CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE CIVIL, CRIMINAL AND FAMILY COURTS IN THE CITY OF NEW YORK
WELFARE TRUST FUND

C/O ADMINISTRATIVE SERVICES ONLY, INC
303 MERRICK ROAD, SUITE 300
LYNBROOK, NY 11563
800-537-1238
WWW.NYSCALA.COM
WWW.ASONET.COM

IMPORTANT INFORMATION REGARDING

SUPPLEMENTAL TERM LIFE INSURANCE BENEFIT

Dear Participant:

We are pleased to announce that Active Full-time or Active Part-Time Employees (with over 20 hours per work week) have the option of purchasing **SUPPLEMENTAL TERM LIFE INSURANCE. This benefit would be in addition to the** $50,000 Group Basic Term Life and Basic Accidental Death and Dismemberment Insurance Policy which is provided **to you at no cost.**

Enclosed you will find important information on **Supplemental Term Life Insurance**. If you wish to elect this option, you **MUST COMPLETE AND RETURN THE FORMS TO ADMINISTRATIVE SERVICES ONLY, INC AT THE ADDRESS ABOVE**.

- You will have the option to purchase additional individual insurance for yourself.
- When purchasing additional insurance for yourself you may also purchase insurance for your spouse and/or dependent children.
- If you do not purchase additional insurance for yourself, you will not have the opportunity to purchase insurance for your spouse or dependent children.
- **For new hires who apply with 30 days of their hire date coverage amounts over $50,000 for a Member and $20,000 for a spouse will be subject to underwriting approval. Current members or new hires who apply more than 30 days after their hire date who wish to purchase the supplemental term life insurance or increase their current amounts WILL require underwriting approval. All Applicants should complete and return the enclosed forms to Administrative Services Only. You may apply at any time as there is no set open enrollment period.**

This enrollment package includes the following:

1) A plan highlight document
2) A supplemental and dependent life insurance premium table
3) An enrollment and statement of Health form
4) A supplemental life insurance election/rejection form with instructions
5) A frequently asked questions form
6) Member and spouse beneficiary forms with instructions

Do not send payments for Supplemental coverage at this time. A.S.O. Brokerage Services, Inc will invoice you upon notification of any approvals for coverage.

If you have any additional questions regarding your Group Term Life Insurance or the Supplemental Life Insurance Benefit, **please contact Administrative Services Only, Inc at 1-800-537-1238 ext 9477**.

Very truly yours,
Board of Trustees

Plan Highlights

Group Basic Life and AD&D, Supplemental and Dependent Life Insurance

Citywide Association of Law Assistants of The Civil, Criminal and Family Courts in the City of New York

ELIGIBILITY

Each Active, Full-time Lawyer working 30 or more hours per week except any person working on a temporary or seasonal basis.

Dependents: You must be insured in order for Dependents to be covered.
Dependents are:

- your legal spouse not legally separated or divorced from you or your domestic partner.
- unmarried financially dependent child(ren)*, live birth to 19 years (to 25 years if full-time student).

*natural and adopted children; stepchildren and foster children in your custody.
Age limit does not apply to handicapped children.

- A person may not have coverage as both an Employee and Dependent.
- Only one insured spouse may cover Dependent children.

BENEFIT AMOUNT

Basic Life and AD&D

$50,000

Supplemental Life

Choose from a minimum of $25,000 to a maximum of $500,000 in $25,000 increments

Amounts of life insurance equal to $150,000 or more may be subject to an earnings cap.

Dependent Life

Spouse

Choose from a minimum of $5,000 to a maximum of $250,000 in $5,000 increments
(spouse amount may not exceed 50% of employee amount)

Dependent Child(ren)

Birth to age 19 : Choose from a minimum of $2,000 to a maximum of $10,000 in $2,000 increments
(up to age 25 if a full-time student)

GUARANTEED ISSUE (INITIAL ELIGIBILITY PERIOD ONLY)

Employee: $50,000
Spouse: $20,000
Child: all child amounts are guaranteed issue

CONTRIBUTION REQUIREMENTS

Basic Life (and AD&D):
Coverage is 100% employer paid.

Supplemental Life:
Coverage is 100% employee paid.

Spouse: Coverage is 100% employee paid.

Dependent Child(ren): Coverage is 100% employee paid.

