Short Term Disability Insurance

Deerfield Community School District

If you were out of work due to an illness or accident, how long would you or your family stay afloat without your paycheck?

The first few months of a disability could be costly. Loss of income during this time may result in a financial hardship that could be difficult to recover. This Short-Term Disability Insurance plan works in coordination with your Long-Term Disability Insurance plan to cover you during the time period before your Long-Term benefits begin.

- If you suffer a disability, this plan would pay up to 66 2/3% of your annual salary divided by 52, depending upon your coverage choice, per week.
- Benefits are paid *in addition to* sick leave pay and Worker's Compensation.
- Benefits are tax-free if you pay for coverage with after-tax dollars. (If unsure, confirm with your employer.) Please see your tax adviser for further specific advice.
- Benefits for a covered illness or injury continue for 60 days, the date you are no longer disabled or until you are eligible to receive benefits under your Long-Term Disability Insurance plan, whichever comes first.
- Benefits start on the 1st day for a covered disability resulting from an accident and 4th day for a disability resulting from an illness.

Summer Coverage

Summer vacation period is included as long as the covered disability would have prevented you from engaging in your normal occupation, if school were in session.

Maternity Coverage

Pregnancy, childbirth and related medical conditions are covered the same as any other illness. Coverage may continue up to 6 weeks for natural childbirth, 8 weeks cesarean delivery or longer if there are complications.

Definition of Disability

Disability and disabled means that the insured person is, as a result of physical disease, injury, pregnancy, substance abuse or mental disorder, unable to perform a majority of the material duties of his or her own occupation.

(over)

For questions, contact: National Insurance Services, 800.627.3660
Denise Yanny, dyanny@NISBenefits.com or Mike Strobl, mstrobl@NISBenefits.com

Return forms to: HR Coordinator - Wendy Helminiak **by:** September 8, 2017

Coverage effective date: October 1, 2017

Choice of Benefit Levels

Your Election cannot exceed 66-2/3% of annual salary divided by 52. Based on this equation, please choose one of the following benefit levels.

If your annual salary is between:	Your choice of the corresponding benefit level or less
$11,465 - $13,648	$147.00
$13,649 - $17,470	$175.00
$17,471 - $21,291	$224.00
$21,292 - $23,475	$273.00
$23,476 -$27,843	$301.00
$27,844 - $32,757	$357.00*
$32,758 - $36,033	$420.00*
$36,034 - $39,309	$462.00*
$39,310 +	$504.00*

Examples:

- Annual salary of $22,000 can apply for a benefit amount of $273 or less.
- Annual salary of $30,000 can apply for a benefit amount of $357 or less.
- Annual salary of $40,000 can apply for a benefit amount of $504 or less.

**If you are choosing coverage for the first time with a weekly benefit amount of $357 or above, you are required to complete and submit the attached medical questionnaire (Evidence of Insurability Form). Applications subject to medical questions may be denied due to the answers to those questions. If you are denied coverage at the higher level, you will be automatically enrolled in the $301 level.*

Pre-Existing Conditions

This provision applies to all new enrollees and all employees electing to increase their Weekly Benefit amount. If you received medical treatment, took prescribed drugs, or consulted a physician for an illness or injury in the 12 months before coverage began or increased, that particular sickness or injury or anything related to the condition will not qualify for benefits during the first 12 months of coverage.

General Exclusions

The policy does not cover any disability: caused or contributed to by war, declared or undeclared, or any act of war; that occurs during any military leave for active duty, including training duty, the National Guard or Coast Guard, or any active or reserve component of the military forces; due to your attempted suicide while sane or insane; as a result of your intentionally self inflicted injuries; caused or contributed to by committing of or attempting to commit a crime; while you are imprisoned, confined in a penal or correctional institution or under house arrest; as a result of your participation in a riot; or as a result of your engaging in an illegal activity.

Administered by:

NATIONAL INSURANCE SERVICES

Corporate Headquarters
250 South Executive Drive, Suite 300, Brookfield, WI 53005
Offices Nationwide
800.627.3660

Underwritten by:

Madison National Life Insurance Company
Independence Holding Group
PO Box 5008, Madison, WI 53705

This is a brief description of disability insurance. For complete details including all benefits, exclusions and limitations, refer to Certificate form number GSDI-C200-(12/06) as issued to your employer.

Madison National Life Insurance Company, Inc. is a Wisconsin Insurance company and a Member of the IHC Group. The IHC Group is an insurance organization composed of Independence Holding Company (NYSE: IHC) and its operating subsidiaries. The IHC Group has been providing life, health and stop loss insurance solutions for over 30 years. For information on the IHC Group, see www.ihcgroup.com.

Insurance Benefit Enrollment Form

NATIONAL INSURANCE SERVICES

Employee: Complete and return this form to your Benefits Administrator.

Benefits Administrator: Retain a copy of this form for your records and provide employee with a copy. Mail original to:
National Insurance Services, Attn: Billing Department
250 S. Executive Drive, Suite 300, Brookfield, WI 53005-4273
Phone: 1.800.627.3660 Fax: 262.785.9269

Enter your information:

Employer Name: Deerfield Community School District			NIS Group Number: 016100	
Full Name (Last name, First name, Middle Initial):			Date of Hire:	
Home Address:	City:	State:	Zip:	
Social Security Number:	☐ Single ☐ Married	U.S. Citizen? ☐ Yes ☐ No*	Date of Birth:	☐ Male ☐ Female
Occupation/Title:			Hours worked per week:	Annual Salary:

*If you are not a U.S. Citizen, please provide a copy of your Visa.

Insurance benefits:

Employer-Provided Insurance Benefits:

☒ Long-Term Disability

Optional Insurance Benefits:

☐ Elect ☐ Decline

Short-Term Disability (Weekly Benefit cannot exceed 66-2/3% of annual salary divided by 52)

CHECK BENEFIT DESIRED

Weekly Benefit	Rate per Month
☐ $147.00	$10.91
☐ $175.00	$12.72
☐ $224.00	$16.34
☐ $273.00	$20.00
☐ $301.00	$21.81

Weekly Benefit	Rate per Month
☐ $357.00*	$26.05
☐ $420.00*	$30.30
☐ $462.00*	$33.33
☐ $504.00*	$36.36
☐ I wish to decline this coverage.	

*To be eligible for these benefit levels, you must provide proof of insurability by answering a health questionnaire and meeting medical requirements.

Sign here (required whether electing or declining any coverage):

I have been given the opportunity to apply for group insurance and agree to accept or decline coverage(s) as noted above. If I am declining coverage(s), I understand that if my dependents or I decide to apply for coverage at a later date, Evidence of Insurability (medical questions) may be required at my own expense and the insurance company must approve coverage. If I have elected any coverage(s) above, I authorize my employer to make any required deductions, if any, from my salary to pay my portion of the insurance premium when my insurance becomes effective.

Warning: Any person who knowingly presents false information on an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Signature:	Date:

