence
- family or medical leave of absence

EE-3-Summary

SECTION 3: ELIGIBILITY FOR COVERAGE

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are in an eligible class you may apply for coverage under this plan on the later of:

- the date the plan is effective

OR

- the date you complete the waiting period.

WHAT IS YOUR WAITING PERIOD?

Your waiting period appears in the PLAN HIGHLIGHTS.

Waiting period is the number of days you must be in active employment in an eligible class before you may apply for coverage.

If you have been continuously employed by the employer but were not in an eligible class, we will apply any prior period of work with the employer toward the waiting period.

Active employment means you are:

- **working for the employer at your work site for earnings the employer pays on a regular basis;**

AND

- **performing the material and substantial duties of your regular occupation.**

Active employment includes normal non-work days such as vacation, weekends and holidays.

Your work site must be:

- **the employer's usual place of business;**
- **an alternative location if directed by the employer;**

OR

- **a location to which your occupation requires you to travel.**

EE-3-1

WHEN DOES YOUR COVERAGE BECOME EFFECTIVE?

Your coverage will be effective on the day determined as follows:

If you apply for coverage within the first 31 days after the date you are first eligible to apply AND

-you are paying for some or all of the cost of your coverage	THEN	your coverage is effective on the date you apply.
OR		
-you are not paying for any of the cost of your coverage	THEN	your coverage is effective on the date you are eligible.

SECTION 3: ELIGIBILITY FOR COVERAGE (continued)

WHEN IS EVIDENCE OF INSURABILITY REQUIRED?

You will need to provide evidence of insurability to us with your application if you:

- apply for coverage more than 31 days after the date you are first eligible to apply;

OR

- voluntarily terminate your coverage and want to reapply for coverage;

OR

- apply for an amount of coverage for which we require proof of insurability.

You must apply for coverage in writing through the employer and use an application form that is satisfactory to us. Your coverage will be effective on the date we approve your application.

> **Evidence of insurability means a statement of your medical history which we will use to assess if you will be approved for coverage.**

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT ON THE DATE YOUR COVERAGE WOULD BE EFFECTIVE?

If you are not in active employment as a result of your injury or a sickness then your coverage will be effective on the date you return to active employment. This applies to your initial coverage, as well as any increases or additions to coverage occurring after your initial coverage is effective.

WILL YOUR COVERAGE CONTINUE IF YOU ARE ON A LAY-OFF OR LEAVE OF ABSENCE?

Your employer may continue your coverage if you are on a lay-off or on an approved leave of absence. Your coverage may continue through the end of the month following the month in which your layoff or leave of absence begins. The cost of your coverage must be paid during the layoff or leave of absence period.

> **Layoff or leave of absence means the employer has agreed in writing and in advance to a temporary absence from active employment for a specified period of time. Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.**

WHAT HAPPENS TO YOUR COVERAGE IF YOU ARE ON A FAMILY OR MEDICAL LEAVE OF ABSENCE?

If you are on a family or medical leave of absence, your coverage will be governed by the employer's Human Resource policy on family and medical leaves of absence.

We will continue your coverage if the following conditions are met:

- premiums for the cost of your continued coverage are paid;

AND

- your leave is approved in advance and in writing by the employer.

Your coverage will continue for up to the greater of:

- the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments;

OR

- the leave period required by applicable state law.

While you are on an approved family or medical leave of absence, we will use earnings from your regular occupation you were performing just prior to the date your leave of absence started to determine our payments to you.

If your coverage does not continue during a family or medical leave of absence, then when you return to active employment:

- you will not have to meet a new waiting period, including a waiting period for coverage of a pre-existing condition;

AND

- you will not have to give us evidence of insurability to reinstate the coverage you had in effect before your leave began.

Family and medical leave of absence means a leave of absence for the birth, adoption or foster care of a child, or for the care of your child, spouse or parent who has a serious health condition as those terms are defined by the Federal Family and Medical Leave Act of 1993 and any amendments, or by applicable state law.

WHEN DOES YOUR COVERAGE UNDER THIS PLAN END?

Your coverage under this plan will end on the earliest of the following:

- the date the policy or plan terminates
- the date you are no longer in an eligible class
- the date your class is no longer eligible for coverage
- the last day for which premium for your coverage has been paid
- the date you cease active employment due to a labor dispute, including but not limited to strike, work slowdown, or lockout
- the date you cease active employment with the employer, unless you are disabled or on an approved layoff or leave of absence.