AD&D SCHEDULE

For Accidental Loss of:	Amount Payable:
Life	100%
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and sight of one eye	100%
One foot and sight of one eye	100%
Speech and hearing	100%
One hand or One foot	50%
Sight of one eye	50%
Speech or Hearing	50%

SUPPLEMENTAL/DEPENDENT LIFE BENEFIT REDUCTION DUE TO AGE

(applicable to employee/spouse coverage)

Age	Original Benefit Reduced To
70	50%

RATE

See attached Rate Sheet.

FEATURES

- Accelerated Death Benefit (expressed as Living Benefit Rider in some states and Imminent Death Benefit in PA)
- Air Bag Benefit
- Conversion Privilege
- FMLA/MSLA Continuation
- Portability
- Seat Belt Benefit
- Waiver of Premium

VALUE ADDED SERVICES

- Bereavement Counseling Service
- Travel Assistance Service

EXCLUSIONS

AD&D EXCLUSIONS:
AD&D benefits will not be payable for a loss: caused by suicide or intentionally self-inflicted injuries; caused by or resulting from war or any act of war, declared or undeclared; to which sickness, disease or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor;
sustained during an insured's commission or attempted commission of an assault or felony; to which the insured's acute or chronic intoxication is a contributing factor; or to which the insured's voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.
For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

This Plan Highlights is a brief description of the key features of the RSL insurance plan. The availability of the benefits and features described may vary by state. It is not a certificate of insurance or evidence of coverage. Insurance is provided under group policy form DRS-6422, et al.

Reliance Standard Plans
Supplemental and Dependent Life Insurance
Premium Table

Plan Holder: Citywide Association of Law Assistants

Scheduled Benefit: Each eligible employee may elect for himself and/or his eligible spouse an amount of insurance shown in the Table below.
For employees age 70 and older: Benefit amounts are reduced according to the age-based reduction chart shown in the Supplemental Life brochure.
Employee/Spouse Premiums:

To find you and your spouse's premium -

- Determine your age band: Your age = your age at your last birthday.
- Select a benefit amount (employees age 70 and older: see above comment).
- Spouse premium: Repeat the steps above for your spouse at your age at your last birthday.
- Employee and spouse rates change as insured moves from one age bracket to the next.

Employee Monthly Premiums

Benefit Amount	Age 18-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70+
$25,000	$1.13	$1.38	$1.83	$2.05	$2.28	$3.40	$5.23	$9.78	$15.00	$28.85	$46.83
$50,000	$2.25	$2.75	$3.65	$4.10	$4.55	$6.80	$10.45	$19.55	$30.00	$57.70	$93.65
$75,000	$3.38	$4.13	$5.48	$6.15	$6.83	$10.20	$15.68	$29.33	$45.00	$86.55	$140.48
$100,000	$4.50	$5.50	$7.30	$8.20	$9.10	$13.60	$20.90	$39.10	$60.00	$115.40	$187.30
$125,000	$5.63	$6.88	$9.13	$10.25	$11.38	$17.00	$26.13	$48.88	$75.00	$144.25	$234.13
$150,000	$6.75	$8.25	$10.95	$12.30	$13.65	$20.40	$31.35	$58.65	$90.00	$173.10	$280.95
$175,000	$7.88	$9.63	$12.78	$14.35	$15.93	$23.80	$36.58	$68.43	$105.00	$201.95	$327.78
$200,000	$9.00	$11.00	$14.60	$16.40	$18.20	$27.20	$41.80	$78.20	$120.00	$230.80	$374.60
$225,000	$10.13	$12.38	$16.43	$18.45	$20.48	$30.60	$47.03	$87.98	$135.00	$259.65	$421.43
$250,000	$11.25	$13.75	$18.25	$20.50	$22.75	$34.00	$52.25	$97.75	$150.00	$288.50	$468.25
$275,000	$12.38	$15.13	$20.08	$22.55	$25.03	$37.40	$57.48	$107.53	$165.00	$317.35	$515.08
$300,000	$13.50	$16.50	$21.90	$24.60	$27.30	$40.80	$62.70	$117.30	$180.00	$346.20	$561.90
$325,000	$14.63	$17.88	$23.73	$26.65	$29.58	$44.20	$67.93	$127.08	$195.00	$375.05	$608.73
$350,000	$15.75	$19.25	$25.55	$28.70	$31.85	$47.60	$73.15	$136.85	$210.00	$403.90	$655.55
$375,000	$16.88	$20.63	$27.38	$30.75	$34.13	$51.00	$78.38	$146.63	$225.00	$432.75	$702.38
$400,000	$18.00	$22.00	$29.20	$32.80	$36.40	$54.40	$83.60	$156.40	$240.00	$461.60	$749.20
$425,000	$19.13	$23.38	$31.03	$34.85	$38.68	$57.80	$88.83	$166.18	$255.00	$490.45	$796.03
$450,000	$20.25	$24.75	$32.85	$36.90	$40.95	$61.20	$94.05	$175.95	$270.00	$519.30	$842.85
$475,000	$21.38	$26.13	$34.68	$38.95	$43.23	$64.60	$99.28	$185.73	$285.00	$548.15	$889.68
$500,000	$22.50	$27.50	$36.50	$41.00	$45.50	$68.00	$104.50	$195.50	$300.00	$577.00	$936.50

