McKinney Independent School District

Group Accident & Group Hospital Indemnity

Benefit Overview

Group Accident Insurance

Group Accident insurance is designed to help covered employees meet the out-of-pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic. Indemnity lump sum benefits are paid directly to the employee based on the amount of coverage listed in the schedule of benefits. The accident base plan is guaranteed issue, so no health questions are required.

Plan Type	On/Off Job
Covered Conditions	See Schedule of Benefits
Wellness Benefit	Included - $50 per insured per calendar year
Premium	Paid by the Employee

Monthly Premium (includes Wellness)			
Employee	**Employee and Spouse**	**Employee and Child**	**Employee, Spouse and Child**
$16.04	$26.30	$28.50	$38.76

Spouse issue ages are 17 through 64 years. Dependent Children issue ages are newborn up to their 26th birthday coverage age defined in the policy.

Group Hospital Indemnity

Group Hospital Indemnity insurance is designed to help provide financial protection for covered individuals by paying a benefit due to a hospitalization and in some cases, for treatment received for an accident or sickness, even if that treatment occurs outside the hospital. Employee can use the benefit to meet the out-of-pocket expenses and extra bills that can occur. Indemnity lump sum benefits are paid directly to the employee based on the amount of coverage listed, regardless of the actual cost of treatment.

Hospital Admission	$1,000 per insured per calendar year
Wellness	Included - $50 per insured per calendar year
Portability	Included
Pre-Existing Condition Period	12/12 Exclusion
Premium	Paid by the Employee

Monthly Premium (includes Wellness)				
Age Band	**Employee**	**Employee and Spouse**	**Employee and Child**	**Employee, Spouse and Child**
17 - 49	$12.52	$24.99	$17.82	$30.29
50 - 59	$14.26	$29.14	$19.56	$34.44
60 - 64	$19.04	$39.19	$24.34	$44.49
65 +	$27.42	$56.79	$32.72	$62.09

Note: *Family Coverage Options assume Employee and Spouse are in the same Age Band. If Employee and Spouse are in different Age Bands, the final Monthly Premium amounts will be different.*

Spouse issue ages are 17 through 64 years. Dependent Children issue ages are newborn up to their 26th birthday or to the maximum coverage age defined in the policy.

Group Accident Insurance

Exclusions
Unum will not pay any benefits for a claim that is caused by, contributed to by or occurs as a result of:

- participating in war or act of war, whether declared or undeclared;
- committing acts of terrorism;
- riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- operating, learning to operate, serving as a crew member of or jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven. This does not include flying as a fare paying passenger;
- engaging in hang-gliding, bungee jumping, sailgliding, parasailing, parakiting;
- participating or attempting to participate in a felony, being engaged in an illegal occupation or being incarcerated in a penal institution;
- committing or trying to commit suicide or injuring oneself intentionally, whether sane or not;
- practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- having a work related injury (unless On-Job Accident is included in the plan);
- having any sickness or declining process caused by a sickness, including physical or mental infirmity including any treatment for allergic reactions. Unum also will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by an injury.

In addition to the Exclusions listed above, if applicable to your plan design, Unum will also not pay the Catastrophic Accidental Dismemberment or Catastrophic Accidental Loss benefit for the following injuries that are caused by or are the result of:

- an insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician; or
- injuries to a dependent child received during the birth.

Termination of Employee Coverage
If you choose to cancel your coverage under the policy, your coverage ends on the first of the month following the date you provide notification to your employer.

Otherwise, your coverage under the policy ends on the earliest of the:
- date this policy is cancelled;
- date you are no longer in an eligible group;
- date your eligible group is no longer covered;
- date of your death;
- last day of the period for which you made any required contributions; or
- last day you are in active employment. However, as long as premium is paid as required, coverage will continue if you elect to continue coverage under the Portability provision or in accordance with the layoff and leave of absence provisions of this policy.

Unum will provide coverage for a payable claim which occurs while you are covered under this policy.

This material is intended to be a brief description of the policy. The policy definitions, exclusions and limitations will be used to determine actual benefit decisions. Product availability and provisions may vary by state. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GA-1 or contact your Unum representative.

THIS IS A LIMITED POLICY

Underwritten by: Unum Life Insurance Company of America, 2211 Congress Street, Portland, ME 04122

AE-1128 (06/17)

Group Hospital Indemnity

Exclusions

Unum will not pay any benefits for a claim that is caused by, contributed to by or occurs as a result of:

- participating in war or act of war, whether declared or undeclared;
- committing acts of terrorism;
- treatment for alcoholism or drug addiction, unless the insured is addicted to a narcotic taken on the advice of a physician;
- treatment for dental care or dental procedures, unless treatment is the result of a covered accident;
- elective procedures and/or cosmetic surgery or reconstructive surgery, unless it is a result of trauma, infection or other diseases;
- participating or attempting to participate in a felony or being engaged in an illegal occupation;
- any pregnancy of a dependent child, including services rendered to her child after birth;
- committing or trying to commit suicide or injuring oneself intentionally, whether sane or not;
- hospital confinement caused by, contributed to by, or resulting from mental illness. However, dementia as a result of stroke, trauma, viral infection, Alzheimer's disease or other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment are covered under this policy;
- any hospital confinement of a newborn following the birth unless the newborn is sick or injured.

Termination of Employee Coverage. If you choose to cancel your coverage under the policy, your coverage will end on the first of the month following the date you provide notification to your employer.

Otherwise, your coverage under the policy ends on the earliest of the:

- date this policy is cancelled;
- date you are no longer in an eligible group;
- date your eligible group is no longer covered;
- date of your death;
- last day of the period for which you made any required contributions; or
- last day you are in active employment.

However, as long as premium is paid as required, coverage will continue if you elect to continue coverage under the Portability provision (if your plan includes a Portability provision) or in accordance with the layoff, leave of absence, and absence due to injury or sickness provisions of this policy.

Unum will provide coverage for a payable claim which occurs while you are covered under this policy.

This material is intended to be a brief description of the policy. The policy definitions, exclusions and limitations will be used to determine actual benefit decisions. Product availability and provisions may vary by state. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GHI-1 or contact your Unum representative.

THIS IS A LIMITED POLICY

Underwritten by: Unum Life Insurance Company of America, 2211 Congress Street, Portland, ME 04122

AE-1166 (01/13)

Group Accident Insurance
Instructions for
Evidence of Insurability Application

Application Type: Check off the applicable application type based on the following definitions:

- **Newly Eligible:** application for insurance on a newly eligible or newly hired employee. Usually an employee applying for this coverage for the first time.
- ~~**Late Applicant:**~~ application for insurance on a previously eligible employee. If you are working for employer in an eligible group and 31 days after the date you were eligible for coverage has passed. Requires completion of health questions in Section 4 if applying for the Hospital Confinement due to Covered Sickness Benefit.
- ~~**Replace Existing Unum Coverage:**~~ Change from existing to later or updated version of this product. Evidence of insurability may be required. A new policy / certificate will be issued to replace the existing policy.
- ~~**Change to Existing Coverage:**~~ If you currently have insurance coverage with Unum and would like to make any changes to your coverage. Including, but not inclusive, to addition or deletion of benefits.
- **Rehire:** If your employment with this group ends and you are rehired.

SECTION 1: Employee Information
Fully complete this section making sure you have answered any and all questions completely and accurately. Information pertaining to your employer name and address (Group number and Eligibility Class, if known) as well as your personal information must be provided.

SECTION 2: Spouse Information
If applying for dependent coverage, fully complete this section making sure you have answered any and all questions completely and accurately.

SECTION 3: Coverage Information
Based on your Plan Highlights (Highlight sheet), choose the amount of coverage you desire (Employee).

Select only one family coverage option for Group Accident.

If your plan includes the option for Hospital Confinement due to Covered Sickness and you wish to elect this Benefit, check Hospital Confinement due to Covered Sickness Benefit under "Optional Employee selected benefits."

If you require assistance to complete this section, please contact your Plan Administrator.

SECTION 4: Medical Profile
If applying for the Hospital Confinement due to Covered Sickness Benefit, answer the health questions in Section 4.

SECTION 5: Employee (Applicant) Statements
You are required to complete this section. This application cannot be processed if you fail to sign and date the application.

NOTE:
If there are unanswered questions or missing information on the application, it may delay consideration of your application for insurance.

APPLICATION FOR
GROUP ACCIDENT INSURANCE
Evidence of Insurability

Unum Life Insurance Company of America ("Unum")
2211 Congress Street • Portland, Maine 04122

Application Type: ☐ Newly Eligible ~~☐ Late Applicant~~ ~~☐ Replace Existing Unum Coverage~~ ~~☐ Change to Existing Coverage~~ ☐ Rehire

SECTION 1: Employee (Applicant) Information – Always Complete

Employee Name (First, Middle, Last)		Social Security Number
Home Address (Street/PO Box)		Gender ☐ F ☐ M
City		Date of Birth (mm/dd/yyyy)
State	Zip Code	Home Phone #
Email Address		Employee ID/Payroll #
Employer Name	Customer Number	Date of Hire (mm/dd/yyyy)
St/PO Box		Occupation
City		
State	Zip Code	Work Phone #
Are you Actively at Work? ☐ Yes ☐ No		Scheduled Number of Work Hours/week
Primary beneficiary		Relationship
Contingent beneficiary		Relationship

SECTION 2: Spouse Information – Complete Only if applying for Spouse Coverage

Name (First, Middle, Last)		Social Security Number
Gender ☐ F ☐ M	Does the Spouse live in the U.S.? ☐ Yes ☐ No If "No," is your Spouse a U.S. Citizen? ☐ Yes ☐ No	Date of Birth (mm/dd/yyyy)
Primary beneficiary		Relationship
Contingent beneficiary		Relationship

SECTION 3 Coverage Information

Group Accident ☐ Employee (only) ☐ Employee, Spouse ☐ Employee, Dependent Child(ren) ☐ Employee, Spouse and Dependent Child(ren)	**Cost per pay period** $_____
Employer selected benefit ☐ Wellness **Optional Employee selected benefit** ☐ Hospital Confinement due to Covered Sickness $_____	$_____ $_____
Total Cost Per Pay Period	$_____

Employee Name: _____ (Applicant)

Employee SSN: _____ (Applicant)

SECTION 4: Complete if applying for the Hospital Confinement due to Covered Sickness Benefit

	Employee (Applicant)	Spouse
1. Current height and weight	___ ft. ___ in. ____ lbs.	___ ft. ___ in. ____ lbs.
2. Have you (applicant) or your spouse (if applying) tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No
3. In the past 12 months, have you or your spouse (if applying) received medical advice or sought treatment for:	☐ Yes ☐ No	☐ Yes ☐ No

- Insulin-dependent diabetes
- Atrial Fibrillation, Angina, Heart Attack, Stroke, Coronary Artery disease, Heart Surgery, Congestive Heart Failure or Cardiomyopathy
- Cirrhosis of the liver or Hepatitis B & C
- High blood pressure treated with 3 or more medications
- Chronic Obstructive Pulmonary disease (COPD) or Emphysema
- Kidney disease (excluding kidney stones)or failure
- Cancer or Malignancy of any kind including Leukemia, Hodgkin's disease or Melanoma (excluding Basal or Squamous Cell carcinoma).

SECTION 5: Employee (Applicant) Statements

I understand the effective date of coverage issued based on this application is subject to the application being acceptable under the rules, limits and standards of Unum Life Insurance Company of America (hereafter Unum) and the insurance is, or would have been, issued as applied for (or if not issued as applied for, then as modified). The effective date of approved coverage will be determined as set forth in the certificate of coverage provided to me. If I pay part or all of the cost of my coverage, the effective date will not be earlier than the first of the month in which payroll deductions begin.

I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am applying allows for alternate methods to pay insurance premiums).

All statements and answers provided on this application are true and complete, and are given to obtain insurance.

CAUTION: Unum will rely on the information provided in order to evaluate this application. If the answers provided are incorrect or untrue, Unum may deny benefits or rescind insurance. Any person who, knowingly and with intent to defraud or deceive any insurance company, submits an insurance application or files a claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

Employee (Applicant) Signature	Date (mm/dd/yyyy)

INSTRUCTIONS

Complete the information below only if you or any person proposed for coverage on the preceding application is currently eligible for Medicare. To be eligible for Medicare, you must be either: (1) age 65 or older; or (2) disabled.

Medicare Certification Form

This is to certify that I have received the "Guide to Health Insurance for People with Medicare" and the "Important Notice to Persons on Medicare".

Employee (Applicant) Signature	Date (mm/dd/yyyy)

GROUP HOSPITAL CONFINEMENT INDEMNITY INSURANCE
EVIDENCE OF INSURABILITY

Instructions for Application

IMPORTANT: PLEASE FILL OUT ALL SECTIONS FULLY AND COMPLETELY BASED ON THE INSTRUCTIONS BELOW.
If there are unanswered questions or missing information on the application, it may delay consideration of your application for insurance.

Instructions for Application

Definition of Application Type: Check the applicable application type:

- **Newly Eligible:** Application for insurance on a newly eligible or newly hired employee, usually a new employee applying for this coverage.
- ~~**Change to Existing Coverage:**~~ Application for insurance for requested changes to an existing Unum policy.
- ~~**Replace Existing Unum Coverage:**~~ Change from existing to later or updated version of this product. Evidence of Insurability may be required. A new policy/certificate will be issued to replace the existing policy
- ~~**Late Applicant:**~~ Application for insurance for a previously eligible employee. An individual is considered to be a late applicant if working for the employer in an eligible group and the period within which coverage could first be applied for without Evidence of Insurability has passed.
- **Rehire:** If employment ends with this group and you are rehired.

Section 1: Employee Information
Fully complete this section making certain to answer any and all questions completely and accurately. Information regarding your employer's name and address, as well as your personal information must be provided. (See your Plan Administrator if further information is needed.)

Section 2: Spouse Information
Complete this information if applying for Spouse coverage. Fully complete this section making certain to answer any and all questions completely and accurately.

Section 3: Coverage Information
Make no more than one selection. If assistance is required for completion, please contact your Plan Administrator.

Section 4: Medical Profile
Complete as required for all underwritten coverage.

Section 5: Employee (Applicant) Statements
This section is required to be completed. This application cannot be processed if you fail to sign and date the application.

APPLICATION FOR GROUP HOSPITAL CONFINEMENT INDEMNITY INSURANCE
Evidence of Insurability

Unum Life Insurance Company of America ("Unum")
2211 Congress Street • Portland, Maine 04122

Application Type: ☐ Newly Eligible ~~☐ Late Applicant~~ ~~☐ Replace Existing Unum Coverage~~ ~~☐ Change to Existing Coverage~~ ☐ Rehire

SECTION 1: Employee (Applicant) Information – Always Complete

Employee Name (First, Middle, Last)		Social Security Number
Home Address (Street/PO Box)		Gender ☐ F ☐ M
City		Date of Birth (mm/dd/yyyy)
State	Zip Code	Home Phone #
Email Address		Employee ID/Payroll #
Employer Name		Date of Hire (mm/dd/yyyy)
Street/PO Box		Occupation
City		
State	Zip Code	Work Phone #
Are you Actively at Work? ☐ Yes ☐ No		Scheduled Number of Work Hours/week

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship

SECTION 2: Spouse Information – Complete Only if applying for Spouse Coverage

Name (First, Middle, Last)		Social Security Number
Gender ☐ F ☐ M	Does the Spouse live in the U.S.? ☐ Yes ☐ No	Date of Birth (mm/dd/yyyy)

SECTION 3: Coverage Information – Complete for Employee (Applicant) and for Spouse (if applicable)

☐ Employee (only) ☐ Employee & Spouse ☐ Employee & Dependent Child(ren)
☐ Employee, Spouse, & Dependent Child(ren)

	Employee (Applicant)	**Spouse**
Will coverage applied for replace or modify any existing Unum insurance coverage?	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes," provide details below:

Insured's Name	Policy Number
Total Cost per Pay Period	$

Employee Name: _____ Employee SSN: _____

SECTION 4: Medical Profile – Complete as required for all underwritten coverage

	Employee (Applicant)	Spouse
1. Current height and weight	___ ft. ___ in. ____ lbs.	___ ft. ___ in. ____ lbs.
2. Have you (applicant) or your spouse (if applying) tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No
3. In the past 3 years, have you (applicant) or your spouse (if applying) received medical advice, sought treatment, including medication, or been hospitalized for any of the following:	☐ Yes ☐ No	☐ Yes ☐ No
– Atrial fibrillation, angina, heart attack, coronary artery disease, heart surgery, congestive heart failure, cardiomyopathy, or heart valve disease		
– Stroke/transient ischemic attack (TIA), aneurysm		
– Vascular disease excluding varicose veins		
– Chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis (excluding asthma)		
– Cirrhosis of the liver, hepatitis (other than A)		
– Diabetes (other than gestational or diet controlled)		
– Alcohol or drug usage		
– High blood pressure with a systolic reading (top number) greater than 166 or a diastolic reading (lower number) greater than 100		
– Kidney disease or failure (excluding kidney stones)		
– Musculoskeletal disease not related to an accidental injury (excluding carpal tunnel syndrome or osteoarthritis)		
– Neurological disease excluding headache or epilepsy if no seizure in the last 3 years		
– Schizophrenia, psychosis, major depressive disorder, bipolar disorder or post traumatic stress disorder		
– Cancer or malignancy of any kind including leukemia, Hodgkin's disease or skin cancer (excluding basal cell or squamous cell carcinoma of the skin)		

Employee Name: _____ Employee SSN: _____

SECTION 5: Employee (Applicant) Statements

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I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am applying allows for alternate methods to pay insurance premiums).

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Employee (Applicant) Signature	Date (mm/dd/yyyy)

INSTRUCTIONS

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