We will provide coverage for a payable disability claim that occurs while you are covered under the policy or plan.

SUMMARY OF THE SHORT TERM DISABILITY BENEFIT SPECIFICS SECTION 4

What will you find in this section?

- what disability means
- when weekly payments start
- returning to work during the elimination period
- requirements of care from a doctor
- when will we not cover a disability
- our payment if you are disabled and not working
- our payment if you are disabled and working
- what are (are not) other income amounts
- cost of living increases to any other income amounts
- when weekly payments stop
- temporary recovery

What terms do we define in this section?

- disability
- material and substantial duties
- reasonable employment option
- own job
- sickness
- injury
- elimination period
- regular care
- doctor
- maximum weekly payment
- gross weekly payment
- maximum capacity
- retirement plan
- disability benefits under a retirement plan
- retirement benefits under a retirement plan
- eligible retirement plan
- maximum payment duration

EE-4S-Summary Rev 10/05

SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS

Disabled/Disability means our determination that your sickness or injury:

- **prevents you from performing with reasonable continuity the material and substantial duties of your own job and a reasonable employment option offered to you by the employer; and**
- **as a result, the income you are able to earn is less than or equal to 80% of your pre-disability earnings.**

Material and substantial duties are the duties that:

- **are normally required for the performance of the occupation;**

AND

- **cannot be reasonably omitted or changed.**

Extended own job w/residual
EE-4S-1.4 rev 10/05

Own job means the specific job you were regularly performing for the employer immediately prior to the date you became disabled, as evidenced by employer documents including, but not limited to, a job description, performance reports, and/or management reports, and which was the source of your income from the employer.

Reasonable employment option means an employment position with the employer for which you are able to perform the material and substantial duties given your education, training and experience. If you have been working in a reasonable employment option for 6 months or more, the reasonable employment option will then be considered your own job.

Sickness means an illness or disease. It also includes an injury which occurs before you are insured. It does not include risk of sickness. This plan does not cover an occupational sickness.

Injury means a bodily injury that occurs while you are insured and is the direct result of an accident and not related to any other cause. It does not include risk of injury. This plan does not cover an occupational injury.

Occupational sickness or occupational injury means a sickness or injury caused by or aggravated by any employment for pay or profit.

Related Rules:

You will not be considered disabled from work in an occupation because of a reduction in your earnings resulting from a change in economic conditions or other factors that are not directly related to your sickness or injury. Examples of factors that we will not consider in determining whether you are disabled include, but are not limited to, recession, job obsolescence, job restructuring or elimination, pay cuts, and job sharing.

You will not be considered disabled from work in an occupation solely because of:

1. Your employer's work schedule that is inconsistent with the normal work schedule of your regular occupation;
2. Your relationship with your employer or other employees of the employer; or
3. The physical relationship of your employer's workplace that is inconsistent with the normal physical environment of your regular occupation.

You will not be considered disabled from work in an occupation solely because of the loss, suspension, restriction, surrender, or failure to maintain a required state or federal license to engage in the occupation.

You will not be considered disabled from work in an occupation solely because of your inability to work more than 40 hours per week in the occupation, even if you were regularly required to work more than 40 hours per week prior to becoming disabled.

Your disability must begin while you are covered under the policy.

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EE-4S-2.2 Rev 10/05

SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS (continued)

DOES YOUR DISABILITY NEED TO CONTINUE FOR A PERIOD OF TIME BEFORE OUR PAYMENTS TO YOU BEGIN?

Your disability must continue through the elimination period before we begin making payments to you.

Elimination period is a period of continuous days of disability. The elimination period begins on the first day of your disability.

WHAT HAPPENS IF YOU RETURN TO WORK DURING THE ELIMINATION PERIOD?

We will consider your disability continuous if you have one or more periods of temporary recovery during the elimination period for a maximum of 30 days AND become disabled again due to the same sickness or injury.

Temporary recovery means any time when we do not consider you to be disabled. The days you are not disabled will not count toward the elimination period.

HOW CAN WE ASSIST YOU IN RETURNING TO WORK?

Other vocational rehabilitation services and workplace modification services may be available to you. These services are designed to coordinate with your LTD plan and can be found in the ADDITIONS TO YOUR LTD PLAN section.

acc of ep = 30 days

EE-4S-3 Rev 10/05

DO YOU NEED TO BE UNDER THE CARE OF A DOCTOR?

