Unimerica Insurance Company

Association Administrative Address:
P.O. Box 17828
Portland, Maine 04112-8828

MSBA

Disability Income Insurance Application

For Minnesota State Bar Association (MSBA)
Policy Number: 1157

TO APPLY:

Send this completed form to:

ADMINISTRATOR
MSBA GROUP INSURANCE PROGRAM
P.O. BOX 10374
Des Moines, IA 50306-8812

QUESTIONS?
CALL**:** 1-800-501-5776
customerservice.service@mercer.com

Please print in INK. Do not erase or use correction fluid. To correct, cross out and initial/date changes.
Answer all questions, then sign the Agreement and Authorization.

Section 1: Member Information

1. Member Name: _____

2. Member SSN: _____ – _____ – _____ 3. Email Address: _____

4. Billing Address: _____ City: _____ State: _____ Zip: _____

5. Home Address: _____ City: _____ State: _____ Zip: _____

6. Date of Birth: _____ /_____/_____ 7. Place of Birth: _____ 8. Citizenship/Country: _____

9. Sex: ❑ Male ❑ Female 10. Daytime Phone #: _____ – _____ – _____

11. Are You a member of the Minnesota State Bar Association ? ❑ Yes ❑ No

12. Current Occupation / Profession:_____ 13. How many hours a week do you work? _____

14. Please describe your duties: _____

15. Beneficiary : _____ 16. Relationship of Beneficiary to you: _____

17. Application is made for: ❑ New Coverage

❑ Increase/Certificate No.: _____ Current Amount of Coverage: $_____

❑ Reinstatement/Certificate No.: _____ Amount of Coverage: $_____

Section 2: Plan Selection for Disability Income Coverage

1. MAXIMUM MONTHLY BENEFIT: $_____ (Members under age 55 may apply for $500 to $10,000 per month, in increments of $500, not to exceed 60% of your Annualized Monthly Income. Members age 55 through age 59 may apply for $500 to $3,000 per month, in increments of $500, not to exceed 60% of your Annualized Monthly Income. If applying to increase coverage, indicate only the ADDITIONAL amount of Monthly Benefit desired.)

2. MAXIMUM BENEFIT PERIOD: (Select one) ❑ Career Plan 65-65 with Residual Disability Benefits ❑ Basic Plan 5-2

3. ELIMINATION PERIOD: (Select one) ❑ 90 days ❑ 180 days

4. OPTIONAL BENEFIT: ❑ Accidental Death and Dismemberment Benefit. Principal Sum _____
(a minimum of $10,000 and a maximum of $100,000 in $10,000 increments)

Section 3: Other Coverage

If You have Disability Income Insurance in force or pending with Unimerica Insurance Company ("Unimerica") or through any other company, provide details below:

Company Name	Type of Coverage	Benefit Amount	Benefit Period	Elimination Period	Will Coverage be Replaced?	Employer Paid
					❑ Yes ❑ No	❑ Yes ❑ No
					❑ Yes ❑ No	❑ Yes ❑ No
					❑ Yes ❑ No	❑ Yes ❑ No
					❑ Yes ❑ No	❑ Yes ❑ No
					❑ Yes ❑ No	❑ Yes ❑ No
					❑ Yes ❑ No	❑ Yes ❑ No

Section 4: Financial Information

1. Business Type (check one): ❑ Proprietorship ❑ Partnership ❑ Corporation ❑ Limited Liability Partnership
❑ Limited Liability Corporation ❑ S-Corporation ❑ Other (specify): _____

2. Percentage of business owned by you: _____ Number of years owned by you: _____
Number of years business has been in existence: _____

3. Annual earned income from your personal services as reported to the IRS on your personal and/or business federal tax return:
Last Calendar Year: $_____ Prior Calendar Year: $_____

Section 5: Member's Statement of Health

1. a) Height _____ft. _____in. b) Weight _____ lbs. c) Weight change last year: _____ lbs.
d) Reason for weight change: (Gain or Loss) _____

2. Name of Personal Physician (if none, please indicate): _____
Physician Address: _____
Date last seen:_____ Reason: _____ Results: _____

3. In the past 180 days, have you ever been:
a) absent from work, or unable to perform any duty of your occupation, because of sickness or injury? ..... ❑ Yes ❑ No
b) been homebound or hospitalized because of sickness or injury? ..... ❑ Yes ❑ No

