Products Underwritten by: Union Security Insurance Company

VOLUNTARY LONG-TERM DISABILITY INSURANCE

SUMMARY OF BENEFITS

FOR THE EMPLOYEES OF SPRING HILL INDEPENDENT SCHOOL DISTRICT

This summary provides a brief description of the long-term disability benefits available to all eligible employees. This is not a Certificate of Coverage. Nothing contained herein will guarantee, waive or alter any terms of any subsequently issued policy or plan. The provisions of such actually issued policy or plan will be based on the insurance applied for by your employer and agreed upon by Union Security Insurance Company. Further, depending on the governing jurisdiction, the actual text of provisions and availability of either the product or product feature(s) may differ from what is presented in this summary of benefits.

ELIGIBILITY
You are eligible for coverage if you are a full-time active employee, you are working at least the minimum number of hours required under the plan, and you have satisfied any applicable waiting periods. When you first become eligible for coverage, you can enroll for coverage within 45 days of the date you become eligible, subject to any plan benefit maximums. If you do not apply within the 45-day period, evidence of insurability will be required to enroll for any amount of coverage.

BENEFIT AMOUNT
You may participate in the policy or plan under any one of the benefit levels outlined in the Rate Schedule, provided the monthly disability benefit level you selected does not exceed 66 2/3% of your regular monthly salary from your employer. If, at any time, the monthly benefit you have chosen exceeds 66 2/3% of your monthly salary, your benefit amount will be reduced to the highest benefit level for which you are eligible.

ELIMINATION PERIOD
If you elect or apply for long-term disability coverage, you may select from the following elimination period options:

1. 0 days for injury, 3 days for sickness*
2. 14 days for injury, 14 days for sickness*
3. 30 days for injury, 30 days for sickness*
4. 90 days for injury, 90 days for sickness

** If you are hospital confined as an in-patient because of your disability, and have selected an elimination period of 30 days or less, benefits begin immediately. In-patient means an individual who is physically confined for an overnight stay, as a registered bed patient in a hospital or institution, as defined in the policy or plan.*

ASSURANT
Employee
Benefits

DURATION OF PAYMENTS
If you elect or apply for long-term disability coverage, the following is your duration of payment option:

Long-term disability benefits are payable for up to Social Security Normal Retirement Age for injury or 5 years for sickness during a continuous period of disability.

DEDUCTIBLE SOURCES OF INCOME
For the first 12 months of benefit payments, the amount of benefit you receive, or are eligible to receive, from Workers' Compensation, an occupational disease law or any other act or law of similar intent will be subtracted from your gross monthly benefit. After 12 months, of benefit payments, the amount of benefit you receive, or eligible to receive, from Social Security, Workers' Compensation or other sources will be subtracted from your gross monthly benefit. Income received from salary continuation or accumulated sick leave plans will not be deducted from your gross disability benefit.

The minimum monthly benefit amount payable under the policy is 25% of the gross monthly benefit regardless of the amount of income you receive from other sources.

PRE-EXISTING CONDITIONS
Benefits will not be paid for losses which occur during the first 24 months after your effective date of coverage which are caused by, contributed to by, or result from a pre-existing condition, unless you are treatment free for 12 consecutive months after your effective date of coverage. A pre-existing condition means a sickness or injury for which you received medical treatment, consultation, care, or services, including diagnostic measures, or took prescribed drugs or medicines in the 12 months just prior to your effective date of coverage.

Increases or additional coverage are also subject to the pre-existing condition limitation, as of the effective date of the increase or additional coverage.

DISABILITIES WITH A LIMITED PAY PERIOD
Disabilities due to mental illness, drug abuse and alcoholism have a limited pay period up to 12 months.

Disabilities due to Special Conditions have a limited pay period up to 12 months.

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PORTABILITY
You may continue coverage if your employment ends. Coverage can be continued at 50% of the monthly benefit amount you are insured for at the time you ended employment. The maximum period of payment will be limited to one year. You may continue coverage until you reach the age of 65. You will be eligible to apply for ported coverage if you have been covered under the policy for 12 consecutive months before your employment ends and met the eligibility requirements as outlined in your certificate of coverage.

DEFINITION OF DISABILITY

TOTAL DISABILITY
Benefits for Total Disability are paid if you are disabled and not working, or have returned to work and, due to your disability, are earning less than 20% of pre-disability earnings.

PARTIAL DISABILITY
Partial Disability benefits are paid if you are working, but due to your disability, are earning at least 20% and less than or equal to 80% of pre-disability earnings.

Depending on the benefit duration, income replacement for up to the first 12 months of a partial disability, in the form of benefits under this plan, return-to-work earnings, and income from other sources, can equal up to 100% of pre-disability earnings. If the total from all of these sources exceeds 100% of pre-disability earnings, the benefit will be reduced by the amount in excess of 100%. Thereafter, benefits for partially disabled employees are reduced by 50% of return to work earnings.

TOTAL AND PARTIAL DISABILITIES
Depending on the benefit duration, you will continue to receive payments beyond 24 months of disability if you are:

1. working in any occupation and continue to have a 20% or more loss in monthly earnings due to your sickness or injury;
2. not working, and due to your sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

When determining eligibility for Total or Partial Disability benefits if school is not in session, your work capacity is measured by determining whether you would be able to perform your work if school were in session.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

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SURVIVOR BENEFIT
A lump-sum benefit equal to three times your gross monthly benefit will be paid to your eligible survivor upon your death, if you were receiving, or were entitled to receive, payments under the policy or plan for 180 or more consecutive days.

ADVANCED SURVIVOR BENEFIT
You may receive an Advanced Survivor Benefit prior to your death if you have been diagnosed with a Terminal Illness. We will pay you a lump sum amount equal to 3 months of your gross monthly benefit if:

- Your disability had continued for 180 or more consecutive days,
- You have been diagnosed with a Terminal Illness or condition;
- Your life expectancy has been reduced to less than 12 months; and
- You are receiving or are eligible to receive monthly payments under the Policy.

This benefit is available to you on a voluntary basis and will be payable one time only under the policy or plan. If you receive this benefit prior to your death, the Survivor Benefit will not be payable upon your death.

WAIVER OF PREMIUM
While you are receiving disability payments under this policy, your monthly premium will be waived.

WORKPLACE MODIFICATION
If you are disabled and are receiving a monthly payment under the policy or plan, an additional workplace modification benefit may be payable to your Employer for your benefit. We may reimburse your Employer for up to 100% of the reasonable costs your Employer incurs through modifications to the workplace to accommodate your return to work, and to assist you in remaining at work. The amount we may pay will not exceed the lesser of three times your last monthly payment; or $5,000. This benefit is available to you on a one time basis.

ASSURANT
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EVIDENCE OF INSURABILITY

- Proof of good health will be required from all individuals if:
  1. you are a late applicant, which means you apply for coverage more than 45 days after the date you are eligible for coverage; or
  2. you voluntarily cancel coverage and are re-applying; or
  3. you apply for a monthly benefit greater than the guarantee issue amount listed in the rate schedule; or
  4. you are increasing your coverage.

- You can increase your coverage amount by one benefit level increment at each policy anniversary date without evidence of insurability as long as the increased amount does not exceed the maximum issue amount or 66 2/3% of your monthly pre-disability salary.

- Increases or additional coverage will be subject to the pre-existing condition limitation.

EXCLUSIONS AND LIMITATIONS

The policy does not cover any disabilities caused by, contributed to by or resulting from your: (a) participation in or attempting to commit a felony or working at an illegal occupation; (b) intentionally self-inflicted injuries; (c) committing or attempting to commit suicide, regardless of mental capacity; (d) being legally intoxicated, under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a doctor; (e) active participation in a riot; (f) pre-existing condition, as defined; (g) commission of a crime for which you have been convicted under federal or state law; (h) elective surgery; (i) participation in or contracting with the armed forces (including Coast Guard) of any country or international authority; (j) riding in or driving any motor-driven vehicle in a race, stunt show, or speed test; or while testing any vehicle on any racecourse or speedway; (k) participating in any sporting event for pay or prize money; or (l) operating, learning to operate, serving as a crew member on, or jumping from or falling from any aircraft, including those which are not motor-driven.

In addition, the policy will not cover a disability due to war, declared or undeclared, or participation in any act of war; or for any period of disability during which you are incarcerated.

ASSURANT
Employee
Benefits

For information and service, please contact:

Matt Jones
Gentry Financial Group
5604 Old Bullard Road, Suite 106
Tyler, Texas 75703

Tel: (903) 939-8133
Fax: (903) 939-8685

For claims service, please contact:

Claims Office
One Riverfront Plaza
Westbrook, Maine 04092-9700

Toll-free: (866) 376-9478
Fax: (207) 591-3776

For all other customer service inquiries, please contact:

Customer Service Center

Toll-free: (800) 877-2701

This Summary of Benefits is not complete without the Product Overview Brochure (form series USIC-GRPDI-EE) or (form series USIC-GRPDI-FDH) and the Rate Schedule(s) (form series USIC-GRPDI-RSA, USIC-GRPDI-RSB and USIC-GRPDI-RSC), including state variations where used.

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ASSURANT Employee Benefits

SPRING HILL INDEPENDENT SCHOOL DISTRICT
Long-Term Disability

Schedule of Benefits and Rates:
You may participate in the policy under any one of the benefit levels outlined below, provided the monthly disability benefit level does not exceed 66 2/3% of your regular monthly salary at the time you apply. If, at any time, the maximum monthly benefit level you have chosen exceeds 66 2/3 % of your monthly salary, we reserve the right to lower your monthly benefit to the highest benefit level for which you are eligible.

Benefit Duration: Social Security Normal Retirement Age for Injury and 5 Years for Sickness **Guarantee Issue Amount:** $5,000

Minimum Gross Annual Salary	Maximum Monthly Benefit	0/3 Elimination Period	14/14 Elimination Period	30/30 Elimination Period	90/90 Elimination Period
$5,400	$300	$12.51	$8.52	$6.75	$3.60
$7,200	$400	$16.68	$11.36	$9.00	$4.80
$9,000	$500	$20.85	$14.20	$11.25	$6.00
$10,800	$600	$25.02	$17.04	$13.50	$7.20
$12,600	$700	$29.19	$19.88	$15.75	$8.40
$14,400	$800	$33.36	$22.72	$18.00	$9.60
$16,200	$900	$37.53	$25.56	$20.25	$10.80
$18,000	$1,000	$41.70	$28.40	$22.50	$12.00
$19,800	$1,100	$45.87	$31.24	$24.75	$13.20
$21,600	$1,200	$50.04	$34.08	$27.00	$14.40
$23,400	$1,300	$54.21	$36.92	$29.25	$15.60
$25,200	$1,400	$58.38	$39.76	$31.50	$16.80
$27,000	$1,500	$62.55	$42.60	$33.75	$18.00
$28,800	$1,600	$66.72	$45.44	$36.00	$19.20
$30,600	$1,700	$70.89	$48.28	$38.25	$20.40
$32,400	$1,800	$75.06	$51.12	$40.50	$21.60
$34,200	$1,900	$79.23	$53.96	$42.75	$22.80
$36,000	$2,000	$83.40	$56.80	$45.00	$24.00
$37,800	$2,100	$87.57	$59.64	$47.25	$25.20
$39,600	$2,200	$91.74	$62.48	$49.50	$26.40
$41,400	$2,300	$95.91	$65.32	$51.75	$27.60
$43,200	$2,400	$100.08	$68.16	$54.00	$28.80
$45,000	$2,500	$104.25	$71.00	$56.25	$30.00
$46,800	$2,600	$108.42	$73.84	$58.50	$31.20
$48,600	$2,700	$112.59	$76.68	$60.75	$32.40
$50,400	$2,800	$116.76	$79.52	$63.00	$33.60
$52,200	$2,900	$120.93	$82.36	$65.25	$34.80
$54,000	$3,000	$125.10	$85.20	$67.50	$36.00
$55,800	$3,100	$129.27	$88.04	$69.75	$37.20
$57,600	$3,200	$133.44	$90.88	$72.00	$38.40
$59,400	$3,300	$137.61	$93.72	$74.25	$39.60
$61,200	$3,400	$141.78	$96.56	$76.50	$40.80
$63,000	$3,500	$145.95	$99.40	$78.75	$42.00
$64,800	$3,600	$150.12	$102.24	$81.00	$43.20
$66,600	$3,700	$154.29	$105.08	$83.25	$44.40
$68,400	$3,800	$158.46	$107.92	$85.50	$45.60
$70,200	$3,900	$162.63	$110.76	$87.75	$46.80
$72,000	$4,000	$166.80	$113.60	$90.00	$48.00
$73,800	$4,100	$170.97	$116.44	$92.25	$49.20
$75,600	$4,200	$175.14	$119.28	$94.50	$50.40

Proof of good health, subject to underwriting standards, is always required to be insured at a benefit level greater than $5,000.

Products Underwritten by: Union Security Insurance Company

ASSURANT Employee Benefits

SPRING HILL INDEPENDENT SCHOOL DISTRICT
Long-Term Disability

Schedule of Benefits and Rates:
You may participate in the policy under any one of the benefit levels outlined below, provided the monthly disability benefit level does not exceed 66 2/3% of your regular monthly salary at the time you apply. If, at any time, the maximum monthly benefit level you have chosen exceeds 66 2/3 % of your monthly salary, we reserve the right to lower your monthly benefit to the highest benefit level for which you are eligible.

Benefit Duration: Social Security Normal Retirement Age for Injury and 5 Years for Sickness **Guarantee Issue Amount:** $5,000

Minimum Gross Annual Salary	Maximum Monthly Benefit	0/3 Elimination Period	14/14 Elimination Period	30/30 Elimination Period	90/90 Elimination Period
$77,400	$4,300	$179.31	$122.12	$96.75	$51.60
$79,200	$4,400	$183.48	$124.96	$99.00	$52.80
$81,000	$4,500	$187.65	$127.80	$101.25	$54.00
$82,800	$4,600	$191.82	$130.64	$103.50	$55.20
$84,600	$4,700	$195.99	$133.48	$105.75	$56.40
$86,400	$4,800	$200.16	$136.32	$108.00	$57.60
$88,200	$4,900	$204.33	$139.16	$110.25	$58.80
$90,000	$5,000	$208.50	$142.00	$112.50	$60.00
$91,800	**$5,100**	**$212.67**	**$144.84**	**$114.75**	**$61.20**
$93,600	**$5,200**	**$216.84**	**$147.68**	**$117.00**	**$62.40**
$95,400	**$5,300**	**$221.01**	**$150.52**	**$119.25**	**$63.60**
$97,200	**$5,400**	**$225.18**	**$153.36**	**$121.50**	**$64.80**
$99,000	**$5,500**	**$229.35**	**$156.20**	**$123.75**	**$66.00**
$100,800	**$5,600**	**$233.52**	**$159.04**	**$126.00**	**$67.20**
$102,600	**$5,700**	**$237.69**	**$161.88**	**$128.25**	**$68.40**
$104,400	**$5,800**	**$241.86**	**$164.72**	**$130.50**	**$69.60**
$106,200	**$5,900**	**$246.03**	**$167.56**	**$132.75**	**$70.80**
$108,000	**$6,000**	**$250.20**	**$170.40**	**$135.00**	**$72.00**
$109,800	**$6,100**	**$254.37**	**$173.24**	**$137.25**	**$73.20**
$111,600	**$6,200**	**$258.54**	**$176.08**	**$139.50**	**$74.40**
$113,400	**$6,300**	**$262.71**	**$178.92**	**$141.75**	**$75.60**
$115,200	**$6,400**	**$266.88**	**$181.76**	**$144.00**	**$76.80**
$117,000	**$6,500**	**$271.05**	**$184.60**	**$146.25**	**$78.00**
$118,800	**$6,600**	**$275.22**	**$187.44**	**$148.50**	**$79.20**
$120,600	**$6,700**	**$279.39**	**$190.28**	**$150.75**	**$80.40**
$122,400	**$6,800**	**$283.56**	**$193.12**	**$153.00**	**$81.60**
$124,200	**$6,900**	**$287.73**	**$195.96**	**$155.25**	**$82.80**
$126,000	**$7,000**	**$291.90**	**$198.80**	**$157.50**	**$84.00**
$127,800	**$7,100**	**$296.07**	**$201.64**	**$159.75**	**$85.20**
$129,600	**$7,200**	**$300.24**	**$204.48**	**$162.00**	**$86.40**
$131,400	**$7,300**	**$304.41**	**$207.32**	**$164.25**	**$87.60**
$133,200	**$7,400**	**$308.58**	**$210.16**	**$166.50**	**$88.80**
$135,000	**$7,500**	**$312.75**	**$213.00**	**$168.75**	**$90.00**

Proof of good health, subject to underwriting standards, is always required to be insured at a benefit level greater than $5,000.

ASSURANT EMPLOYEE BENEFITS

UNION SECURITY INSURANCE COMPANY (the "Company")

Administrative Office: One Riverfront Plaza, Westbrook, ME 04092-9700

EMPLOYEE ENROLLMENT FORM FOR GROUP DISABILITY

This Area for Agent or Plan Administrator Use Only.

Group Number: 55842	Requested effective date of coverage: The first day of ____________, ________ Month Year

To enroll, please type or print in dark ink and return to your Agent or Employer. Keep a copy for your records. Any changes must be initialed by the Applicant.

Last Name	First Name	Middle Initial	Birth Date (MM/DD/YY)	Gender ☐ M ☐ F	Social Security No.

Home Address Number/Street	City	State	Zip

Home Phone Number ( )	Employer Name Spring Hill ISD	Your Work Location/Site

Date of Hire	Occupation	Annual Income $	Your scheduled work hours per week

Will the coverage applied for with this enrollment application:
a. *replace* any existing disability income? ☐ Yes ☐ No
b. *be in addition* to any existing disability income? ☐ Yes ☐ No

All applicants review the following guidelines and complete this section to request coverage.

- Amounts must be elected according to the Rate Schedule provided.
- Depending on the amount of coverage you elect, you may be required to complete the Health Questions.
- Consult your agent for details concerning maximum amounts of insurance and Evidence of Insurability requirements.

Coverage	(N)ew (I)ncrease (D)ecrease (C)ancel	Monthly Benefit Amount	If (I) Or (D), My Prior Coverage Was	Monthly Premium / Rate
Short-Term Disability ☐ **Yes** ☐ **No** **Elimination Period**________________ **Max. Period of Payment**___________				
Long-Term Disability ☐ **Yes** ☐ **No** **Elimination Period**__________________ **Max. Period of Payment**_____________				

Number of Salary Deductions/Year ________

I authorize the Payroll Department to deduct the required premium from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and the Company, and are to be paid to the Company when due. I understand I am responsible for paying any premium due for which the Payroll Department cannot make a regularly scheduled deduction. I understand that in order to revoke this authorization, I must notify my Payroll Department in writing to cancel the premium deductions and abide by any rules specified by the employer's benefit plan and/or by law.

The insurance applied for shall be in force as of the date described in the certificate provided the Company approves my application without any modifications as to the plan amount or premium. If the application is approved with any such modification, the insurance shall not take effect until the certificate has been delivered to and accepted by me and furthermore shall not take effect if there has been a change in the health of any person to be insured as stated since the date of application.
All of the information on this application is complete, correct and true to the best of my knowledge and belief.

Dated at: ______________________________________ On: ___________________________________
City State Month Day Year

_______________________________________ _____________________________________
Signature of Employee Printed Name of Employee

Health Questions ***(For Employees Applying for Amounts of Insurance over the Guaranteed Issue Limit, Enrolling Late, Increasing Coverage, or Enrolling again after having Cancelled Coverage)***

Last Name	First Name	Middle Initial	Social Security No.

Please answer the following questions.
If you answer "YES" to any questions, please provide details in REMARKS below.

Height _________ Weight _________

1. Have you gained or lost 10 or more pounds during the past 12 months? ☐ Yes ☐ No
   If "YES", how much? _________________

2. Have you within the past 5 years: ☐ Yes ☐ No
   a. Received or been advised to receive any medication, treatment, surgery, therapy, testing, observation, or consultation by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium, health resort or any other health related facility?
   b. Used any illegal drugs? ☐ Yes ☐ No

3. In the past 5 years, have you had, been treated for or been advised to seek treatment for persistent cough, fatigue or swollen glands, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, patches in mouth, skin lesions, prolonged night sweats, visual disturbance or recurring diarrhea, fever or infection? ☐ Yes ☐ No

4. Have you ever been diagnosed as having acquired immunodeficiency syndrome (AIDS)? ☐ Yes ☐ No

5. Are you pregnant? ☐ Yes ☐ No

6. Have you ever had, been medically diagnosed, treated or been advised to seek treatment for: Arthritis; back, neck or joint disorder; asthma; emphysema or lung disorder; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental, nervous or eating disorder; seizures; or immune system disorder? ☐ Yes ☐ No

   "Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure.

Name, address and telephone number of personal physician ____

____

REMARKS – If you answered "YES" to any health question above, please provide details below. Should you require additional space, please use a separate sheet of paper and attach it to this form.

Question No.	First Name	Description of illness, injury, or pregnancy, medication or treatment	Duration (dates) & No. of episodes	Residual effects/ results	Name and address of attending physician or hospital (*include zip code*)

If Answering Health Questions, the Employee signature is required on page 3 of this form.

IMPORTANT NOTICE TO APPLICANTS ---- PLEASE READ CAREFULLY

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION FOR INSURANCE UNDERWRITING PURPOSES (excluding psychotherapy notes)

(This authorization complies with the HIPAA Privacy Rule)

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Disability Reinsurance Management Services, Inc. (Disability RMS), and the Company, *excluding psychotherapy notes*, and including, but not limited to, any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and **HIV/AIDS*** information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Disability RMS, the Company, and the above-described representatives to evaluate my application for disability and/or life insurance and may be redisclosed to any organization or person employed by or representing Disability RMS or the Company solely to assist with this purpose. I give my permission to Disability RMS, the Company or its reinsurers to release any information to other life insurance companies as I may come in contact with. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules, or any other federal or state law.

This authorization will remain in effect a maximum of six (6) months from the date of the signature below. A photocopy of this authorization is as valid as the original. I understand that my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand that I or my authorized representatives have the right to revoke this authorization by notifying Disability RMS in writing. However, such revocation is not effective to the extent that Disability RMS and/or the Company have relied previously upon this authorization for the use or disclosure of my protected health information pursuant to this authorization, and as a result, may be the basis for denying insurance or during a contestability period under applicable law. Failure to sign this authorization may impair our ability to evaluate my application and as a result may be a basis for denying my application for disability and/or life insurance coverage.

NOTICE REGARDING MEDICAL INFORMATION BUREAU AND INSURANCE INFORMATION PRACTICES

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112, Telephone number: (617) 426-3660.
You have the right to gain access to and request correction of information contained in our files. However, we will not disclose information which relates to a claim or to a civil or criminal proceeding. If you wish to receive a more detailed explanation of our information practices, including a description of access and correction rights as well as circumstances under which non-authorized disclosures or personal information may be made, please contact Senior Vice-President, Underwriting and Administration, 2323 Grand Boulevard, Kansas City, MO 64108-2670.

I have read the NOTICE REGARDING MEDICAL INFORMATION BUREAU AND INSURANCE INFORMATION PRACTICES and the AUTHORIZATION TO OBTAIN MEDICAL INFORMATION FOR INSURANCE UNDERWRITING PURPOSES and I have made a copy of my application for my records. To the best of my knowledge and belief, all statements made on this application are true and complete. I understand that my application for insurance will be accepted or declined on the basis of these statements.

Unless specific state language is provided below, and except for Virginia residents, the following general fraud notice applies: *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.*

Dated at: ______________________________ On: ________/________/__________
City State Month Day Year

______________________________ ______________________________
Signature of Employee Printed Name of Employee