We require you to be under the regular care of a doctor for the sickness or injury causing your disability in order to be eligible to receive payments from us.

Regular care means:

- **you personally visit a doctor as often as is medically required to effectively manage and treat your disabling condition(s), according to generally accepted medical standards;**

AND

- **you are receiving appropriate treatment and care, according to generally accepted medical standards. Treatment and care for the sickness or injury causing your disability must be given by a doctor whose specialty or experience is appropriate.**

Doctor means a person:

- **regularly performing tasks that are within the limits of the person's medical license**
  AND
  who is licensed to practice medicine and prescribe and administer drugs or to perform surgery;
- **with a doctoral degree in Psychology (Ph.D. or Psy.D.) and whose primary practice is treating patients;**
- **who is a legally qualified medical practitioner according to the laws and regulations of the jurisdiction in which regular care is being given.**

We will not recognize you, your spouse, children, parents, or siblings as a doctor for a claim you submit.

MAY WE REQUIRE YOU TO BE EXAMINED OR INTERVIEWED BY INDIVIDUALS OTHER THAN THE DOCTOR PROVIDING REGULAR CARE?

We may require you to be examined by doctor(s), other medical practitioner(s) or vocational expert(s) of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so. In addition, we may require an interview with you by an authorized representative of ours.

WHEN WILL WE NOT COVER A DISABILITY?

We will not cover a disability if it is due to:

- war, declared or not, or any act of war;
- intentionally self-inflicted injuries or illness, while sane or insane;
- your active participation in a riot;
- your attempt to commit or your commission of a felony under federal or state law, or your being engaged in an illegal occupation;
- an injury arising out of, or in the course of, any work for wage or profit;
- a sickness for which you are entitled to benefits under any Workers' Compensation Act, Occupational disease law, Compulsory Benefit Act or law or similar law, unless you are a partner or sole proprietor not covered by any of these acts or laws.
- your service in the armed forces, military reserves or National Guard of any country or International authority, or in a civilian unit serving with such forces;
- cosmetic or reconstructive surgery, except for complications arising from any such surgery or for surgery necessary to correct a deformity caused by accidental injury or sickness;
- an accident resulting from or caused by your operation of a motor vehicle while intoxicated according to the laws of the jurisdiction where the accident occurred; or
- an accident resulting from or caused by your being under the influence of drugs or any controlled substance, unless taken as prescribed by your doctor.

No benefits are payable for any period of disability during which you are incarcerated in a penal or correctional facility for a period of 30 or more consecutive days or for which you are not under the regular care of a doctor.

If your professional or occupational license or your certification is suspended, revoked or surrendered, loss of your license or certification, by itself, does not mean you are disabled.

non-occ

EE-4S-5.1 Rev 10/05

SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS (continued)

HOW MUCH WILL OUR WEEKLY PAYMENT TO YOU BE IF YOU ARE DISABLED AND NOT WORKING OR DISABLED AND WORKING, EARNING LESS THAN 20% OF YOUR PRE-DISABILITY EARNINGS?

Our payment will be figured by using the following Steps 1 through 4:

Step 1: Multiply your weekly pre-disability earnings by the benefit percentage.
Step 2: Compare this amount to the maximum weekly payment for this plan.
Step 3: Take the lesser of the amounts from Steps 1 and 2. This is your gross weekly payment.
Step 4: Subtract from the gross weekly payment any other income amounts, except any income you earn or receive from any form of employment or income you could have earned from working to maximum capacity. This is the payment that you may receive.

HOW MUCH WILL OUR WEEKLY PAYMENT BE IF YOU ARE DISABLED AND WORKING, EARNING BETWEEN 20% AND 80% OF YOUR PRE-DISABILITY EARNINGS?

Our payment will be figured by using the following Steps 1 through 4:

Step 1: Multiply your weekly pre-disability earnings by the benefit percentage.
Step 2: From 100% of your weekly pre-disability earnings subtract any other income amounts, including any income you earn or receive from any form of employment or income you could have earned from working to maximum capacity.
Step 3: Compare the results from Steps 1 and 2 with the maximum weekly payment for this plan.
Step 4: The payment you may receive is the lesser of the amounts from Step 3.

Your loss of earnings must be as a result of or due to the same sickness or injury for which you are disabled.

IF YOU ARE DISABLED AND WORKING, EARNING MORE THAN 80% OF YOUR PRE-DISABILITY EARNINGS, THEN NO PAYMENT WILL BE MADE.

WHAT IF YOUR CURRENT INCOME FLUCTUATES?

If your current income fluctuates, we may average amounts over a four (4) consecutive week period of time.

EE-4S-6 Rev 10/05

Maximum weekly payment means the maximum weekly amount for which you are insured under this plan.

Gross weekly payment means the weekly payment amount before we subtract other income amounts.

Your pre-disability earnings, benefit percentage, and maximum weekly payment appear in the PLAN HIGHLIGHTS.

WHAT IF YOU ARE DISABLED FOR ONLY PART OF A WEEK?

Your weekly payment from us is pro-rated. This means that if you are disabled for only part of a week, you will receive a payment equal to 1/7th of a full weekly payment for each day of the week you are disabled.

SECTION 4: SHORT TERM DISABILITY BENEFIT SPECIFICS (continued)

WHAT ARE OTHER INCOME AMOUNTS?

These are amounts, other than payments you are receiving from us, that include:

1. any benefits and awards you receive or are eligible to receive under:
   a. Workers' Compensation Law
   b. occupational disease law
   c. any other similar act or law

2. any disability income benefits you receive or are eligible to receive under:
   a. any compulsory benefit act or law
   b. any other group insurance plan with the employer or with an association
   c. any other group insurance plan with another employer which you become insured under while you are disabled under this plan
   d. any governmental retirement system as a result of your job with the employer

3. any benefits under the United States Social Security Act, The Canada Pension Plan, The Quebec Pension Plan and includes any similar plan or act. Benefits include:
   a. disability benefits you, your spouse, or your children receive or are eligible to receive as a result of your disability.
   b. retirement benefits you receive, your spouse or your children receive as a result of your receipt of retirement benefits.

   If your disability begins after your 70th birthday, and you were receiving Social Security retirement benefits before your disability began, then we will not reduce our payments to you by these retirement benefits.

4. any benefits you receive from the employer's sick leave or formal salary continuation plan.

5. any income you earn or receive from any form of employment, including any income you could have earned while disabled by working to your maximum capacity, but you do not do so. We may require you to send us proof of your income. We will adjust our payments to you based on this information. As a part of the proof, we can require you to send us appropriate tax and financial records we believe we need to substantiate your income.

   Maximum capacity means, based on the limiting factors of your identified sickness or injury, the greatest extent of work you are able to do in an occupation from which you must be considered disabled in order to receive disability benefits.

Primary/Family

EE-4S-8.1 Rev 10/05

6. any benefits from the employer's retirement plan you:
   a. receive as disability benefits
   b. voluntarily choose to receive as retirement benefits
   c. receive as retirement benefits once you reach the greater of age 62 or normal retirement age (as defined in the employer's retirement plan).

   Regardless of how the retirement funds from the plan are distributed, for the purposes of figuring our payment to you, we consider employee and employer contributions to be distributed at the same time throughout your lifetime.

   This plan does not reduce payments you receive from us for your contributions to the employer's retirement plan, or for amounts you roll over or transfer to an eligible retirement plan.

   Retirement plan is a defined contribution plan or defined benefit plan. These are plans that provide retirement benefits to employees and are not funded entirely by employee contributions.

   Disability benefits under a retirement plan are benefits that are paid due to disability and which do not reduce the retirement benefit that would have been paid if the disability had not occurred.

   Retirement benefits under a retirement plan are benefits that are paid based on the employer's contribution to the retirement plan. Disability benefits that reduce the retirement benefit under the plan will also be considered a retirement benefit.

   Eligible retirement plan is defined in §402 of the Internal Revenue Code of 1986 and includes future amendments to §402 affecting the definition.

7. any benefits for loss of time or lost wages you receive from the mandatory portion of a no-fault motor vehicle insurance plan, or automobile liability insurance policy.

8. any amounts you receive under any unemployment compensation law.

9. any amounts you receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

EE-4S-9 Rev 6/96

If you receive any of the other income amounts in a lump sum payment, we will pro-rate the lump sum on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of your maximum payment duration.

Other income amounts must be payable as a result of the same disability for which you are receiving a payment from us, except for retirement benefits and any income you earn or receive from any form of employment.

DO WE HAVE THE RIGHT TO ESTIMATE OTHER INCOME AMOUNTS?

We have the right to estimate the amount of benefits you may be eligible to receive under Other Income Amounts, items 1, 2 and 3a. We can reduce our payments to you by this estimated amount if:

- you have not been awarded such benefits but have not been denied such benefits;

OR

- you have been denied such benefits and the denial is being appealed;

OR

- you are reapplying for such benefits.

We will not reduce our payments to you by these estimated amounts if:

- you apply (or reapply) for benefits and appeal your denial through all of the administrative levels we believe are necessary;

AND

- you sign our payment option form stating you promise to pay back to us any overpayment of benefits caused by an award.

If we reduce our payments to you by an estimated amount:

- then we will adjust our payments to you when you give us proof of the amount awarded;

OR

- we will give you a lump sum refund of the estimated amount if you were denied benefits and have completed all appeals (or reapplications) we believe are necessary.]

EE-4S-10 Rev. 6/96

WHAT ARE NOT OTHER INCOME AMOUNTS?

We will not subtract from our payments to you any amounts you receive from the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- credit disability insurance
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and military disability income plans
- a retirement plan from another employer
- individual retirement accounts (IRA)
- informal salary continuation plan
- benefits from individual disability plans

WHAT HAPPENS IF YOU RECEIVE A COST OF LIVING INCREASE TO ANY OF THE OTHER INCOME AMOUNTS?

Other than for increases in income you earn or receive from any form of employment, once we have subtracted an other income amount from your gross disability payment, we will not further reduce our payments to you due to a cost of living increase in any other income amount.

WHEN WILL OUR PAYMENTS TO YOU STOP?

We will stop payments on the earliest of the following dates:

- the date you are no longer disabled according to this plan;
- the date you reach the end of the maximum payment duration;

  Maximum payment duration means the period of time during which we will send you a weekly payment. Your maximum payment duration appears in the PLAN HIGHLIGHTS.
- the date your current income exceeds 80% of your pre-disability earnings. If your current income fluctuates, we may average amounts over a four (4) consecutive week period of time instead of stopping our payments on the date your current income reaches 80% of your pre-disability earnings;
- the date you die;
- the date you fail to provide proof of continuing disability;
- the date you refuse to participate in an approved rehabilitation program;
- the date you complete the elimination period of any Group Long Term Disability plan provided by the employer;
- the date you cease to be under the regular care of a doctor, or refuse to undergo, at our expense, an examination or testing by a doctor or vocational, rehabilitation, or health assessment testing when we require such examination or testing;
- the date you refuse to receive medical treatment, including taking prescribed medicines, that your doctor has recommended and that is generally acknowledged by doctors to cure or improve the sickness or injury for which you are claiming benefits under the policy so as to reduce its disabling effect;
- the date you refuse to make a good faith effort to adhere to necessary wellness programs that your doctor has recommended and that are generally acknowledged by doctors to cure or improve the sickness or injury for which you are claiming benefits under the policy so as to reduce its disabling effect. We will work with your treating doctor to determine the necessary wellness programs, if any, in accordance with generally accepted medical standards.

  We will give you 30 days prior written notice of our intent to apply this provision to terminate benefits. During those 30 days you will have an opportunity to begin or resume reasonable efforts to adhere to the medically necessary Wellness Programs. We will not terminate benefits if there is no reasonable basis for believing that you will be able to return to productive employment in your regular occupation or another gainful occupation on a full-time or part-time basis if you adhere to the recommended wellness programs.

  Wellness programs include, but are not limited to, appropriate programs for dietary and nutritional improvement, weight management, smoking cessation, abstention from the excessive or illegal use of alcohol or narcotics, regular participation in exercise activities, stress management, pain management, behavioral therapy, coaching, and the regular taking of prescribed medications;
- The date you refuse to try or attempt to work with the assistance of:
  1. modifications made to your work environment, functional job elements or work schedule; or
  2. adaptive equipment or devices,

  that a qualified doctor has indicated will accommodate the limiting factors of the sickness or injury for which you are claiming benefits under the policy and will enable you to perform the material and substantial duties of an occupation from which you must be considered disabled in order to receive disability benefits;
- If you are considered to reside outside the United States or Canada. You will be considered to reside outside of these countries if you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of disability benefits.

WHAT HAPPENS IF YOU HAVE A TEMPORARY RECOVERY BUT YOU BECOME DISABLED AGAIN DUE TO THE SAME INJURY OR SICKNESS AS A PRIOR DISABILITY?

If you return to work, earning more than 80% of your pre-disability earnings, and the same sickness or injury causes your disability to occur again within six months of the date the prior disability ended, we will resume our payments to you if you were continuously insured under the plan for the period of your temporary recovery. You will not need to complete a new elimination period for this disability.

Your current period of disability will be subject to the same terms of the plan that applied to your prior period of disability.

If you become entitled to payments under any other group short term disability plan (including a plan with the employer that became effective after your disability began), you will not be eligible for payments under this plan.

A disability due to other causes will be treated as a new disability and will be subject to all of the provisions of this plan.

EE-4S-13 Rev 3/99

SUMMARY OF THE CLAIM INFORMATION SECTION 5

What will you find in this section?

- notifying us of a claim
- giving us proof of claim
- filing a claim
- information needed in the proof of claim
- when payments to you begin
- who we make payments to

EE-5-Summary

SECTION 5: CLAIM INFORMATION

WHEN DO YOU NOTIFY US OF A CLAIM?

You need to notify us in writing of your claim within 30 days prior to the end of the elimination period. If you are not able to notify us within this time, then you need to notify us as soon as reasonably possible. Notice includes a notice you give, or which is given on your behalf, to us at our home office, or to an authorized agent of ours.

WHEN DO YOU NEED TO GIVE US PROOF OF YOUR CLAIM?

Early proof of claim will allow us to make a timely claim decision. You need to send to our home office written proof (or telephonic or electronic proof, if we have agreed to accept such forms) of your claim within the first 90 days after the elimination period ends. If you are unable to give us proof of your claim within this time, then you must give us proof of your claim within the next 12 months. If you do not have the legal capacity to make responsible decisions concerning yourself, then you may give us proof of your claim after this period.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE A CLAIM?

You can get a claim form from the employer, or you may ask us for a form. If you ask us for a claim form, but you do not receive the form from us within 15 days after asking for it, then you should send written proof (or telephonic or electronic proof, if we have agreed to accept such forms)] of your claim to us without waiting for the form.

You and the employer must fill out your claim form. Once you and the employer have completed the claim form, give the claim form to the doctor providing you regular care for your sickness or injury causing disability. The doctor must fill out the physician section of the form. Send the completed form to us or, if we have agreed to accept proof of your claim in a telephonic or electronic format, you may start the process by contacting us at [1-800-xxx-xxxx] within the stated timeframes.
.

WHAT AUTHORITY DO WE HAVE IN DETERMINING YOUR ELIGIBILITY FOR BENEFITS?

We have the discretionary authority to determine your eligibility for benefits and to construe the terms of the policy to make a benefits determination.

WHAT INFORMATION DO YOU NEED TO INCLUDE IN YOUR PROOF OF CLAIM?

Your proof of claim must include:

- that you are under the regular care of a doctor
- the date your disability began
- the cause of your disability as determined by objective medical tests and examinations acceptable to the medical community
- the extent of your disability, including restrictions and limitations which prevent you from performing your regular occupation
- the name and address of all hospital(s) or institution(s) where you received treatment, including all doctors who provided regular care
- appropriate documentation of your earnings

We may request that you send proof of continuing disability indicating that you are under the regular care of a doctor. We must receive this proof within 30 days of the date we ask for it. In some cases, we will require you to give us authorization to obtain additional medical and non-medical information as part of your proof of claim. We may temporarily suspend our payments to you if you do not cooperate, or do not submit the appropriate information.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

Once we approve your claim, you will begin to receive payments after you complete the elimination period. We will send you a payment for any period for which we are liable. If the policy or a plan is canceled, the cancellation will not affect a payable claim.

WHO DO WE MAKE PAYMENTS TO?

We will make all payments to you.

WHAT HAPPENS IF WE OVERPAY YOUR CLAIM?

We have the right to recover overpayments due to:

- fraud;
- an error we make in processing your claim;
- your receipt of other income amounts.

If we determine that we overpaid your claim, then we require you repay us in full. We will determine the method by which you will repay us. We reserve the right to apply our future payments to you toward overpayments. We have the right to recover overpayments from your eligible survivors or estate. We will not recover more money from you than the amount we paid to you.