If Yes to (a) or (b), for how many days? _____ Date(s):_____Reason:_____

4. Have you used tobacco/nicotine-containing products or smoked any substance in any form or manner in cigarettes, cigars or a pipe within the last 12 months? ..... ❑ Yes ❑ No

5. During the past 5 years, have you engaged in deep sea diving, parachuting/paragliding, rock/mountain climbing, or motorized speed racing? In MN, indicate Yes/No for deep sea diving, parachuting/paragliding, rock/mountain climbing, or organized motorized speed racing? ..... ❑ Yes ❑ No

Section 5: Member's Statement of Health (continued)

6. During the past 5 years, have you ever been medically diagnosed as having, or been treated for a condition stated below? Indicate Yes/No and give details under Medical Details. Except in KS and MN, include conditions for which you have experienced symptoms.

a) chest pain, high blood pressure, palpitations, or any disease or disorder of the heart or circulatory system? ..... ❑ Yes ❑ No

b) shortness of breath, persistent hoarseness or cough, bronchitis, asthma, emphysema,tuberculosis, allergies, chemical sensitivities or any disease or disorder of the lung? ..... ❑ Yes ❑ No

c) diabetes, any glandular, thyroid, or other endocrine disease or disorder? ..... ❑ Yes ❑ No

d) arthritis, gout, neck or back problems, sciatica, carpal tunnel syndrome, disease or disorder of the musculoskeletal system, bones, joints, muscles, connective tissue disease or any chronic pain condition? ..... ❑ Yes ❑ No

e) depression, anxiety, any mental condition, headaches, epilepsy, dizziness, tremor, stroke, Transient Ischemic Attack (TIA) or other brain, nervous or neurological disease? ..... ❑ Yes ❑ No

f) cancer, disease or disorder of the skin, lymph nodes, lesions, cysts, tumors, anemia or immune system? ..... ❑ Yes ❑ No

g) liver, digestive system, either kidney, urinary or reproductive tract, prostate or sexually transmitted diseases (Except for HIV)? ..... ❑ Yes ❑ No

h) dementia, confusion, memory loss, Parkinson's disease, or Alzheimer's disease? ..... ❑ Yes ❑ No

i) loss of hearing or vision, or disease or disorder of the eyes, ears, nose or throat? ..... ❑ Yes ❑ No

j) chronic fatigue, Epstein Barr virus, fibromyalgia? .. ❑ Yes ❑ No

k) complications of pregnancy ..... ❑ Yes ❑ No

l) Are you pregnant? ..... ❑ Yes ❑ No
If "yes," due date:_____

7. During the past 5 years, have you had, been told you have, or been treated for a disease or disorder of the blood?..... ❑ Yes ❑ No
A Disease or Disorder of the Blood includes all conditions of the blood presently recognized as disorders, both primary disorders (e.g. disorders of the red blood cells, white cells, platelets and clotting factors, immune disorders whether congenital or acquired) and disorders that reflect other disease processes (e.g. infections, malignancies and sources of blood loss.)

8. During the past 5 years, have you had or been advised to have any surgical operation, hospitalization, medical care, x-ray, EKG, blood test or other diagnostic test?..... ❑ Yes ❑ No

9. During the past 5 years, have you consulted, or are you planning to consult, or have you received treatment from any physician, psychiatrist, psychologist, counselor, chiropractor or other practitioner, clinic or hospital?..... ❑ Yes ❑ No

10. Are you presently under observation or treatment, or presently have any physical impairment or deformity, or within the past 12 months taken medication (prescription or non-prescription) for any reason?..... ❑ Yes ❑ No

11. During the past 5 years, have you:
    a. Sought, been advised to seek, or received counseling or treatment for the use of alcohol?..... ❑ Yes ❑ No
    b. Used narcotics, cocaine, heroin, hallucinogens, barbiturates, marijuana, or other habit forming drugs; sought, or been advised to seek, or received counseling or treatment for the use of prescribed or non-prescribed drugs; or ever been arrested for the possession of or use of prescribed or non-prescribed drugs?..... ❑ Yes ❑ No

12. Have you ever:
    a. been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?..... ❑ Yes ❑ No
    b. tested positive for the presence of the Human Immunodeficiency ("HIV") Virus or HIV antibodies?..... ❑ Yes ❑ No

Section 6: Medical Details (Please provide details if you answered YES to any item in the Member Statement of Health Section)

If you need more space, attach separate sheet with additional information.

Question #	Reason/Condition	Diagnosis/Treatment/ Results	Names, Address & Phone No. of Physician and/or Hospital	Date of Onset	Date Last Seen	No. of Days Lost from Work

Section 7: Fraud Notice

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime and may be subject to civil penalties, criminal penalties, and/or the denial of insurance benefits.

Section 8: Agreement and Authorization

I declare that all the statements made in this form are, to the best of my knowledge and belief: true and complete; and, that they are the basis on which insurance requested by me may be issued. I understand that: I am completing an insurance application; and, that each response must be: complete; and accurate. I understand all statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me; my personal representative; or, my beneficiary.

I authorize: any licensed physician; medical practitioner; pharmacy benefit manager; hospital; clinic or other medical or medically related facility; other insurer or reinsurer; Medical Information Bureau, Inc. ("MIB"); health care clearinghouse; and, any of their affiliates; representatives; or, business associates; or, other organization; institution or person; that has any records or knowledge of me or my health or that of my Dependents, to disclose the information to: the Unimerica Insurance Company; and, its affiliates ("Unimerica"). This information will be used to determine my eligibility for benefits.

I authorize Unimerica to: obtain; use; and disclose; my medical, claim or benefit records. This includes any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities, including health care providers. I authorize Unimerica to disclose the information to the Policy's administrator; or as may be required by law. I authorize Unimerica, or its reinsurers, to make a brief report of my personal health information to MIB.

I understand that information I authorize a person or entity to obtain and use may be: re-disclosed; and no longer protected by federal privacy regulations; except as prohibited by state law. I agree that a photocopy of this form shall be as valid as the original.

I understand that: this authorization is voluntary; and, I may refuse to sign the authorization. My refusal may, however, affect my ability to: enroll in the Policy; or, receive benefits. I understand I may revoke this authorization at any time by notifying Unimerica in writing. Such revocation will not affect any action taken or information released prior to the revocation; and, will not affect any legal right Unimerica has to contest any insurance or claim under the Policy. Unless I have revoked it earlier, this authorization is valid as long as I am continually insured with Unimerica. However, Unimerica must provide to me, at each renewal of the Policy, a written notice of the contents of the authorization and that the authorization remains in effect unless revoked. This authorization will cease to valid for use on or after any Policy renewal date that Unimerica does not provide such notice.

I have not given the agent; or, any other persons any health information not included on this form. I understand that Unimerica is not bound by any statements I have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

I understand that any condition which is excluded under the Policy will not be covered at any time. I certify that: I have read; or have had read to me; this completed application; and, that I realize any false statements or misrepresentation in it may result in loss of coverage under the Policy. I understand that, subject to the Deferred Effective Date provisions, coverage will not take effect until Unimerica grants its underwriting approval.

I certify that I have received the Insurance Information Practices Notice. I acknowledge that I have read the applicable Fraud Warning Notices provided with this application.

In Minnesota, this authorization excludes information on blood borne pathogens and HIV antibody tests if performed: on criminal offenders or their victims as the result of a crime reported to police; or on any person giving or receiving emergency care including the patient, emergency medical, fire, or police personnel, or any person qualifying for this exemption under Minnesota law, including the Good Samaritan law.

Member Signature:_____ **Dated:** _____

The following additional notice applies **only** to residents of Maine: This authorization excludes disclosure of the result of a test for HIV if the applicant has not developed symptoms of the disease AIDS or ARC. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS/ARC. Residents of Maine should also note that failure to sign an authorization statement may impair the ability of a regulated insurance agency to evaluate claims or process applications and may be a basis for denying an application or claim for benefits.

Retain a photocopy of this application for your records and return the original to:

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
P.O. BOX 10374, Des Moines, IA 50306-8812

Unimerica Insurance Company
Administrative Offices: 6300 Olson Memorial Highway, Golden Valley, MN 55427
Phone: 1-866-615-8727

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway, Suite 101
White Bear Lake, MN 55110
Phone: (651) 407-3149

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $300,000. Subject to this $300,000 limit, the guaranty association will pay up to $300,000 in life insurance death benefits, $100,000 in net cash surrender and net cash withdrawal values for life insurance, $300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $100,000 in annuity net cash surrender and net cash withdrawal values, $300,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $300,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $100,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $7,500,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $7,500,000, the $7,500,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE."