Spouse Monthly Premiums

Benefit Amount	Age 18-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70+
$5,000	$0.23	$0.28	$0.37	$0.41	$0.46	$0.68	$1.05	$1.96	$3.00	$5.77	$9.37
$10,000	$0.45	$0.55	$0.73	$0.82	$0.91	$1.36	$2.09	$3.91	$6.00	$11.54	$18.73
$15,000	$0.68	$0.83	$1.10	$1.23	$1.37	$2.04	$3.14	$5.87	$9.00	$17.31	$28.10
$20,000	$0.90	$1.10	$1.46	$1.64	$1.82	$2.72	$4.18	$7.82	$12.00	$23.08	$37.46

$25,000	$1.13	$1.38	$1.83	$2.05	$2.28	$3.40	$5.23	$9.78	$15.00	$28.85	$46.83
$30,000	$1.35	$1.65	$2.19	$2.46	$2.73	$4.08	$6.27	$11.73	$18.00	$34.62	$56.19
$35,000	$1.58	$1.93	$2.56	$2.87	$3.19	$4.76	$7.32	$13.69	$21.00	$40.39	$65.56
$40,000	$1.80	$2.20	$2.92	$3.28	$3.64	$5.44	$8.36	$15.64	$24.00	$46.16	$74.92
$45,000	$2.03	$2.48	$3.29	$3.69	$4.10	$6.12	$9.41	$17.60	$27.00	$51.93	$84.29
$50,000	$2.25	$2.75	$3.65	$4.10	$4.55	$6.80	$10.45	$19.55	$30.00	$57.70	$93.65
$55,000	$2.48	$3.03	$4.02	$4.51	$5.01	$7.48	$11.50	$21.51	$33.00	$63.47	$103.02
$60,000	$2.70	$3.30	$4.38	$4.92	$5.46	$8.16	$12.54	$23.46	$36.00	$69.24	$112.38
$65,000	$2.93	$3.58	$4.75	$5.33	$5.92	$8.84	$13.59	$25.42	$39.00	$75.01	$121.75
$70,000	$3.15	$3.85	$5.11	$5.74	$6.37	$9.52	$14.63	$27.37	$42.00	$80.78	$131.11
$75,000	$3.38	$4.13	$5.48	$6.15	$6.83	$10.20	$15.68	$29.33	$45.00	$86.55	$140.48
$80,000	$3.60	$4.40	$5.84	$6.56	$7.28	$10.88	$16.72	$31.28	$48.00	$92.32	$149.84
$85,000	$3.83	$4.68	$6.21	$6.97	$7.74	$11.56	$17.77	$33.24	$51.00	$98.09	$159.21
$90,000	$4.05	$4.95	$6.57	$7.38	$8.19	$12.24	$18.81	$35.19	$54.00	$103.86	$168.57
$95,000	$4.28	$5.23	$6.94	$7.79	$8.65	$12.92	$19.86	$37.15	$57.00	$109.63	$177.94
$100,000	$4.50	$5.50	$7.30	$8.20	$9.10	$13.60	$20.90	$39.10	$60.00	$115.40	$187.30
$105,000	$4.73	$5.78	$7.67	$8.61	$9.56	$14.28	$21.95	$41.06	$63.00	$121.17	$196.67
$110,000	$4.95	$6.05	$8.03	$9.02	$10.01	$14.96	$22.99	$43.01	$66.00	$126.94	$206.03
$115,000	$5.18	$6.33	$8.40	$9.43	$10.47	$15.64	$24.04	$44.97	$69.00	$132.71	$215.40
$120,000	$5.40	$6.60	$8.76	$9.84	$10.92	$16.32	$25.08	$46.92	$72.00	$138.48	$224.76
$125,000	$5.63	$6.88	$9.13	$10.25	$11.38	$17.00	$26.13	$48.88	$75.00	$144.25	$234.13