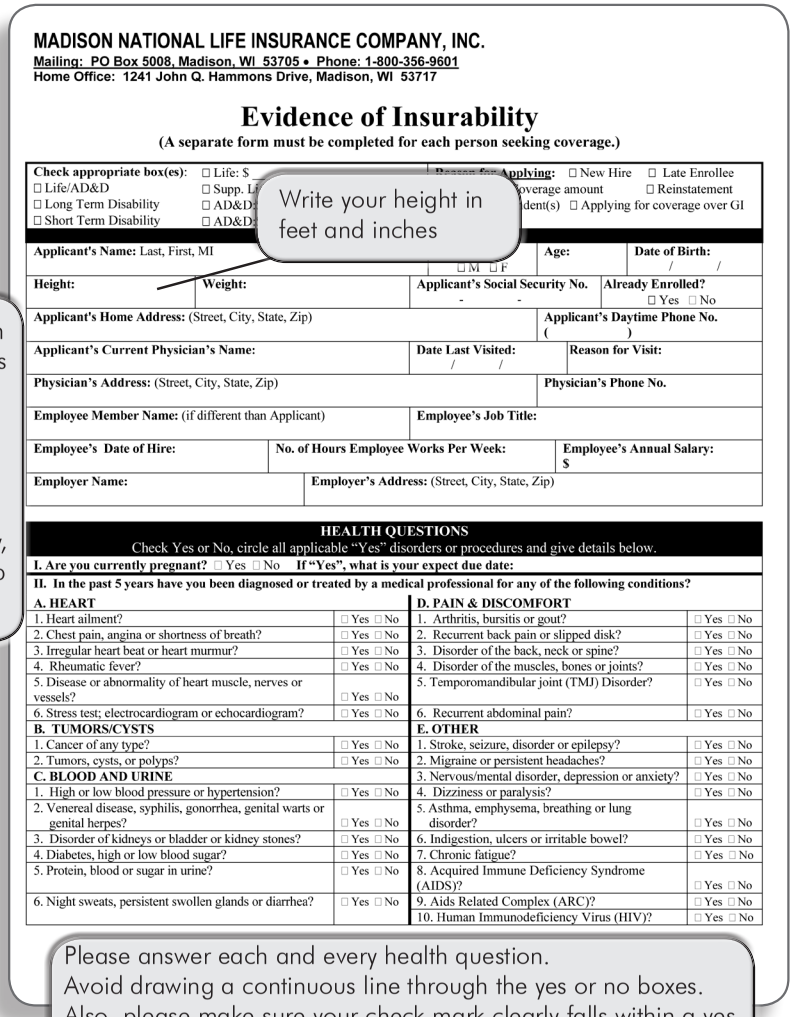
Please note: Please fill out the attached "Evidence of Insurability" medical questionnaire form ONLY if any of the following applies to you:

- **If you enroll after 30 days of becoming employed or becoming eligible.**
- **If you wish to increase coverage after 30 days of becoming employed.**
- **If you are applying for a $357 Short-Term Disability Insurance benefit or higher.***
- **If the 10 lives participation requirement is not met.**

*If you are denied for that level of coverage, you will be automatically enrolled in the plan with a weekly benefit amount of $301.

Helpful Hints When Filling Out Your "Evidence of Insurability" Application

In order to process your request for Life and or Disability Insurance you are required to complete the following application. Please use **blue or black ink** and make sure all questions are answered completely and fully. An incomplete document with missed answers will result in the application being returned to you and a delay in the processing of your request. **If you are requesting coverage for family members, complete an additional form for each person.**



MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601
Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717

Evidence of Insurability
(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es): ☐ Life: $ ☐ Life/AD&D ☐ Supp. Li ☐ Long Term Disability ☐ AD&D ☐ Short Term Disability ☐ AD&D — Reason for Applying: ☐ New Hire ☐ Late Enrollee ☐ Increase in coverage amount ☐ Reinstatement ☐ Dependent(s) ☐ Applying for coverage over GI

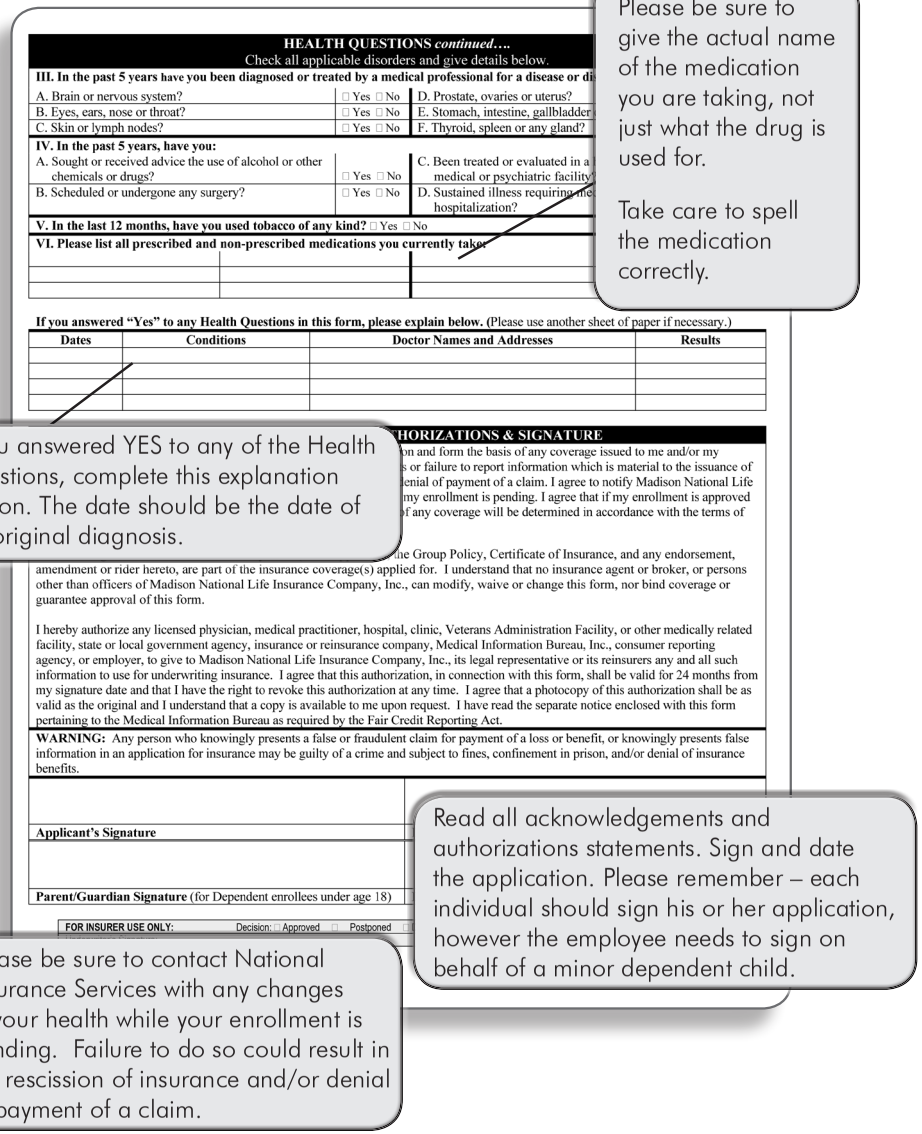
Applicant's Name: Last, First, MI | Age: | Date of Birth: / /
☐M ☐F
Height: | Weight: | Applicant's Social Security No. - - | Already Enrolled? ☐ Yes ☐ No
Applicant's Home Address: (Street, City, State, Zip) | Applicant's Daytime Phone No. ( )
Applicant's Current Physician's Name: | Date Last Visited: / / | Reason for Visit:
Physician's Address: (Street, City, State, Zip) | Physician's Phone No.
Employee Member Name: (if different than Applicant) | Employee's Job Title:
Employee's Date of Hire: | No. of Hours Employee Works Per Week: | Employee's Annual Salary: $
Employer Name: | Employer's Address: (Street, City, State, Zip)

HEALTH QUESTIONS
Check Yes or No, circle all applicable "Yes" disorders or procedures and give details below.

I. Are you currently pregnant? ☐ Yes ☐ No **If "Yes", what is your expect due date:**

II. In the past 5 years have you been diagnosed or treated by a medical professional for any of the following conditions?

A. HEART		**D. PAIN & DISCOMFORT**	
1. Heart ailment?	☐ Yes ☐ No	1. Arthritis, bursitis or gout?	☐ Yes ☐ No
2. Chest pain, angina or shortness of breath?	☐ Yes ☐ No	2. Recurrent back pain or slipped disk?	☐ Yes ☐ No
3. Irregular heart beat or heart murmur?	☐ Yes ☐ No	3. Disorder of the back, neck or spine?	☐ Yes ☐ No
4. Rheumatic fever?	☐ Yes ☐ No	4. Disorder of the muscles, bones or joints?	☐ Yes ☐ No
5. Disease or abnormality of heart muscle, nerves or vessels?	☐ Yes ☐ No	5. Temporomandibular joint (TMJ) Disorder?	☐ Yes ☐ No
6. Stress test; electrocardiogram or echocardiogram?	☐ Yes ☐ No	6. Recurrent abdominal pain?	☐ Yes ☐ No
B. TUMORS/CYSTS		**E. OTHER**	
1. Cancer of any type?	☐ Yes ☐ No	1. Stroke, seizure, disorder or epilepsy?	☐ Yes ☐ No
2. Tumors, cysts, or polyps?	☐ Yes ☐ No	2. Migraine or persistent headaches?	☐ Yes ☐ No
C. BLOOD AND URINE		3. Nervous/mental disorder, depression or anxiety?	☐ Yes ☐ No
1. High or low blood pressure or hypertension?	☐ Yes ☐ No	4. Dizziness or paralysis?	☐ Yes ☐ No
2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes?	☐ Yes ☐ No	5. Asthma, emphysema, breathing or lung disorder?	☐ Yes ☐ No
3. Disorder of kidneys or bladder or kidney stones?	☐ Yes ☐ No	6. Indigestion, ulcers or irritable bowel?	☐ Yes ☐ No
4. Diabetes, high or low blood sugar?	☐ Yes ☐ No	7. Chronic fatigue?	☐ Yes ☐ No
5. Protein, blood or sugar in urine?	☐ Yes ☐ No	8. Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No
6. Night sweats, persistent swollen glands or diarrhea?	☐ Yes ☐ No	9. Aids Related Complex (ARC)?	☐ Yes ☐ No
		10. Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No



HEALTH QUESTIONS *continued….*
Check all applicable disorders and give details below.

III. In the past 5 years have you been diagnosed or treated by a medical professional for a disease or di

A. Brain or nervous system?	☐ Yes ☐ No	D. Prostate, ovaries or uterus?	
B. Eyes, ears, nose or throat?	☐ Yes ☐ No	E. Stomach, intestine, gallbladder	
C. Skin or lymph nodes?	☐ Yes ☐ No	F. Thyroid, spleen or any gland?	

IV. In the past 5 years, have you:

A. Sought or received advice the use of alcohol or other chemicals or drugs?	☐ Yes ☐ No	C. Been treated or evaluated in a medical or psychiatric facility?	
B. Scheduled or undergone any surgery?	☐ Yes ☐ No	D. Sustained illness requiring me hospitalization?	

V. In the last 12 months, have you used tobacco of any kind? ☐ Yes ☐ No

VI. Please list all prescribed and non-prescribed medications you currently take:

If you answered "Yes" to any Health Questions in this form, please explain below. (Please use another sheet of paper if necessary.)

Dates	Conditions	Doctor Names and Addresses	Results

HORIZATIONS & SIGNATURE

on and form the basis of any coverage issued to me and/or my s or failure to report information which is material to the issuance of denial of payment of a claim. I agree to notify Madison National Life my enrollment is pending. I agree that if my enrollment is approved f any coverage will be determined in accordance with the terms of

he Group Policy, Certificate of Insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of Madison National Life Insurance Company, Inc., can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related facility, state or local government agency, insurance or reinsurance company, Medical Information Bureau, Inc., consumer reporting agency, or employer, to give to Madison National Life Insurance Company, Inc., its legal representative or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization, in connection with this form, shall be valid for 24 months from my signature date and that I have the right to revoke this authorization at any time. I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request. I have read the separate notice enclosed with this form pertaining to the Medical Information Bureau as required by the Fair Credit Reporting Act.

WARNING: 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 may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Applicant's Signature

Parent/Guardian Signature (for Dependent enrollees under age 18)

FOR INSURER USE ONLY: Decision: ☐ Approved ☐ Postponed

Write your height in feet and inches

Provide both your address and your physician's address completely, including address, city, state and zip code.

Please answer each and every health question. Avoid drawing a continuous line through the yes or no boxes. Also, please make sure your check mark clearly falls within a yes or no box.

If you answered YES to any of the Health Questions, complete this explanation section. The date should be the date of the original diagnosis.

Please be sure to give the actual name of the medication you are taking, not just what the drug is used for.

Take care to spell the medication correctly.

Please be sure to contact National Insurance Services with any changes in your health while your enrollment is pending. Failure to do so could result in the rescission of insurance and/or denial of payment of a claim.

Read all acknowledgements and authorizations statements. Sign and date the application. Please remember – each individual should sign his or her application, however the employee needs to sign on behalf of a minor dependent child.

If you have any questions when you complete this form please feel free to contact Pauline Gayle at National Insurance Services at 800-627-3660 ext 1263 between the hours of 8 am and 5 pm central time, Monday through Friday.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601
Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717

Return application to:
National Insurance Services
250 South Executive Drive, Suite 300
Brookfield, WI 53005-4273
Attention: Billing Department

Evidence of Insurability

(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es):		**Reason for Applying:** ☐ New Hire ☐ Late Enrollee
☐ Life/AD&D	☐ Supp. Life:$ _____	☐ Increase in Coverage amount ☐ Reinstatement
☐ Long Term Disability	☐ AD&D:$ _____	☐ Adding Dependent(s) ☐ Applying for coverage over GI
☐ Short Term Disability	☐ AD&D:$	☐ Other:

APPLICANT INFORMATION

Applicant's Name: Last, First, MI	**Sex:** ☐ M ☐ F	**Age:**	**Date of Birth:** / /

Height:	**Weight:**	**Applicant's Social Security No.** - -	**Already Enrolled?** ☐ Yes ☐ No

Applicant's Home Address: (Street, City, State, Zip)	**Applicant's Daytime Phone No.** ( )

Applicant's Current Physician's Name:	**Date Last Visited:** / /	**Reason for Visit:**

Physician's Address: (Street, City, State, Zip)	**Physician's Phone No.**

Employee Member Name: (if different than Applicant)	**Employee's Job Title:**

Employee's Date of Hire:	**No. of Hours Employee Works Per Week:**	**Employee's Annual Salary:** $

Employer Name:	**Employer's Address:** (Street, City, State, Zip)

HEALTH QUESTIONS

Check Yes or No, circle all applicable "Yes" disorders or procedures and give details below.

I. Are you currently pregnant? ☐ Yes ☐ No **If "Yes", what is your expected due date:**

II. In the past 5 years have you been diagnosed or treated by a medical professional for any of the following conditions?