Additional language may be added to the notice if approved by the commissioner prior to its use in the form. This section does not apply to fraternal benefit societies regulated under chapter 64B.

Subd. 9. Combination fixed-variable policy. The notice required in subdivision 8 must clearly describe what portions of a combination fixed variable policy are not covered by the Minnesota life and health insurance guaranty association. The notice requirements specified in subdivision 7, paragraph (c), do not apply to a combination fixed-variable policy.

Subd. 10. Effect of notices. The distribution, delivery, contents, or interpretation of the notices described in subdivision 7, 8, or 9 shall not mean that either the policy or contract, or the owner or holder thereof, would be covered in the event of the impairment or insolvency of a member insurer if coverage is not otherwise provided by sections 61B.18 to 61B.32. Failure to receive the notice does not give the policyholder, contract holder, certificate holder, insured, owner, beneficiaries, assignees, or payees any greater rights than those provided by sections 61B.18 to 61B.32.

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AUTOMATIC CHECK WITHDRAWAL REQUEST: By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

Checking Account

Routing #: ___ ___ ___ ___ ___ ___ ___ ___ ___ Account #: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____ Date: _____

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Group Disability Income Plan

FOR MEMBERS OF THE MSBA

Disability Income Insurance Protection helps replace income lost while you are disabled. It is a very important element of anyone's insurance portfolio since it is specifically designed to help provide income so you can continue to support your family and pay your bills if you're unable to work because of sickness or injury.

WHO IS ELIGIBLE TO APPLY

All members of the MINNESOTA STATE BAR ASSOCIATION who are under the age of 60, reside in the United States, and actively at work in their profession (at least 30 hours/week) can apply for coverage.

Qualification

Acceptance into this Plan is subject to evidence of insurability as determined by the insurance company. Depending on the amount of insurance you apply for, it may be necessary for you to have a paramedical exam, blood test, and urinalysis, all of which can be conducted at your convenience and at no cost to you.

HOW MUCH INSURANCE IS AVAILABLE

The maximum monthly benefit amount which can be issued is determined by your age and earnings.

Members under age 55:

Up to $10,000 per month

Members age 55 through 59:

Up to $3,000 per month

Members should elect a monthly benefit amount up to $10,000, provided that when combined with other disability insurance you may have in force the total does not exceed 60% of your average monthly earnings for the 12 month period immediately preceding your application. Income includes commissions, but does not include bonuses, overtime pay and other extra compensation. Business owners and self-employed members should consult with your plan administrator to calculate your monthly benefit amount.

Monthly benefit amounts automatically reduce on the premium due date following attainment of age 65, if the monthly benefit is greater than $2,200, it will reduce to $2,200. Any reduction in coverage will not apply if you are already on a disability claim prior to age 65.

Choice of Benefit Periods

Eligible MSBA members have a choice of two benefit plans.

Both plans provide coverage when you are totally or residually disabled as result of injury or sickness which wholly and continuously prevents you from performing the material and substantial duties of your occupation.

- **Career Plan/To Age 65** ... This Plan pays benefits up to age 65 for disabilities that start prior to age 63. For disabilities starting on or after age 63, benefits will be paid for up to two years.
- **Basic Plan/5 Year Plan** ... Accident benefits are payable for up to five years for disabilities that start prior to age 60. For those that start at age 60 through 62, benefits can be paid to age 65. For disabilities starting on or after age 63, benefits will be paid for up to two years. Sickness benefits are payable for a two-year maximum period.

Choice of Elimination Periods

You must first satisfy an elimination period by a period of continuous disability prior to receiving benefits. By choosing a longer elimination period, you can significantly reduce your cost. With this Plan, you can choose from elimination periods of 90 or 180 days.

Preferred Definition of Disability

Disability coverage is provided when you are totally or residually disabled as result of injury or sickness which wholly and continuously prevents you from performing the material and substantial duties of your occupation. Your occupation means the occupation or profession in which You are regularly engaged at the time you became covered and disabled. If your occupation or profession is limited to a recognized specialty within the scope of your degree or license, the insurance company will deem Your specialty to be Your occupation. Your Occupation means the occupation in which you are regularly engaged at the time you become disabled. If your occupation is limited to a recognized specialty, the insurance company will deem your specialty to be your occupation.

