Voluntary Short-Term Disability Insurance

Why Short-Term Disability Insurance?

Short-term disability insurance works alongside your long-term disability insurance plan to cover you during the period of time before your long-term benefits kick in, generally 90 days or more. The first few months of an illness or injury that takes you out of work may be costly. How would you keep your family afloat during this period of time without a paycheck?

Disability insurance is paycheck insurance. The plan will pay you a percentage of your salary if you were to suffer a covered disability and unable to work. Disability benefits can help you pay your mortgage or rent, health insurance payments, college tuition and more.

What are your chances of needing disability insurance?

Unfortunately, your chances are higher than you may think. In fact, the risk of long-term disability during a worker's career is greater than the risk of premature death. Yet most workers would never think of going without life insurance protection for their families.[1]

- You have a 1 in 5 chance of becoming disabled between the ages of 35-65.
- You have a 1 in 7 chance of becoming disabled for at least five years before you turn 65.
- If you are age 30 right now, you have a 1 in 3 chance of having a long-term disability before you turn 60. At age 40, the odds are 3 to 10. At 50, it's less than 1 in 5.[2]

The question to ask yourself is: "Am I willing to take a risk with those odds?" Generally, people are not willing to take that risk, which is why they purchase disability insurance.

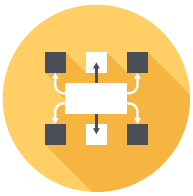
Voluntary Short-Term Disability Insurance

What causes disabilities?

Many think that accidents and injuries cause most disabilities. However, disability is more often caused by conditions such as arthritis, cancer, pregnancy and heart disease.[3]

Why purchase disability insurance through my employer?

This voluntary disability insurance plan is being offered through your employer so that you can purchase insurance at group rates instead of individual rates. The premium payments will be conveniently deducted from your paycheck.



Won't Social Security, Workers' Comp and other insurance plans cover me if I'm disabled?

- Health insurance only covers medical services and prescriptions, not income.
- Worker's Comp insurance provides benefits ONLY if a disability is a result of an on-the job accident, injury or occupational disease. Most disabilities are not job-related.
- Unemployment compensation is for those who are physically and mentally able to work.
- That leaves Social Security Disability Insurance (SSDI). However, only 30-35% of workers who apply for SSDI are approved the first time.[4]

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[1] Guide to Disability Income Insurance, America's Health Insurance Plans, 2013.

[2] www.protectyoubetter.org/Research-Center/Disability-Insurance.aspx

[3] Council for Disability Awareness, www.disabilitycanhappen.org

[4] Social Security Disability SSI Resource Center www.ssdrc.com/8-13.html

NATIONAL INSURANCE SERVICES
Corporate office: 250 South Executive Drive, Suite 300
Brookfield, WI 53005
ph: 800.627.3660/fx: 262.785.9269

©National Insurance Services of WI, Inc.

Insurance Benefit Enrollment Form

Return to: National Insurance Services, Attn: Billing Department
250 S. Executive Drive, Suite 300 Brookfield, WI 53005-4273
Phone 1.800.627.3660 Fax 262.785.9269

NATIONAL INSURANCE SERVICES

Enter your information:

Employer Name: City of Bloomington			NIS Group Number: 024839	
Full Name (Last name, First name, Middle Initial):			Date of Hire:	
Home Address:	City:		State:	Zip:
Social Security Number:	☐ Single ☐ Married	U.S. Citizen? ☐ Yes ☐ No*	Date of Birth:	☐ Male ☐ Female
Occupation/Title:			Hours worked per week:	Annual Salary:

*If you are not a U.S. Citizen, please provide a copy of your Visa.

Insurance benefits:

Optional Insurance Benefits:

☐ Elect ☐ Decline

Short-Term Disability Amount $_____ You may elect coverage in $100 increments not to exceed 60% of your income or $1,800 (whichever is less).

Election Amount cannot exceed 60% of annual salary divided by 52:

_____ / 52 = _____ x 60% = _____

(Annual Salary) (Weekly Salary) (Maximum Weekly Benefit – must round down to nearest $100)

TO CALCULATE YOUR PREMIUM:

_____ x _____ / 10 = _____

(My weekly Benefit Election) (Rate) (My Monthly Premium)

Short-Term Disability Rates

Age	Rate per $10 of Weekly Benefit	Age	Rate per $10 of Weekly Benefit
0-24	$0.54	45-49	$0.50
25-29	$0.51	50-54	$0.66
30-34	$0.41	55-59	$0.86
35-39	$0.42	60-64	$1.04
40-44	$0.46	65+	$1.28

Sign here (required whether electing or declining any coverage):

I have been given the opportunity to apply for group insurance and agree to accept or decline coverage(s) as noted above. If I am declining coverage(s), I understand that if my dependents or I decide to apply for coverage at a later date, Evidence of Insurability (medical questions) may be required at my own expense and the insurance company must approve coverage. If I have elected any coverage(s) above, I authorize my employer to make any required deductions, if any, from my salary to pay my portion of the insurance premium when my insurance becomes effective.

Warning: Any person who knowingly presents false information on an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Signature:	Date:

Instructions for the employee: Complete and return this form to your Benefits Administrator.

Instructions for the Benefits Administrator: Retain a copy of this form for your records and provide employee with a copy. Mail original to National Insurance Services at the address above.

Please note: Please fill out the attached "Evidence of Insurability" medical questionnaire form.

Helpful Hints When Filling Out Your "Evidence of Insurability" Application

In order to process your request for Life and or Disability Insurance you are required to complete the following application. Please use **blue or black ink** and make sure all questions are answered completely and fully. An incomplete document with missed answers will result in the application being returned to you and a delay in the processing of your request. **If you are requesting coverage for family members, complete an additional form for each person.**

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601
Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717

Evidence of Insurability

(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es): ☐ Life: $ ☐ Life/AD&D ☐ Supp. Li ☐ Long Term Disability ☐ AD&D: ☐ Short Term Disability ☐ AD&D: **Reason for Applying:** ☐ New Hire ☐ Late Enrollee ☐ Coverage amount ☐ Reinstatement ☐ Dependent(s) ☐ Applying for coverage over GI

Applicant's Name: Last, First, MI | **Sex:** ☐ M ☐ F | **Age:** | **Date of Birth:** / /

Height: | **Weight:** | **Applicant's Social Security No.** - - | **Already Enrolled?** ☐ Yes ☐ No

Applicant's Home Address: (Street, City, State, Zip) | **Applicant's Daytime Phone No.** ( )

Applicant's Current Physician's Name: | **Date Last Visited:** / / | **Reason for Visit:**

Physician's Address: (Street, City, State, Zip) | **Physician's Phone No.**

Employee Member Name: (if different than Applicant) | **Employee's Job Title:**

Employee's Date of Hire: | **No. of Hours Employee Works Per Week:** | **Employee's Annual Salary:** $

Employer Name: | **Employer's Address:** (Street, City, State, Zip)

HEALTH QUESTIONS
Check Yes or No, circle all applicable "Yes" disorders or procedures and give details below.

I. Are you currently pregnant? ☐ Yes ☐ No **If "Yes", what is your expect due date:**

II. In the past 5 years have you been diagnosed or treated by a medical professional for any of the following conditions?

A. HEART		**D. PAIN & DISCOMFORT**	
1. Heart ailment?	☐ Yes ☐ No	1. Arthritis, bursitis or gout?	☐ Yes ☐ No
2. Chest pain, angina or shortness of breath?	☐ Yes ☐ No	2. Recurrent back pain or slipped disk?	☐ Yes ☐ No
3. Irregular heart beat or heart murmur?	☐ Yes ☐ No	3. Disorder of the back, neck or spine?	☐ Yes ☐ No
4. Rheumatic fever?	☐ Yes ☐ No	4. Disorder of the muscles, bones or joints?	☐ Yes ☐ No
5. Disease or abnormality of heart muscle, nerves or vessels?	☐ Yes ☐ No	5. Temporomandibular joint (TMJ) Disorder?	☐ Yes ☐ No
6. Stress test; electrocardiogram or echocardiogram?	☐ Yes ☐ No	6. Recurrent abdominal pain?	☐ Yes ☐ No
B. TUMORS/CYSTS		**E. OTHER**	
1. Cancer of any type?	☐ Yes ☐ No	1. Stroke, seizure, disorder or epilepsy?	☐ Yes ☐ No
2. Tumors, cysts, or polyps?	☐ Yes ☐ No	2. Migraine or persistent headaches?	☐ Yes ☐ No
C. BLOOD AND URINE		3. Nervous/mental disorder, depression or anxiety?	☐ Yes ☐ No
1. High or low blood pressure or hypertension?	☐ Yes ☐ No	4. Dizziness or paralysis?	☐ Yes ☐ No
2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes?	☐ Yes ☐ No	5. Asthma, emphysema, breathing or lung disorder?	☐ Yes ☐ No
3. Disorder of kidneys or bladder or kidney stones?	☐ Yes ☐ No	6. Indigestion, ulcers or irritable bowel?	☐ Yes ☐ No
4. Diabetes, high or low blood sugar?	☐ Yes ☐ No	7. Chronic fatigue?	☐ Yes ☐ No
5. Protein, blood or sugar in urine?	☐ Yes ☐ No	8. Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No
6. Night sweats, persistent swollen glands or diarrhea?	☐ Yes ☐ No	9. Aids Related Complex (ARC)?	☐ Yes ☐ No
		10. Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No

Write your height in feet and inches

Provide both your address and your physician's address completely, including address, city, state and zip code.

Please answer each and every health question.
Avoid drawing a continuous line through the yes or no boxes.
Also, please make sure your check mark clearly falls within a yes or no box.

HEALTH QUESTIONS *continued….*
Check all applicable disorders and give details below.

III. In the past 5 years have you been diagnosed or treated by a medical professional for a disease or di

A. Brain or nervous system?	☐ Yes ☐ No	D. Prostate, ovaries or uterus?	
B. Eyes, ears, nose or throat?	☐ Yes ☐ No	E. Stomach, intestine, gallbladder	
C. Skin or lymph nodes?	☐ Yes ☐ No	F. Thyroid, spleen or any gland?	

IV. In the past 5 years, have you:

A. Sought or received advice the use of alcohol or other chemicals or drugs?	☐ Yes ☐ No	C. Been treated or evaluated in a medical or psychiatric facility?	
B. Scheduled or undergone any surgery?	☐ Yes ☐ No	D. Sustained illness requiring me hospitalization?	

V. In the last 12 months, have you used tobacco of any kind? ☐ Yes ☐ No

VI. Please list all prescribed and non-prescribed medications you currently take:

If you answered "Yes" to any Health Questions in this form, please explain below. (Please use another sheet of paper if necessary.)

Dates	Conditions	Doctor Names and Addresses	Results

HORIZATIONS & SIGNATURE

on and form the basis of any coverage issued to me and/or my s or failure to report information which is material to the issuance of denial of payment of a claim. I agree to notify Madison National Life my enrollment is pending. I agree that if my enrollment is approved f any coverage will be determined in accordance with the terms of

he Group Policy, Certificate of Insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of Madison National Life Insurance Company, Inc., can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related facility, state or local government agency, insurance or reinsurance company, Medical Information Bureau, Inc., consumer reporting agency, or employer, to give to Madison National Life Insurance Company, Inc., its legal representative or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization, in connection with this form, shall be valid for 24 months from my signature date and that I have the right to revoke this authorization at any time. I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request. I have read the separate notice enclosed with this form pertaining to the Medical Information Bureau as required by the Fair Credit Reporting Act.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Applicant's Signature

Parent/Guardian Signature (for Dependent enrollees under age 18)

FOR INSURER USE ONLY: Decision: ☐ Approved ☐ Postponed

Please be sure to give the actual name of the medication you are taking, not just what the drug is used for.

Take care to spell the medication correctly.

If you answered YES to any of the Health Questions, complete this explanation section. The date should be the date of the original diagnosis.

Read all acknowledgements and authorizations statements. Sign and date the application. Please remember – each individual should sign his or her application, however the employee needs to sign on behalf of a minor dependent child.

Please be sure to contact National Insurance Services with any changes in your health while your enrollment is pending. Failure to do so could result in the rescission of insurance and/or denial of payment of a claim.

If you have any questions when you complete this form please feel free to contact Pauline Gayle at National Insurance Services at 800-627-3660 ext 1263 between the hours of 8 am and 5 pm central time, Monday through Friday.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601
Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717

Return application to:
National Insurance Services
250 South Executive Drive, Suite 300
Brookfield, WI 53005-4273
Attention: Billing Department

Evidence of Insurability

(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es): ☐ Life: $ _____ ☐ Life/AD&D ☐ Supp. Life:$ _____ ☐ Long Term Disability ☐ AD&D:$ _____ ☐ Short Term Disability ☐ AD&D:$	**Reason for Applying:** ☐ New Hire ☐ Late Enrollee ☐ Increase in Coverage amount ☐ Reinstatement ☐ Adding Dependent(s) ☐ Applying for coverage over GI ☐ Other:

APPLICANT INFORMATION

Applicant's Name: Last, First, MI	**Sex:** ☐ M ☐ F	**Age:**	**Date of Birth:** / /
Height:	**Weight:**	**Applicant's Social Security No.** - -	**Already Enrolled?** ☐ Yes ☐ No
Applicant's Home Address: (Street, City, State, Zip)			**Applicant's Daytime Phone No.** ( )
Applicant's Current Physician's Name:	**Date Last Visited:** / /	**Reason for Visit:**	
Physician's Address: (Street, City, State, Zip)			**Physician's Phone No.**
Employee Member Name: (if different than Applicant)	**Employee's Job Title:**		
Employee's Date of Hire:	**No. of Hours Employee Works Per Week:**	**Employee's Annual Salary:** $	
Employer Name:	**Employer's Address:** (Street, City, State, Zip)		

HEALTH QUESTIONS

Check Yes or No, circle all applicable "Yes" disorders or procedures and give details below.

I. Are you currently pregnant? ☐ Yes ☐ No **If "Yes", what is your expected due date:**

II. In the past 5 years have you been diagnosed or treated by a medical professional for any of the following conditions?

A. HEART		**D. PAIN & DISCOMFORT**	
1. Heart ailment?	☐ Yes ☐ No	1. Arthritis, bursitis or gout?	☐ Yes ☐ No
2. Chest pain, angina or shortness of breath?	☐ Yes ☐ No	2. Recurrent back pain or slipped disk?	☐ Yes ☐ No
3. Irregular heart beat or heart murmur?	☐ Yes ☐ No	3. Disorder of the back, neck or spine?	☐ Yes ☐ No
4. Rheumatic fever?	☐ Yes ☐ No	4. Disorder of the muscles, bones or joints?	☐ Yes ☐ No
5. Disease or abnormality of heart muscle, nerves or vessels?	☐ Yes ☐ No	5. Temporomandibular joint (TMJ) Disorder?	☐ Yes ☐ No
6. Stress test; electrocardiogram or echocardiogram?	☐ Yes ☐ No	6. Recurrent abdominal pain?	☐ Yes ☐ No
B. TUMORS/CYSTS		**E. OTHER**	
1. Cancer of any type?	☐ Yes ☐ No	1. Stroke, seizure disorder or epilepsy?	☐ Yes ☐ No
2. Tumors, cysts, or polyps?	☐ Yes ☐ No	2. Migraine or persistent headaches?	☐ Yes ☐ No
C. BLOOD AND URINE		3. Nervous/mental disorder, depression or anxiety?	☐ Yes ☐ No
1. High or low blood pressure or hypertension?	☐ Yes ☐ No	4. Dizziness or paralysis?	☐ Yes ☐ No
2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes?	☐ Yes ☐ No	5. Asthma, emphysema, breathing or lung disorder?	☐ Yes ☐ No
3. Disorder of kidneys or bladder or kidney stones?	☐ Yes ☐ No	6. Indigestion, ulcers or irritable bowel?	☐ Yes ☐ No
4. Diabetes, high or low blood sugar?	☐ Yes ☐ No	7. Chronic fatigue?	☐ Yes ☐ No
5. Protein, blood or sugar in urine?	☐ Yes ☐ No	8. Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No
6. Night sweats, persistent swollen glands or diarrhea?	☐ Yes ☐ No	9. Aids Related Complex (ARC)?	☐ Yes ☐ No
		10. Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No

HEALTH QUESTIONS *continued….*

Check all applicable disorders and give details below.

III. In the past 5 years have you been diagnosed or treated by a medical professional for a disease or disorder of the:

A. Brain or nervous system?	☐ Yes ☐ No	D. Prostate, ovaries or uterus?	☐ Yes ☐ No
B. Eyes, ears, nose or throat?	☐ Yes ☐ No	E. Stomach, intestine, gallbladder or liver?	☐ Yes ☐ No
C. Skin or lymph nodes?	☐ Yes ☐ No	F. Thyroid, spleen or any gland?	☐ Yes ☐ No

IV. In the past 5 years, have you:

A. Sought or received advice for the use of alcohol or other chemicals or drugs?	☐ Yes ☐ No	C. Been treated or evaluated in a hospital or medical or psychiatric facility?	☐ Yes ☐ No
B. Scheduled or undergone any surgery?	☐ Yes ☐ No	D. Sustained illness requiring medical care or hospitalization?	☐ Yes ☐ No

V. In the last 12 months, have you used tobacco of any kind? ☐ Yes ☐ No

VI. Please list all prescribed and non-prescribed medications you currently take:

If you answered "Yes" to any Health Questions in this form, please explain below. (Please use another sheet of paper if necessary.)

Dates	Conditions	Doctor Names and Addresses	Results

ACKNOWLEDGEMENTS, AUTHORIZATIONS & SIGNATURE

I understand all statements and answers I have given are to be relied upon and form the basis of any coverage issued to me and/or my dependents under the Group Policy. I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Madison National Life Insurance Company, Inc. of any change in my medical condition while my enrollment is pending. I agree that if my enrollment is approved by Madison National Life Insurance Company, Inc., the effective date of any coverage will be determined in accordance with the terms of the Group Policy, including any Actively at Work requirement. I understand that if my coverage includes AD&D insurance, the AD&D coverage may have a War exclusion for benefits.

I acknowledge this Evidence of Insurability form (when approved), the Group Policy, Certificate of Insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of Madison National Life Insurance Company, Inc., can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related facility, state or local government agency, insurance or reinsurance company, consumer reporting agency, or employer, to give to Madison National Life Insurance Company, Inc., its legal representative or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization, in connection with this form, shall be valid for 24 months from my signature date and that I have the right to revoke this authorization at any time. I agree that a photocopy of this authorization is available to me upon request. I understand this information collected may, in certain circumstances, be disclosed to third parties with this authorization. I also understand I have the right to see my personal records and correct personal information collected.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Applicant's Signature	**Date**
Parent/Guardian Signature (for Dependent enrollees under age 18)	**Date**

FOR INSURER USE ONLY: Decision: ☐ Approved ☐ Postponed ☐ Declined	Effective Date:
Underwriter's Signature:	Date: