Continental American Insurance Company

Election Form – Conversion Group Long Term Disability

Instructions on Completing the Form

Employer (Policyholder or Recordkeeper):

1. Complete all of Section 1 when coverage terminates.
2. Provide a copy to your employee on or before the employee's termination date.
3. Retain a copy for your records.

Applicant:

1. To enroll in this plan, you must have been enrolled in your employer's long term disability plan for a minimum of 12 months.
2. Review Section 1 for accuracy.
3. Complete Section 2 and select a plan option. The option selected may not exceed the benefit maximum under your former plan.
4. Mail a copy of this form along with the first premium payment to Continental American Insurance Company at the LTD Conversion Processing Unit address below.
5. Maintain a copy for your records.

Mailing Address and Contact Information

Continental American Insurance Company LTD Conversion Processing Unit P.O. Box 740272 Atlanta, GA 30374-0272	Toll Free: 1.800.206.8826

Section 1 – Completed by the Employer (Policyholder and/or Recordkeeper)

Employer Group Name	Group Number	Division Department	
Applicant's Coverage Termination Date	Date of Notice of Coverage Termination	Legal Gender □ M □ F	
Applicant's First, M.I., Last Name	SSN	Date of Birth	Age
Applicant's Mailing Address	City	State	ZIP
Applicant's Annual Salary at Coverage Termination	Reason for Coverage Termination □ Job Termination □ Retirement □ No Longer an Eligible Employee		
Applicant's Group Coverage LTD Effective Date	Was the applicant actively at work on termination date? □ Yes □ No		
Eligibility Period □ 31 Days □ 60 Days	Applicant's Occupation and Job Duties		
Scheduled benefit percent under the prior group LTD plan (e.g., 50%, 60%, 66⅔%)	Maximum Monthly Benefit		

Was Employee covered under the prior LTD plan for 12 months or more? □ Yes □ No	Employee effective date of prior plan		
The information provided is correct and complete to the best of my knowledge and belief.			
Signature of Policyholder's duly authorized representative		Date	
Policyholder's Group Contact First, Last Name		Employer Group Contact Email Address	
Policyholder's Mailing Address	City	State	ZIP

Section 2 – Election Form: To Be Completed by Applicant

Election Eligibility Period: You must apply for Portability coverage within the Eligibility Period. This period starts on the date your prior group long term disability plan was terminated.

Are you eligible for coverage under any other Group Long Term Disability Plan? □ Yes □ No
Are you enrolled for coverage under any other Group Long Term Disability Plan? □ Yes □ No

Plan Options (check one):

□ **Plan A:** Standard Maximum: 60% of your monthly earnings as of the date your LTD coverage terminated under the Group Plan, to a monthly maximum benefit of $4,000.*

□ **Plan B:** 60% of your monthly earnings as of the date your LTD coverage terminated under the Group Plan, to a monthly maximum benefit of $8,000.* To enroll for this option, you are required to submit medical evidence of insurability. The amount in excess of $4,000 will not become effective until you are notified of acceptance by Continental American Insurance Company.

*If your Scheduled Benefit and/or the Maximum Monthly Benefit under the prior Plan you are converting was less than the amount under the option you have selected, the conversion plan issued to you will include the lesser amounts.

Direct billing mode (check one):
□ Quarterly
□ Semi-Annually
□ Annually

The first Premium payment must be submitted with application.
To determine the first amount of premium due, see enclosed LTD portability rates.

Note: All coverage amounts are subject to applicable state laws.

Amount of premium enclosed: $ _____ (Refer to the premium calculation worksheet).

All forms and the first premium payment must be received by CAIC before the end of your eligibility period.

Comments:

Important Notices

Notice of *10 Day Right to Examine Coverage Under the Master Policy

You may cancel coverage under the Master Policy no later than 10 days after the Certificate has been received by you. You may cancel it by returning the Certificate, with a written request to cancel at our LTD Conversion Processing Unit address. Upon our receipt of the Certificate, and request to cancel, your coverage will be void from the inception. We will refund all premiums paid less any indebtedness and it shall be as if no Certificate was issued.

* In Utah you have 30 days to examine and return the Certificate.
* In North Dakota you have 20 days to examine and return the Certificate.

Authorization and Agreements

I, the undersigned applicant, wish to become a participating member in the Continental American Insurance Company Trust, a discretionary group trust established in Delaware ("Trust"). The Trustee and Policyholder is Wilmington Trust Company, and the Trust Administrator is Continental American Insurance Company. The Insurer is Continental American Insurance Company. This election form also serves as my application ("Application") to become a participating member in the Trust and to receive insurance coverage under the group master insurance policy ("Master Policy") issued to the Trustee. I am acquainted with the rules of eligibility. I understand that the effective date of the insurance for which I am applying is subject to the approval of the Trust Administrator, acting on behalf of the Insurer. I understand that the benefits provided by the Insurer are subject to the terms of the Master Policy issued to the Trustee, as amended from time to time, and the certificate of coverage ("Certificate") to be issued to me evidencing my coverage under the Master Policy. I understand that the Master Policy may be terminated by the Insurer or the Policyholder following due written notice. I agree to remit to the Trust Administrator regularly in advance the required premium due for insurance benefits. I understand that failure to pay billed premiums will result in automatic termination of insurance coverage at the end of the grace period. In that case I will owe and agree to pay the premium due for the grace period. I represent that all information contained in this Application is true and complete to the best of my knowledge and belief.

Nevada Residents: Failure to pay billed premiums during the grace period will result in automatic termination of coverage retroactive back to the day prior to the date the grace period began.

I understand and agree that:

- This Election Form will be part of the Master Policy that provides insurance coverage. A copy of this Election Form will be attached to my Certificate when issued;
- The Master Policy permits the Trustee to change, reduce, restrict, or terminate my rights or benefits under the Master Policy without my consent upon 60 days, written notice;
- Plans are underwritten by Continental American Insurance Company; and
- The maximum coverage provided under this LTD Conversion Plan is limited to the lesser of coverage provided under my prior plan and the coverage enrolled for under this plan.

□ I agree to accept electronic delivery of my certificate of coverage and any notices as it relates to my Plan.

□ I request delivery of my certificate of coverage and any notices by U.S. Mail.

Written Signature			
I have read, or have had read to me, this completed Election Form. I understand that coverage is voluntary and I may cancel this insurance plan at any time upon written notice to CAIC at the Conversion Unit address. I represent that all information provided by me is true and correct to the best of my knowledge and belief. **The Fraud Statement for your state of residence should be reviewed prior to signing and submitting the application.**			
Signature of Applicant		Date	
Applicant's First, Middle, Last Name			
Applicant's Telephone Number		Applicant's Email Address	
Applicant's Mailing Address	City	State	ZIP

Rates and Premium Calculation

Quarterly Rates Per $100 Of Monthly Benefit

Rates are subject to change based on rate increases implemented on all converted business in accordance with state laws and regulations.

Attained Age Rate for Employee	Term Long Term Disability Rate
<25	$2.26
25 – 29	$2.78
30 – 34	$3.91
35 – 39	$6.20
40 – 44	$9.07
45 – 49	$12.73
50 – 54	$17.15
55 – 59	$21.14
60 – 64	$21.27
Coverage ends at age 65.	

Premium Calculation Worksheet

Long Term Disability Insurance	Example Calculation	Your Calculation
1. Age	44	
2. Quarterly rate from table above	$9.07	
3. Annual earnings	$60,000	
4. Divide Line 3 by 12 to get monthly earnings	$5,000	
5. Multiply Line 4 by 60% (If greater than $4,000, use $4,000)	$3,000	
6. Divide Line 5 by 100	30	
7. Multiply Line 6 by Line 2 for quarterly premium due	$272.10	
8. Multiply Line 6 x 2 for semi-annual premium due	$544.20	
9. Multiply Line 6 x 4 for annual premium due	$1,088.40	
Total Premium Due		**$**

Fraud Warnings and Other Notices

If you have applied for insurance under a policy issued in one of the following states, **or** if you reside in one of the following states, note the following applicable warning:

FOR RESIDENTS of: Arkansas, District of Columbia, Rhode Island, and all other states except as listed below:

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 is guilty of a crime and may be subject to fines and confinement in prison.

FOR RESIDENTS of: Alabama

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 is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For Residents of: Arizona

Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of: Delaware

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

For Residents of: California

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For Residents of: Connecticut

A person is guilty of insurance fraud when the person, with the intent to injure, defraud or deceive any insurance company: (1) Presents or causes to be presented to any insurance company, any Written or oral statement including computer generated documents as part of, or in support of, any application for any policy of insurance or a claim for payment or other benefit pursuant to such policy of insurance, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such application or claim; or (2) assists, abets, solicits, or conspires with another to prepare or make any Written or oral statement that is intended to be presented to any insurance company in connection with, or in support of, any application for any policy of insurance or any claim for payment or other benefit pursuant to such policy of insurance, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such application or claim for the purposes of defrauding such insurance company.

For Residents of: Florida

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

For Residents of: Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files a 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 of law.

For Residents of: Kansas and Massachusetts

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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, and may subject such person to criminal and civil penalties.

For Residents of: Maryland

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of: New Hampshire

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of

claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in section 638:20. as provided in RSA 638:20.

For Residents of: Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For Residents of: Ohio

Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

For Residents of: Pennsylvania

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.

For Residents of: Maine, Tennessee, and Washington

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For Residents of: All Other States

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.