Presumptive Disability

You will be presumed totally disabled if injury or illness results in the total and irrecoverable loss (that cannot be restored or corrected by medical or surgical treatment) of any one of the following: the ability to speak; hearing in both ears; sight in both eyes; use of both hands or of both feet or of one hand and one foot.

Optional benefit available:

Accidental Death & Dismemberment Coverage

Eligible members applying for disability income insurance may elect an additional tier of insurance protection, Accidental Death & Dismemberment insurance. AD&D insurance provides an additional benefits for losses that may occur as a result of an accident. AD&D pays for loss of life, hands, sight, eyes, speech, hearing or the combination of any of the above. Partial benefits are paid for partial losses.

Optional Accidental Death & Dismemberment is available in amounts from $10,000 to $100,000

Annual Rates: $ .70 per $1,000

Plan Features

Partial or Residual Disability Benefit Available Even If You Return To Work

(Included with Career Plan)

While you are recovering from a disability, you may be eligible to receive a residual disability benefit if you return to work but are earning less than before you were disabled. Residual or Partial Disability Benefits are payable when an insured has a 20% or greater loss of income.

The Residual Disability must begin while you are covered under this benefit and before age 65; continue beyond the elimination period; and require the regular care of a Physician. Benefits end according to the benefit period selected; when you are able to return to work (30+ hours/week); when your earnings exceed 80% of pre-disability earnings; or when you become totally disabled.

Rehabilitation Services

Rehabilitation services may be offered to provide disabled insureds with a rehabilitation program to assist in returning to work. A team of vocational rehabilitation specialists will work with you, your physician and appropriate specialists to develop a plan to conduct a review, offer suggestions, and possible funding for a return-to-work program. Participation in this program is voluntary.

Benefits Covered for Pregnancy

This plan provides benefits for any loss or disability due to normal pregnancy commencing 30 days or more after coverage becomes effective. Complications of pregnancy are covered. See your certificate of coverage or ask you plan administrator for details.

Survivor Income Continuation Benefit

If you die while receiving disability benefits and were receiving the benefits for at least 12 continuous months immediately before you died, this plan will pay your beneficiary a monthly Survivor Income Continuation Benefit for up to 3 months (not to exceed the maximum benefit period).

Transplant Benefit

If a total disability results from your donation of an organ for an organ transplant procedure while you are covered under the Policy; the elimination period that would waived and monthly benefits would be paid. Maximum benefit period is 12 months and is payable only once in a lifetime. Benefit payments will be subject to all of the provisions contained in the Policy, except for those that are in conflict with the provisions of this transplant benefit

Successive Periods of Disability

Recurrent disabilities due to the same or related medical causes will be treated as one continuous period of disability; and applied to your maximum benefit period as though one continuous period of disability. This applies unless you no longer qualified for a monthly disability benefit under this policy for at least 3 consecutive months.

Waiver of Premium

If you are under age 60 and are totally disabled for 6 continuous months while covered under the Policy; premiums becoming due for your coverage during the continuation of your benefit period for that total disability will be waived. You must continue to meet all eligibility requirements.

PREMIUM INFORMATION

Your insurance cost is based on your attained age when your coverage becomes effective and increases on the first premium due date after you reach a higher age bracket.

SEMIANNUAL PREMIUMS PER $100 MONTHLY BENEFIT

MEMBER'S AGE	CAREER PLAN	BASIC PLAN
90-DAY WAITING PERIOD		
Under 30	$5.00	$2.20
30–39	7.00	2.90
40–49	11.70	5.10
50–59	18.90	9.10
60–64	18.70	13.60
65–69*	16.60	16.60
180-DAY WAITING PERIOD		
Under 30	$4.50	$1.80
30–39	6.40	2.40
40–49	10.60	4.20
50–59	17.10	7.50
60–64	15.40	11.20
65–69*	13.70	13.70

*Monthly benefits in excess of $2,200 are reduced to $2,200 upon attainment of age 65 if not disabled.

HOW TO CALCULATE YOUR PREMIUM

1. Determine the monthly benefit you want. (Must be in multiples of $100.) Divide by 100.
2. Select the PLAN and the WAITING PERIOD you want. Look up the cost for your age bracket
3. Multiply the cost by the number you derived in Step 1.

For Example: A 45-year-old member is applying for a $3,000 per month benefit and a 90-day waiting period under the Career Plan.

$3000 ÷ 100 = 30 x $11.70 = $351.00 semiannual premium

(Annual and quarterly payment modes are also available.)

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

Effective Date of Coverage

Coverage will become effective the 1st day of the month on or next following the month the application is approved.You must meet all eligibility requirements on the effective date including being actively at work as defined under this coverage.

What Is Not Covered

The Policy does not cover, and we will not pay a benefit for any Loss or Disability: due to an act or accident of war or act of war, declared or undeclared, whether civil or international, or due to any substantial armed conflict between organized forces of a military nature; due to suicide or intentionally self-inflicted Injury; due to committing or attempting to commit a felony except that this exclusion will apply only when an arrest for such activity results in a conviction (if the arrest does not result in a conviction, then any benefits due and withheld shall be paid); due to your being engaged in an illegal occupation, except that this exclusion will apply only when an arrest for such activity results in conviction (if the arrest does not result in a conviction, then any benefits due and withheld shall be paid); due to normal pregnancy (except that Complications of Pregnancy are covered). However, We will pay for any Loss or Disability due to normal pregnancy commencing 30 days or more after Your Certificate Effective Date shown in Your Schedule; due to injury sustained during travel or flight in, or descent from any aircraft, unless as a fare-paying passenger on a commercial airline flying between established airports on a scheduled route; or a charter flight seating 15 or more people; or while You are in the armed forces of any country or international authority for a period greater than 30 days (in such event the pro rata unearned premium shall be returned to You for any period of full-time active duty for more than 30 days provided You notify us within 12 months of entering the armed forces).

Termination

Your insurance under the Policy will cease on the first to occur of:

1. the date the Policy is cancelled;
2. the Premium Due Date that the required premium for Your coverage is not paid, subject to the Grace Period;
3. the first day of the month on or next following the date You attain the Policy Termination Age;
4. the date You cease to be a member of the Policyholder;
5. the date We or the Policyholder cancel coverage for a class of persons to which You belong;
6. the date You are no longer in class eligible for coverage;
7. the date You retire, except due to Disability covered by the Policy; or
8. the first day of the month following a 60 day continuous period during which You cease to be Actively at Work,except due to Disability covered by the Policy or due to a layoff or leave that meets the conditions stated in a Continuation provision of the Policy.

HOW TO APPLY...

In three easy steps

1. Refer to the Plan description for benefits and premium costs as you fill out the application form.
2. Do not send any money until Unimerica Insurance Company has approved your Application and notifies you of the premium contribution due, based on the information you have provided.
3. Mail the completed Application form to:

   Administrator
   MSBA Group Insurance Program
   P.O. BOX 10374
   Des Moines, IA 50306-8812

If you have any questions about your eligibility or the features of this Plan, call a service representative toll-free at 1-800-501-5776.

PLEASE NOTE

The information you supply when you fill out your Application can make the medical underwriting process quicker and easier. By providing complete and accurate information, you avoid delays that may occur while we wait for missing information to be received and shorten the time needed for underwriting decisions and approvals. Complete medical information should include the name of the physician(s) or hospital(s), street address (and suite or room number), city, state and zip code. Also, a brief description of the nature of illness or injury, symptoms, treatment and results. The insuring company relies on your answers and statements. Misstatements or failures to report information on your Application may be used as the basis for denying or reducing claim benefits, or even invalidating your insurance.

30-DAY FREE LOOK

When you receive your Policy, read it carefully. If you're not completely satisfied with the terms of your new insurance plan, simply return your Policy, without claim, within 30 days and your premium will be promptly refunded. No questions asked!

HOW TO FILE A CLAIM

To file a claim, write the Administrator for the proper forms. This brochure contains a partial description of coverages. For a complete description of coverage, refer to Master Policy 1157 issued to Minnesota State Bar Association and or your certificate. This plan may not be available in all states. Contact your plan administrator for details.

This Plan is Underwritten by:

Unimerica Insurance Company
10701 West Research Drive
Milwaukee, WI 53226

This Plan is Administered by:

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
MSBA Group Insurance Program
P.O. Box 10374
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