A. HEART		**D. PAIN & DISCOMFORT**	
1. Heart ailment?	☐ Yes ☐ No	1. Arthritis, bursitis or gout?	☐ Yes ☐ No
2. Chest pain, angina or shortness of breath?	☐ Yes ☐ No	2. Recurrent back pain or slipped disk?	☐ Yes ☐ No
3. Irregular heart beat or heart murmur?	☐ Yes ☐ No	3. Disorder of the back, neck or spine?	☐ Yes ☐ No
4. Rheumatic fever?	☐ Yes ☐ No	4. Disorder of the muscles, bones or joints?	☐ Yes ☐ No
5. Disease or abnormality of heart muscle, nerves or vessels?	☐ Yes ☐ No	5. Temporomandibular joint (TMJ) Disorder?	☐ Yes ☐ No
6. Stress test; electrocardiogram or echocardiogram?	☐ Yes ☐ No	6. Recurrent abdominal pain?	☐ Yes ☐ No
B. TUMORS/CYSTS		**E. OTHER**	
1. Cancer of any type?	☐ Yes ☐ No	1. Stroke, seizure disorder or epilepsy?	☐ Yes ☐ No
2. Tumors, cysts, or polyps?	☐ Yes ☐ No	2. Migraine or persistent headaches?	☐ Yes ☐ No
C. BLOOD AND URINE		3. Nervous/mental disorder, depression or anxiety?	☐ Yes ☐ No
1. High or low blood pressure or hypertension?	☐ Yes ☐ No	4. Dizziness or paralysis?	☐ Yes ☐ No
2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes?	☐ Yes ☐ No	5. Asthma, emphysema, breathing or lung disorder?	☐ Yes ☐ No
3. Disorder of kidneys or bladder or kidney stones?	☐ Yes ☐ No	6. Indigestion, ulcers or irritable bowel?	☐ Yes ☐ No
4. Diabetes, high or low blood sugar?	☐ Yes ☐ No	7. Chronic fatigue?	☐ Yes ☐ No
5. Protein, blood or sugar in urine?	☐ Yes ☐ No	8. Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No
6. Night sweats, persistent swollen glands or diarrhea?	☐ Yes ☐ No	9. Aids Related Complex (ARC)?	☐ Yes ☐ No
		10. Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No

HEALTH QUESTIONS *continued….*

Check all applicable disorders and give details below.

III. In the past 5 years have you been diagnosed or treated by a medical professional for a disease or disorder of the:

A. Brain or nervous system?	□ Yes □ No	D. Prostate, ovaries or uterus?	□ Yes □ No
B. Eyes, ears, nose or throat?	□ Yes □ No	E. Stomach, intestine, gallbladder or liver?	□ Yes □ No
C. Skin or lymph nodes?	□ Yes □ No	F. Thyroid, spleen or any gland?	□ Yes □ No

IV. In the past 5 years, have you:

A. Sought or received advice for the use of alcohol or other chemicals or drugs?	□ Yes □ No	C. Been treated or evaluated in a hospital or medical or psychiatric facility?	□ Yes □ No
B. Scheduled or undergone any surgery?	□ Yes □ No	D. Sustained illness requiring medical care or hospitalization?	□ Yes □ No

V. In the last 12 months, have you used tobacco of any kind? □ Yes □ No

VI. Please list all prescribed and non-prescribed medications you currently take:

If you answered "Yes" to any Health Questions in this form, please explain below. (Please use another sheet of paper if necessary.)

Dates	Conditions	Doctor Names and Addresses	Results

ACKNOWLEDGEMENTS, AUTHORIZATIONS & SIGNATURE

I understand all statements and answers I have given are to be relied upon and form the basis of any coverage issued to me and/or my dependents under the Group Policy. I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Madison National Life Insurance Company, Inc. of any change in my medical condition while my enrollment is pending. I agree that if my enrollment is approved by Madison National Life Insurance Company, Inc., the effective date of any coverage will be determined in accordance with the terms of the Group Policy, including any Actively at Work requirement.

I acknowledge this Evidence of Insurability form (when approved), the Group Policy, Certificate of Insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of Madison National Life Insurance Company, Inc., can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related facility, state or local government agency, insurance or reinsurance company, consumer reporting agency, or employer, to give to Madison National Life Insurance Company, Inc., its legal representative or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization, in connection with this form, shall be valid for 24 months from my signature date and that I have the right to revoke this authorization at any time. I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.

WARNING: 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 may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Applicant's Signature	**Date**
Parent/Guardian Signature (for Dependent enrollees under age 18)	**Date**

FOR INSURER USE ONLY:	Decision: □ Approved □ Postponed □ Declined	Effective Date:
Underwriter's Signature:		Date: