



BlueCross BlueShield of Oklahoma

Group Long-Term Disability Insurance Conversion Enrollment Kit

Overview

We are pleased to offer you this group long-term disability (LTD) Insurance conversion coverage.

The conversion coverage allows you to convert your group LTD insurance provided by your former employer. Benefits and amounts of insurance under the LTD conversion coverage may differ from those under your former employer's group LTD policy. You are responsible for payment of all LTD conversion coverage premiums.

Eligibility

You are eligible to apply for the LTD conversion coverage if you were covered for at least twelve (12) consecutive months on the date you end employment, under a group LTD policy provided by your former employer. To be eligible your coverage must end due to termination of employment, other than retirement. If you are eligible and would like to be considered for this insurance, you must apply within thirty-one (31) days after the termination of your coverage under the prior group LTD policy.

You will not be eligible to apply for this conversion insurance if your group LTD policy coverage ended for any of the following reasons:

1. If the group policy from which you wish to convert terminated;
2. You no longer belong to a class eligible for coverage under the group policy;
3. You retire;
4. You fail to pay any contributions required for your coverage;
5. You are or become insured under another group long-term disability plan or policy within 31 days after employment ends;
6. You are on a leave of absence on the date you would be eligible to apply for conversion;
7. You are disabled under the terms of the group policy; or
8. You recover from a disability and do not return to work for your employer.

Why Convert Your LTD Coverage?

The conversion privilege gives you the option of maintaining some level of long-term disability coverage in the event employment terminates. It is a valuable benefit for you if you wish to take some time in transitioning from one employer to another. If you meet the eligibility requirements and apply within thirty-one (31) days of your coverage terminating under the group LTD policy, the conversion enrollment cannot be declined.

LTD Conversion Coverage Duration

This conversion coverage is intended to be transitional LTD coverage if you have no other group LTD coverage option at the time of termination. This LTD conversion coverage extends for up to one (1) year. You may terminate coverage sooner than one year should you choose, but the longest period for which you will be offered coverage is one (1) year.

Benefits

Below is a summary of the benefits you may receive and the limitations and exclusions that may apply. The Certificate of Insurance you will receive after your insurance becomes effective will provide more details.

| | | |
|---|---|-----------------------|
| Your Benefits would begin | Following 180 consecutive days of Total Disability. This period is referred to as the Elimination Period. | |
| Your Monthly Benefit | 60% of your covered monthly earnings at the time of termination, subject to a maximum monthly benefit of \$3,500, less benefits from other income. If your benefit percentage and/or maximum monthly benefit under the former policy are less than the above, your coverage under this conversion coverage will be calculated based on the former policy's benefit percentage and/or maximum monthly benefit. Your gross monthly benefit amount will be stated in your Certificate of Insurance. | |
| Your benefits will be reduced from other income you may receive or are eligible to receive | Your benefit will be reduced by Other Income Benefits you receive or are eligible to receive (such as, but not limited to, Social Security Disability benefits for you and your dependents, Social Security Retirement benefits for you and your dependents, Workers' Compensation). | |
| Your Minimum Benefit | The greater of: <ul style="list-style-type: none">• \$50; or• 10% of the Monthly Benefit prior to any Other Income Benefit reductions | |
| Maximum Duration of Benefits | Age at Disablement | Duration of Benefits |
| | 61 or younger | To your 65th birthday |
| | 62 | 42 months |
| | 63 | 36 months |
| | 64 | 30 months |
| | 65 | 24 months |
| | 66 | 21 months |
| | 67 | 18 months |
| | 68 | 15 months |
| | 69 or older | 12 months |
| Definition of Disability | Due to sickness or injury, the inability to engage in any occupation for wages, remuneration or profit, for which you are qualified by education, training or experience on a full-time or part-time basis. | |
| Exclusions – not covered under the conversion policy | Benefits will not be paid for disability that arises from: <ul style="list-style-type: none">• Loss of professional license or certification for non-medical reasons• Commission of, participation in, or attempt to commit an assault or felony• Intentionally self-inflicted injuries• Attempted suicide, regardless of mental capacity• Being under the influence of drugs• Intoxication• Participation in a war, declared or undeclared, or any act of war• Active military duty• Active participation in a riot• Engaging in any illegal or fraudulent occupation• Commission of a crime for which you have been convicted• Elective cosmetic surgery except when due to injury or sickness• Travel or flight in any aircraft while a member of a crew or operating the aircraft• Occupational sickness or injury | |

Limitations

Disability due to the following conditions will have limited benefit durations:

- Mental or Nervous Disorders – 12 months. Limitation does not apply if hospital-confined at end of 12 months.
- Substance Abuse – 24 months.

Must be participating in treatment program to qualify for benefits.

- Special Conditions – 24 months.

Disability benefits are limited for conditions due to certain neck and back disorders, chronic fatigue syndrome, fibromyalgia, carpal tunnel syndrome or environmental allergic illness.

The lifetime cumulative maximum duration for all disabilities due to a Mental Disorder, Substance Abuse and Special Conditions is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities are not continuous and/or not related.

Survivor Income Benefit

A Survivor Income Benefit equal to 3 times the monthly benefit paid to you immediately prior to your death will be paid to your survivor. Your survivor is your spouse if living or otherwise your eligible children under age 23. You must have been disabled for 6 more consecutive months and receiving a monthly benefit for the Survivor Income Benefit to be paid.

When Coverage Ends

Your LTD conversion coverage will end on the earliest of the following to occur:

1. The date you stop making any required contribution toward payment of premiums
2. Twelve (12) months from the effective date of coverage under the LTD Conversion Policy
3. The date you become covered under another group long-term disability policy
4. The date you request termination under the policy
5. The date you are retired or pensioned
6. The date you die
7. The date on which the LTD Conversion Policy is terminated

The above chart provides only a brief description of your coverage under the long-term disability (“LTD”) conversion coverage.

For more information, including complete details on all benefits, exclusions, limitations and reductions in coverage, please refer to the Certificate of Insurance you will receive if you elect to become insured for LTD conversion coverage. Certain provisions in the Certificate of Insurance you receive for your LTD conversion coverage may vary based on any applicable state regulatory requirements.

Your Cost

The cost for your coverage will depend on your age and covered monthly earnings as of the date your premiums are due. You may request to pay your premium on an annual (one payment), semi-annual (two payments) or quarterly (four payments) basis. Contact us at (888) 381-9727 if you need assistance.

Quarterly premium rates for the coverage are as follows:

| Quarterly Rate Per \$100 Covered Monthly Earnings | |
|---|--|
| Attained Age as of Policy Effective Date | Quarterly Rate per \$100 of Covered Monthly Earnings with Prior Employer |
| Under age 25 | \$1.27 |
| 25 through 29 | \$1.64 |
| 30 through 34 | \$2.14 |
| 35 through 39 | \$2.79 |
| 40 through 44 | \$4.25 |
| 45 through 49 | \$7.72 |
| 50 through 54 | \$12.19 |
| 55 through 59 | \$14.99 |
| 60 or older | \$16.02 |

Your prior employer will supply us with your covered monthly earnings as of your termination date, which is subject to a maximum monthly earnings of \$5,833.33. Your corresponding LTD Conversion Policy benefit amount is calculated below.

How to Calculate Your Cost

Step 1. Your current age: _____

Step 2: Quarterly Rate from above chart: _____

Step 3: Your basic monthly earnings (use the amount shown in Item 8 on your Conversion Enrollment Form found later in this packet): _____

Step 4: Divide the amount in Step 3 by 100: _____

Step 5: Your QUARTERLY PREMIUM (multiply amount in Step 2 by amount in Step 4): _____

Step 6: Your SEMI-ANNUAL PREMIUM (multiply amount in Step 5 by 2): _____

Step 7: Your ANNUAL PREMIUM (multiply amount in Step 5 by 4): _____

Step 8: Your first payment (the amount shown for the premium mode you choose from Step 5, 6 or 7). This is the amount of the check you send with your enrollment form: _____

A thirty-one (31) day grace period is included in your policy. This period begins on the date the LTD conversion premium is due.

How Do I Apply for Coverage?

If you are interested in applying for LTD conversion coverage, complete and sign the LTD Conversion Application Form that is included in this kit and send it to the following address, along with your first premium payment:

Dearborn Life Insurance Company
Attn: LTD Conversion Policy Application Dept.
701 E. 22nd Street
Lombard, IL 60148

Reminders:

1. Be sure the Employer section on the first page of the application form is completed and signed by your Employer.
2. Complete and sign the Employee section of the application in its entirety.
3. Make copies of your application and keep a record for your files before submitting the enrollment.
4. We will review your enrollment for completeness and verify eligibility including confirmation that the premium for the group LTD policy is fully paid up. If we need additional information, we will contact you directly. Once your enrollment is approved, we will mail you your welcome letter and LTD Conversion Certificate of Insurance.

Who Should I Contact If I Become Disabled?

You should contact Dearborn Life Insurance Company at **(888) 381-9727**. You will be provided with the necessary forms to file your claim. Both you and your doctor(s) will need to complete the claim form.

All claims are administered by:

Dearborn Life Insurance Company

Attn: Claim Department
P.O. Box 7071
Downers Grove, IL 60515
(888) 381-9727

When Should Notice of a Claim Be Provided?

Written notice of a claim must be sent to us within thirty (30) days after your elimination period begins or as soon as reasonably possible.

When Should Proof of a Claim Be Provided?

For any total disability covered by the Conversion Policy, written proof must be sent to us within ninety (90) days after your elimination period began. If it is not reasonably possible to provide proof within ninety (90) days, your claim will not be affected if the proof is sent as soon as possible.

Dearborn Life Insurance Company
Employer Questionnaire For Group Long-Term Disability Conversion Coverage

This form is to be completed by the Employer when a person desires and is eligible to convert his/her group long-term disability insurance to long-term disability conversion coverage. The following page is to be completed by the employee and submitted with premium to the address shown on the following page within 31 days following the date of termination of insurance.

1. Employee's Full Name: _____

2. Name of Group Policyholder: _____

Address of Group Policyholder: _____

Group Policy No. Federal Employer ID No.: _____

Branch or Location (if different from Policyholder): _____

3. Employee's Date of Hire: _____

4. Employee's effective date of insurance under your Group LTD policy: _____

5. Date person last worked: _____ Date insurance terminated: _____

6. If dates differ in (5), please explain: _____

7. Employee's occupation on the termination date: _____

8. Employee's last Basic Monthly Earnings before termination: _____

9. Date notice of conversion privilege was given to employee: _____

10. Was the employee covered under your present LTD policy for 12 consecutive months?
Yes ____ No ____

11. Did the employee leave as a result of retirement? Yes ____ No ____

12. Is the employee now disabled from a sickness or injury? Yes ____ No ____

13. Is there a disability claim for this employee pending for a disability benefit under your group LTD Policy?
Yes ____ No ____ Not Sure ____

To the best of my knowledge, the above information is correct and complete.

Preparer's Printed Name: _____

Preparer's Title: _____

Preparer's Signature: _____ Date Signed: _____

Preparer's Telephone Number: _____

Request for Conversion

Administrative Office: 701 East 22nd Street, Lombard, Illinois 60148

Dearborn Life Insurance Company Employer Enrollment Form for Group Long-Term Disability Conversion Coverage

The information below must be completed by the employee and submitted with premium to the address shown below **within 31 days following the date of termination of insurance.**

SEND TO:
Dearborn Life Insurance Company
Attention: LTD Conversion Administration
701 E. 22nd Street
Lombard, IL 60148

1. Insured Person's Full Name (please print)

2. Home Address (Street & No.)

City, State & Zip Code

Email Address: _____

3. Sex: Male _____ Female _____

4. Social Security No.: _____

5. Date of Birth: _____

6. Are you covered for any other group long-term disability insurance?
Yes _____ No _____

7. Have you submitted a claim or are you receiving benefits under your group long-term disability policy from which you are terminating? Yes _____ No _____

8. Premium Mode: _____ Quarterly _____ Semi-Annual _____ Annual

To the best of my knowledge, the above information is correct and complete.

Employee's Printed Name: _____

Employee's Signature: _____ Date Signed: _____

Employee's Telephone Number: _____