



# Term Life & Short-Term Disability (STD) Insurance

**GUARANTEE  
ISSUE**

## **WHY GROUP TERM LIFE INSURANCE & SHORT-TERM DISABILITY INSURANCE?**

**Term Life Insurance:** When you provide your employees with an EPIC Base Term Life program, you're giving them security and a solid financial foundation, and a promise to help when they need it most.

**Short-Term Disability Insurance:** When a valuable employee is absent from his or her job due to an injury or illness, paying compensation out of pocket can be devastating to your bottom line. You can hedge against such losses with an EPIC Short-Term Disability Plan.

### **Package Features Include:**

- Low group insurance rates
- Issue to groups as small as 2 employees
- Easy to enroll, no medical questions
- Local administration, The EPIC Life Insurance Company – a Wisconsin-based insurance carrier
- All industries accepted
- Up to three plans to choose from, depending on number of employees

*Underwritten & Administered by  
The EPIC Life Insurance Company*

*A Subsidiary of WPS Health Insurance  
Madison, Wisconsin*



THE EPIC LIFE INSURANCE COMPANY

## BENEFITS SUMMARY

### Term Life Insurance Benefits Include:

- Flat amount of Term Life Insurance benefits
- Waiver of Premium: if employee becomes disabled prior to age 60, we'll waive Life premium for as long as disabled or until he or she reaches age 70
- Living Benefit Provision: in the event of terminal illness (defined as having a medically-certified life expectancy of less than 12 months) the insured may elect payment of up to 50% of the Life benefit
- Accidental Death & Dismemberment benefit included. This benefit is up to 1 times your level base Life amount
- Coverage reduces at age 65 to 65%, at age 70 to 50%
- Life Conversion Privilege: convert to an individual policy up to \$10,000, subject to policy provisions

- Optional Dependent Life Coverage:
  - Option A – \$5,000 Spouse & \$2,000 each Child
  - Option B – \$10,000 Spouse & \$4,000 each Child

### Short-Term Disability Benefits Include:

- 60% of salary up to flat amount/choice of 3 plans by group size
- Benefits begin on 8th day of disability from accident or illness. Benefits payable for a maximum of 26 weeks. (8-8-26)
- Survivor benefit equal to 3 weeks lump sum payment
- Maternity treated same as any illness
- Optional: 24-hour coverage may be available for owners/officers who opt out of workers compensation benefits coverage, subject to EPIC approval

## ENROLLING IS AS EASY AS... ONE... TWO... THREE!

### ONE

From below, employer chooses ONE plan. Choices are limited by the following group size requirements:

- 2-9 lives: Plan I only
- 10-24 lives: Choose Plan I or Plan II
- 25+ lives: Choose Plan I, II or III

Remember choose only one benefits plan for the entire group, then select desired Dependent Life Coverage.

PLAN I: \$15,000 Life/AD&D & \$200 STD; 8-8-26*		
Age	Monthly	
	Male Rate	Female Rate
<30	\$ 5.85	\$ 13.60
30-39	7.15	11.75
40-49	8.90	11.35
50-59	16.25	14.80
60+	29.05	21.25

PLAN II: \$20,000 Life/AD&D & \$250 STD; 8-8-26*		
Age	Monthly	
	Male Rate	Female Rate
<30	\$ 7.15	\$ 16.20
30-39	8.80	13.87
40-49	10.40	13.45
50-59	17.45	17.40
60+	31.85	23.00

PLAN III: \$25,000 Life/AD&D & \$300 STD; 8-8-26*		
Age	Monthly	
	Male Rate	Female Rate
<30	\$ 9.05	\$ 20.55
30-39	10.85	17.80
40-49	13.20	17.10
50-59	21.60	21.60
60+	36.95	28.15

OPTIONAL DEPENDENT LIFE COVERAGE			
Option	Monthly		
	Spouse	Child	Rate
A	\$5,000	\$2,000	\$1.80
B	\$10,000	\$4,000	\$3.15

\* Benefits begin on 8th day of disability from accident or illness. Benefits payable for a maximum of 26 weeks. (8-8-26)

**An industry load factor may apply. Please see the Industry Table on the back cover.**

# TWO

## GROUP PREMIUM CALCULATION

- Select the plan (I, II or III) to offer to your employees
- For each employee, find their rate by age bracket in one of the tables at left. (Use the Premium Calculation Box or a separate sheet if needed)
- Then add all rates to get the base monthly premium total \$ \_\_\_\_\_
- If your business is on the Industry Table on the back cover, multiply by the SIC Industry factor (1.2) \$ \_\_\_\_\_

### OPTIONS

- Multiply times 1.1 of total monthly premium if 24-hour coverage is chosen \$ \_\_\_\_\_
- From table at left, add Dependent Life Insurance rate and multiply times the number of families covered (if chosen) \$ \_\_\_\_\_
- Total all lines, this is your group's monthly premium \$ \_\_\_\_\_

PREMIUM CALCULATION BOX			
EMPLOYEE	AGE	SEX	PREMIUM
1.			\$
2.			\$
3.			\$
4.			\$
5.			\$
6.			\$
7.			\$
8.			\$
9.			\$
10.			\$
<b>Total:</b>			\$

# THREE

## COMPLETE EMPLOYER AND EMPLOYEE APPLICATION

### To enroll complete:

- Employer application
- Employee application
- Group Benefit Request Form
- First month's premium

### Return all enrollment applications and first month's premium to:

Your HBA Endorsed Agency

### Important Underwriting Guidelines:

Eligibility	Contribution	Minimum Employee Participation by Group Size
<ul style="list-style-type: none"> <li>• Employee is full time</li> <li>Groups &lt;25 lives, full time is minimum 30 hrs/week</li> <li>Groups &gt;25 lives, full time is minimum 80 hrs/month</li> </ul>	<ul style="list-style-type: none"> <li>• Employer contributes minimum of 50% of premium</li> </ul>	<ul style="list-style-type: none"> <li>• 2-9 lives: 100% of eligible employees must join</li> <li>• 10+ lives: 75% of eligible employees must join</li> <li>• 2+ lives: 75% of eligible employees must join Dependent Life Coverage</li> </ul>



## THE EPIC ADVANTAGE

Formed in 1984 as a WPS Health Insurance subsidiary, The EPIC Life Insurance Company has since earned a reputation for excellent products, superior service, and security.

We owe our achievements to the top-quality benefits and personalized service we provide to our customers, backed by our strong work ethic. With this successful combination, you'll find that EPIC is larger than life... yet down to earth.



THE EPIC LIFE INSURANCE COMPANY

Ask about other EPIC group insurance products available to you —  
Dental, Long-Term Disability, Short-Term Disability, Term Life, and Vision.

## INDUSTRY TABLE

**NOTE:** Monthly rates from enrollment step one increase by 20% for the following industries:

SIC CODE	INDUSTRY	SIC CODE	INDUSTRY
100-299	Agriculture	7380-7381	Miscellaneous Business Services
800-1499	Forestry, Mining, Oil & Gas	7389-7399	Business Services NEC
2800-2819	Industrial Chemical	7900-7996	Dance, Bowling, Racing, Amusement Parks
2873-2899	Agricultural Chemicals	9100-9299	Public Administration
3292-3292	Asbestos Products	9511-9511	Water & Air Resources
3300-3493	Primary Metal Industries	9532-9599	Government Administration
4000-4699	Transportation		

**OPTION:** Add 10% to rates for optional 24-hour coverage benefit

**NEED HELP?** If you are not sure of your SIC Code or need help with rates, please call the EPIC Sales department at 800-236-8809.

## EXCLUSIONS

### Life Coverage Provisions

**We won't pay Life benefits for self-inflicted injuries, sickness, or death:**

**Residents of Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Nebraska, and Ohio:** If a participant commits suicide within two years from his/her effective date of coverage under the policy, no proceeds are payable for that participant's death. We will return the total premium paid to us for that participant's Life coverage under the policy.

**We won't pay AD&D benefits for any loss:**

- resulting from weight control or any treatment of obesity not caused by an organic condition
- resulting from participation in a riot or in the commission of a crime
- resulting from an act of declared war or armed aggression
- incurred for which any government body or its agencies are liable, while an employee is on active duty or training in the armed forces, National Guard, or Reserves of any state or country;
- from injuries in any aircraft, except as a passenger in a commercial aircraft on a regularly-scheduled flight
- due to sickness or disease
- due to accidents involving racing or speeding contests
- from injuries sustained while legally intoxicated
- from injuries sustained while under the influence of any controlled substance, unless prescribed by and taken under the direction of a physician
- from an employee's injury which arises out of or occurs during employment with the employer; this doesn't apply if the employer selects occupational AD&D coverage

• **Residents of Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Nebraska, and Ohio:** any loss which results, whether a participant is sane or insane, from an intentionally self-inflicted injury or sickness, suicide, or attempted suicide

• **Residents of Nebraska:** also no Voluntary Term Life or AD&D.

**Bacterial infections:**

- **Residents of Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Nebraska, and Ohio:** No benefits are payable due to bacterial infections, unless due to accidental food poisoning
- **Residents of Missouri:** No benefits are payable due to bacterial infections, unless the bacterial infection is due to the accidental ingestion of a contaminated substance, or a pyogenic infection resulting from an accidental bodily injury.

### STD Coverage Provisions

**We won't pay STD benefits for any loss:**

- resulting from weight control or any treatment of obesity not caused by an organic condition
- resulting from participation in a riot or in the commission of a crime
- resulting from an act of declared war or armed aggression
- incurred for which any government body or its agencies are liable, while an employee is on active duty or training in the armed forces, National Guard, or Reserves of any state or country
- suicide provision as stated in the certificate.

**We won't pay STD benefits for any disability:**

- during which the employee isn't under the care and attendance of a physician
- for any total disability covered by Workers' Compensation or similar laws, even if the employee does not choose to claim such benefits
- during any period of time the employee is also on a paid sick leave from the employer or any other group disability coverage to which he or she may be entitled
- which benefits were received under other income benefits.

**NOTE:** This brochure is only a general outline of benefits, limitations, and exclusions. You can find a more detailed description of the coverage in the applicable certificate of insurance or benefits booklet. A certificate or benefits booklet will be issued to each employee who becomes insured under the plan. Coverages are subject to the terms, conditions, and provisions of the applicable EPIC insurance policy(ies) issued to the employee by EPIC if the employee meets underwriting and other requirements. Any provisions listed in this brochure that conflict with local, state, or federal laws will automatically conform to those laws.

This product exclusively distributed for members of the  
Home Builders/Remodelers Association of Mahoning Valley.



  
THE EPIC LIFE INSURANCE COMPANY  
A Subsidiary of WPS Health Insurance  
[www.epiclifeline.com](http://www.epiclifeline.com)

# PARTICIPATING MEMBER'S GROUP APPLICATION

Please complete entire application, using dark black ink.



New Group  Change to Existing Group Number \_\_\_\_\_

(Please complete the Participating Member Information and any other sections applicable to your requested change.)

Requested Effective Date \_\_\_\_\_ **Important**—coverage won't become effective until we notify you in writing.

Requested Anniversary Date \_\_\_\_\_

Participating Member \_\_\_\_\_ Tax ID Number \_\_\_\_\_

Address \_\_\_\_\_ P.O. Box \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_ FAX Number \_\_\_\_\_ Date Business Started \_\_\_\_\_

Name/Title of Insurance Contact Person \_\_\_\_\_ Telephone Number \_\_\_\_\_

Type of Ownership <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship	Nature of Business (please be specific)	SIC
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Will this coverage replace existing group insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide name of current carrier	Anticipated Termination Date
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Please list the name of all subsidiaries and/or affiliated companies. Are you requesting coverage for this group?

_____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Eligible Employees _____
_____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Eligible Employees _____
_____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Eligible Employees _____
_____ →	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Eligible Employees _____

Is the firm applying for coverage eligible to file a tax return with the above named subsidiaries and/or affiliated companies?  Yes  No

A. Total Number of Employees \_\_\_\_\_ Seasonal Employees \_\_\_\_\_  
 Employees in Classes Not Eligible \_\_\_\_\_ Employees in Probationary Period \_\_\_\_\_  
 Part-time Employees \_\_\_\_\_ Other (please explain) \_\_\_\_\_  
 Total Number of *Ineligible* Employees \_\_\_\_\_ Employees are eligible if they work: 30 hours per week for groups with 2-24 eligible employees; or 80 hours or more per month for groups with 25 or more eligible employees.  
 Total Number of *Eligible* Employees \_\_\_\_\_ (Subtract ineligible employees from Total Employees)

B. To the best of your knowledge, and belief, is any employee or dependent proposed for coverage now disabled, not at work, unable to work, confined to a hospital or contemplating a confinement, on a leave of absence, handicapped, or otherwise incapacitated as of the requested effective date?  
 Yes  No If yes, please provide each person's name and status \_\_\_\_\_

C. Are any employees or dependents (including spouses) proposed for coverage currently on group continuation coverage, including COBRA?  
 Yes  No If yes, please provide each person's name and status \_\_\_\_\_

Please provide any class descriptions for your group and check the appropriate probationary period for each class. Please note that groups with 2-25 enrolled employees can only have one probationary period.

Group Dental/Vision/Life/AD&D/STD Coverages—Employee Class Description

Class 1 _____ 1st day of the calendar month following	<input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 120 <input type="checkbox"/> 150	<input type="checkbox"/> _____ days of full-time employment
Class 2 _____ 1st day of the calendar month following	<input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 120 <input type="checkbox"/> 150	<input type="checkbox"/> _____ days of full-time employment
Class 3 _____ 1st day of the calendar month following	<input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 120 <input type="checkbox"/> 150	<input type="checkbox"/> _____ days of full-time employment

Are any classes of eligible employees to be excluded from any coverage?  Yes  No  
 (If yes, please explain and identify each coverage). \_\_\_\_\_

For Office Use Only	PL	GN	DIV	ED	CC
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- A.** Eligibility (please check one)  Employee & Dependents (including spouse)  
 Employee Only
- B.** What percentage of the premium is to be paid by the participating member for each of the following coverages?
- |                                |       |                |       |              |
|--------------------------------|-------|----------------|-------|--------------|
| 1. Group Term Life/AD&D        | _____ | % per Employee |       |              |
| 2. Group Dependent Term Life   | _____ | % per Employee |       |              |
| 3. Group Short Term Disability | _____ | % per Employee |       |              |
| 4. Group Vision                | _____ | % per Employee | _____ | % per Family |
| 5. Group Dental                | _____ | % per Employee | _____ | % per Family |
- C.** The applicable benefit options are the coverage and corresponding benefit options stated in the final written quote or proposal that was issued by EPIC and signed by the Participating Member's Representative in Section 6 below. If EPIC approves this application, the actual benefit options for this participating member's group coverage(s) will be contained in the EPIC's Certificate(s) of Insurance which is part of the group insurance policy(ies) issued by EPIC to the participating member as the group policyholder.

**A. Premium**

A check for \$ \_\_\_\_\_ made payable to EPIC is being submitted with this application as payment by this participating member to be applied toward the initial month's premium if this application is approved by EPIC and the group policy/coverage is issued. The monthly premium billed by EPIC will be due and payable to EPIC on the first day of the coverage month.

**B. Group Billing Options**

- Automatic Withdrawal.** We electronically transfer your premium directly from your bank account monthly. If you select automatic withdrawal from your checking account, please attach a check with "VOID" written across it and complete the Authorization Agreement for Electronic Fund Transfer in Section 9 of this application.
- Direct Bill.** We will send a premium notice directly to your billing address. You return payment to EPIC by the premium due date. An additional \$5.00 fee will be added to your bill if you select this option.

EPIC may investigate the information on this application. Any findings may be used to deny coverage for one or more employees of the group or the entire group. Please indicate the name, title, and telephone number of an employee in your firm who can provide necessary clarification of the employee and group information provided on this application.

Name \_\_\_\_\_ Position/Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

I hereby certify that all information recorded in this application is true and complete to the best of my knowledge. I have been advised: • Not to terminate all existing coverage(s), whether on an insured or self-funded basis, unless and until EPIC notifies me in writing that coverage(s) has been approved • EPIC doesn't guarantee approval of this application or issuance of coverage(s) • This application or any coverage may be declined by EPIC • The agent represents the participating member, not EPIC • Pre-existing conditions may be subject to waiting periods and other policy limitations and restrictions.

I understand that EPIC will rely, in part, on the information provided in this application to issue or deny coverage(s). If EPIC approves this application, I understand coverage(s) will become effective on the date assigned by them; no coverage(s) will be in force until that date. I understand no coverage(s) will become effective for an eligible employee (and his/her dependents, if any) if he/she isn't actively at work with the participating member on the assigned effective date. Such coverage(s) will become effective on the first day after he/she returns to work on a full-time basis performing all the usual tasks of his/her job.

I understand no agent or other person has the authority to alter, bind EPIC, waive or change any terms, conditions, and/or provisions of the policy(ies) or any other requirement imposed by EPIC. I understand the participating member represents its employees and their dependents, not EPIC. As the participating member's authorized representative and acting on that participating member's behalf, I understand, agree with, and approve each and every certification made by the writing agent in Agent Certification Section of this application.

If this application is approved, I understand that EPIC will not be, and are not, a plan sponsor, plan administrator, or fiduciary for any purpose under the Employee Retirement Income Security Act (ERISA) of 1974, as amended, or under any other state or federal law. I understand the participating member is solely responsible for carrying out any obligation created, required, or imposed by ERISA or any other law, as it may apply to such group insurance policies.

Signature of Participating Member Representative \_\_\_\_\_ Date \_\_\_\_\_

I hereby certify and represent all of the following as being true: • I asked all questions accurately and fully recorded all information given by the Participating Member Representative in this application • I advised the Participating Member Representative not to terminate existing coverage unless, and until, EPIC notifies him/her, in writing, that this application has been approved • I used only advertising approved by EPIC to solicit this application • I told the Participating Member Representative nothing inconsistent with, or contrary to, the approved advertising about the benefits, group policy(ies)/and or coverage(s) • I didn't guarantee EPIC's approval of this application or EPIC's issuance of coverage(s) • I didn't tell the Participating Member Representative that EPIC will cover any pre-existing condition(s) of any person proposed for coverage, and • I made no false, misleading, or deceptive statements or representations and complied with all applicable insurance laws, underwriting requirements, and the marketing/sales standards maintained by EPIC.

I hereby certify and represent all of the following as being true: • I told the Participating Member Representative that EPIC has no liability for anything I said or failed to say before, during, or after the application process, that's not subsequently confirmed in writing by an authorized officer of EPIC, including, but not limited to answers given by me in response to questions asked by that representative or anyone else; • I told the Participating Member Representative that EPIC is not liable for any statement, representation, or other information provided to that Representative or anyone else that isn't expressly contained in a written document provided to them and signed by an authorized officer of EPIC; • I understand that I'm liable for any acts or omissions to the extent provided by law; and • I understand I have no authority to alter this application, bind EPIC by making promises and/or representations, or to waive or change the terms, conditions, and/or provisions of the group insurance policy(ies) or any requirement imposed by EPIC.

Signature of Writing Agent \_\_\_\_\_ Date \_\_\_\_\_

Please Print Writing Agent's Name \_\_\_\_\_ Writing Agent's Social Security Number \_\_\_\_\_

Agency \_\_\_\_\_ Tax ID Number \_\_\_\_\_

Business Address \_\_\_\_\_  
Number and Street City State Zip

Agency Telephone Number \_\_\_\_\_ Agency Number \_\_\_\_\_

Agency FAX Number \_\_\_\_\_ EPIC Representative Name \_\_\_\_\_

Initial issue of contract documents are to be sent to: ( ) District Office ( ) Agency ( ) Participating Member  
( ) Other \_\_\_\_\_

**IMPORTANT—DID YOU REMEMBER TO INCLUDE:**

- A copy of EPIC's quote and proposal.
- Completed and signed Employee(s) Group Enrollment Application for each eligible employee.
- A check made payable to EPIC for the first month's premium.
- A copy of the most recent bill from the prior carrier or administrator.
- A copy of the group's most recent Quarterly Wage and Tax Report (groups with 51 or more eligible employees should include a census of all full and part-time employees).

Agency FAX Number \_\_\_\_\_ EPIC Representative Name \_\_\_\_\_

Participating Member's Legal Name \_\_\_\_\_ Group Number \_\_\_\_\_

I hereby authorize The EPIC Life Insurance Company, hereinafter called COMPANY, to initiate, if necessary, debit entries and adjustments for any credit entries in error to my:

- Checking Account\*       Savings Account      (select one)

indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

Depository Name \_\_\_\_\_ Branch \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Transit Number \_\_\_\_\_ Account Number \_\_\_\_\_

This authority is to remain in force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination.

Signature of Participating Member Representative \_\_\_\_\_ Date \_\_\_\_\_

Name and Title of Participating Member Representative (Please print) \_\_\_\_\_

Telephone Number \_\_\_\_\_

\*IF USING A CHECKING ACCOUNT, PLEASE ATTACH A CHECK WITH "VOID" WRITTEN ACROSS IT.