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Mailing Address:
Symetra Life Insurance Company
Group Division
PO Box 34690
Seattle, WA 98124-1690

DISABILITY INCOME INSURANCE ENROLLMENT FORM

TO BE COMPLETED BY THE EMPLOYER

POLICY # _____

EMPLOYER/POLICYHOLDER NAME: _____

STREET ADDRESS | **CITY** | **STATE** | **ZIP CODE**

EMPLOYEE OCCUPATION/JOB TITLE | **EMPLOYEE DATE OF EMPLOYMENT**

EFFECTIVE DATE OF COVERAGE | **FULL OR PART TIME EMPLOYEE**

$ _____ **/** ☐ **HR** ☐ **WK** ☐ **MO** ☐ **YR**
BASIC EARNINGS | **CLASS NUMBER (IF APPLICABLE)**

I. EMPLOYEE INFORMATION

NAME _____ **SEX** ☐ **M** ☐ **F**

STREET ADDRESS | **CITY** | **STATE** | **ZIP CODE**

HOME TELEPHONE NUMBER | **DATE OF BIRTH** | **MARITAL STATUS**

II. BENEFITS: PLEASE CHECK IF YOU WISH TO ENROLL AND INCLUDE BENEFIT AMOUNT

Short-Term Disability Income Insurance:	☐ YES	☐ NO	%	OR	$
Long-Term Disability Income Insurance:	☐ YES	☐ NO	%	OR	$
Voluntary Short-Term Disability Income Insurance:	☐ YES	☐ NO	%	OR	$
Voluntary Long-Term Disability Income Insurance:	☐ YES	☐ NO	%	OR	$
Other:	☐ YES	☐ NO	%	OR	$
Other:	☐ YES	☐ NO	%	OR	$
Other:	☐ YES	☐ NO	%	OR	$

III. SELECTION/WAIVER OF GROUP INSURANCE

I, the undersigned, an employee of the above-named policyholder, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance **(Not applicable if the [Employer] pays 100% of the required contribution).**

I hereby waive my right at this time to elect the insurance coverages which I did not select above. I understand that if I do not enroll within 31 days, when first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

All information submitted by me on this form to the best of my knowledge and belief is true and complete.

EMPLOYEE SIGNATURE _____ **DATE SIGNED** _____

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EVIDENCE OF INSURABILITY

Symetra Life Insurance Company ▪ Group Division ▪ 777 108th Avenue NE, Suite 1200 ▪ Bellevue, WA 98004-5135 ▪ www.symetra.com
Mailing Address: PO Box 34690 ▪ Seattle, WA 98124-1690 ▪ Phone 1-800-426-7784 ▪ TTY/TDD 1-800-833-6388

LGC-8741 10/06

DISCLOSURE NOTICE TO APPLICANTS FOR INSURANCE:

This brief description of our underwriting process is designed to help you to understand how an application for insurance is handled, the type and sources of information we may collect about you, the circumstances under which we may disclose that information to others and your right to learn the nature and substance of that information upon written request. Your medical history and current physical condition, which is obtained from various sources, are factors, which are considered in determining your insurability.

Sources of Information:
Your application, including the medical history, is a primary source of information in the evaluation process. We may also ask for a report from your doctor, hospital, pharmacy, or another insurance company. When we do so, we use the authorization form you sign with your application. It is sometimes necessary that we ask you to take a physical examination or other special tests such as an electrocardiogram and/or blood test.

Disclosure to Others:
Personal information obtained about you during the underwriting process is confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary for the conduct of our business. Examples of situations where we share information about you are as follows:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company would have access to our application file.
2. We may release information to another life insurance company to whom you have applied for life or health insurance or to whom you have submitted a claim for benefits, if you have authorized them to obtain this information.
3. We would disclose information to government regulatory officials, law enforcement authorities and others where required by law.

Employee's Copy

Disclosure to You:
If an adverse underwriting decision is made, we will notify you of the reason(s) for that decision and the source of the information upon which our action is based. Medical record information, however, will be given only to a licensed physician of your choice.

Symetra Life Insurance Company respects your right to the privacy of your personal information. This notice is provided to you to help you understand that information, which is obtained, is treated in a confidential manner. You have a right of access and correction with respect to all personal information collected. Upon written request, we will provide you with a more detailed description of our information practices and your rights of access and correction.

Click here to Clear Page

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Evidence of Insurability For Group Coverage

Group Policy No.

Company Name (Employer)

Company Address

City | State | ZIP

Name of Employee | Date of Hire

Job Title | Basic Annual Earnings

Home Address

City | State | ZIP

Home Phone ( ) _____ **Work Phone** ( ) _____

COVERAGES REQUESTED:

- ☐ Basic Employee Life (total) $ _____
- Basic Employee Life (in-force) $ _____
- ☐ Supplemental Trust Life (total) $ _____
- Supplemental Trust Life (in-force) $ _____
- ☐ Spouse Life (total) $ _____
- Spouse Life (in-force) $ _____
- ☐ Child Life $ _____
- ☐ Supplemental Life (total) $ _____
- Supplemental Life (in-force) $ _____
- ☐ Dependent Life $ _____
- ☐ Long Term Disability
- ☐ Short Term Disability
- ☐ Other: _____

HEALTH INFORMATION (INCLUDE ONLY THOSE INDIVIDUALS APPLYING FOR COVERAGE)

NAME	RELATION-SHIP	SEX	DATE OF BIRTH Mo/Day/Yr	STATE OF BIRTH	HT. Ft	HT. In	WT.	FULL NAME AND ADDRESS OF PERSONAL PHYSICIAN
1.	EMPLOYEE							
2.	SPOUSE							
3.								
4.								

The following health questions must be answered fully and truthfully to the best of your knowledge and belief. If any misstatements or omissions are made, they may be the basis for later rescission of your insurance coverage. Rescission voids your coverage and claims will not be paid.

1. Are any applicants pregnant? ☐ Yes* ☐ No
   ***If yes, please give details on the next page including due date.**
2. Are any applicants currently taking any medication? ☐ Yes* ☐ No
   ***If yes, please give details on the next page.**
3. In the past ten years, or as indicated below, have any of the applicants been treated for, or been diagnosed by a member of the medical profession as having any of the following: ☐ Yes* ☐ No
   ***If yes, please indicate condition and provide details on the next page.**

a) ____ Heart Disorder, Chest Pain, Circulatory Disorder
b) ____ High Blood Pressure
c) ____ Mental & Nervous Disorder, Depression
d) ____ Alcoholism and/or Drug Habits
e) ____ Stomach, Abdominal, Intestinal Disorder
f) ____ Brain or Nervous System Disorder
g) ____ Stroke, Paralysis
h) ____ Cancer, Tumors
i) ____ Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection/Disease, or tested Positive to the AIDS virus (HIV)
j) ____ Abnormal Physical Exam, Lab or X-ray. (5 years)
k) ____ Reproductive Organ Disorder
l) ____ Sexually Transmitted Disease
m) ____ Kidney Disorder
n) ____ Liver Disorder
o) ____ Gland Disorder
p) ____ Diabetes
q) ____ Developmental Disorder
r) ____ Birth Defect
s) ____ Epilepsy, Seizures
t) ____ Lungs, Respiratory Disorder
u) ____ Bone, Joint, Connective Tissue Disorder
v) ____ Accident or Injury
w) ____ Blood Disorder
x) ____ Infectious Diseases
y) ____ Back, Neck Pain, or Discomfort

4. Have you consulted, been advised or been examined by any healthcare provider for any other medical reason within the last ten years, or as indicated above? ***If yes, please indicate condition and provide details on the next page.**
   ☐ Yes* ☐ No

IMPORTANT: PLEASE SIGN AND DATE ON THE NEXT PAGE

HEALTH INFORMATION

Question # Or Letter	Name of Person	Details of Yes Answers	Onset Mo. Yr.	Duration	Degree of Recovery	Full Name and Full Address of Attending Physician

Please read the following notice that we are required by law to give you.

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

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.

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: 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.

WEST VIRGINIA: 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.

Signature of Employee:_____Print Name:_____Date:_____

Signature of Spouse:_____Print Name:_____Date:_____
(if applying)

SYMETRA FINANCIAL

Symetra Life Insurance Company
Group Benefits
PO Box 34690
Seattle, WA 98124-1690

Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.

Authorization for Release of Medical Information to Symetra Life Insurance Company

Group Life Policy Number: _____

Name of insured/patient (please type or print): _____ Date of birth: _____

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____

Signature of Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

LB-85 3/06