$130,000	$5.85	$7.15	$9.49	$10.66	$11.83	$17.68	$27.17	$50.83	$78.00	$150.02	$243.49
$135,000	$6.08	$7.43	$9.86	$11.07	$12.29	$18.36	$28.22	$52.79	$81.00	$155.79	$252.86
$140,000	$6.30	$7.70	$10.22	$11.48	$12.74	$19.04	$29.26	$54.74	$84.00	$161.56	$262.22
$145,000	$6.53	$7.98	$10.59	$11.89	$13.20	$19.72	$30.31	$56.70	$87.00	$167.33	$271.59
$150,000	$6.75	$8.25	$10.95	$12.30	$13.65	$20.40	$31.35	$58.65	$90.00	$173.10	$280.95
$155,000	$6.98	$8.53	$11.32	$12.71	$14.11	$21.08	$32.40	$60.61	$93.00	$178.87	$290.32
$160,000	$7.20	$8.80	$11.68	$13.12	$14.56	$21.76	$33.44	$62.56	$96.00	$184.64	$299.68
$165,000	$7.43	$9.08	$12.05	$13.53	$15.02	$22.44	$34.49	$64.52	$99.00	$190.41	$309.05
$170,000	$7.65	$9.35	$12.41	$13.94	$15.47	$23.12	$35.53	$66.47	$102.00	$196.18	$318.41
$175,000	$7.88	$9.63	$12.78	$14.35	$15.93	$23.80	$36.58	$68.43	$105.00	$201.95	$327.78
$180,000	$8.10	$9.90	$13.14	$14.76	$16.38	$24.48	$37.62	$70.38	$108.00	$207.72	$337.14
$185,000	$8.33	$10.18	$13.51	$15.17	$16.84	$25.16	$38.67	$72.34	$111.00	$213.49	$346.51
$190,000	$8.55	$10.45	$13.87	$15.58	$17.29	$25.84	$39.71	$74.29	$114.00	$219.26	$355.87
$195,000	$8.78	$10.73	$14.24	$15.99	$17.75	$26.52	$40.76	$76.25	$117.00	$225.03	$365.24
$200,000	$9.00	$11.00	$14.60	$16.40	$18.20	$27.20	$41.80	$78.20	$120.00	$230.80	$374.60
$205,000	$9.23	$11.28	$14.97	$16.81	$18.66	$27.88	$42.85	$80.16	$123.00	$236.57	$383.97
$210,000	$9.45	$11.55	$15.33	$17.22	$19.11	$28.56	$43.89	$82.11	$126.00	$242.34	$393.33
$215,000	$9.68	$11.83	$15.70	$17.63	$19.57	$29.24	$44.94	$84.07	$129.00	$248.11	$402.70
$220,000	$9.90	$12.10	$16.06	$18.04	$20.02	$29.92	$45.98	$86.02	$132.00	$253.88	$412.06
$225,000	$10.13	$12.38	$16.43	$18.45	$20.48	$30.60	$47.03	$87.98	$135.00	$259.65	$421.43
$230,000	$10.35	$12.65	$16.79	$18.86	$20.93	$31.28	$48.07	$89.93	$138.00	$265.42	$430.79
$235,000	$10.58	$12.93	$17.16	$19.27	$21.39	$31.96	$49.12	$91.89	$141.00	$271.19	$440.16
$240,000	$10.80	$13.20	$17.52	$19.68	$21.84	$32.64	$50.16	$93.84	$144.00	$276.96	$449.52
$245,000	$11.03	$13.48	$17.89	$20.09	$22.30	$33.32	$51.21	$95.80	$147.00	$282.73	$458.89
$250,000	$11.25	$13.75	$18.25	$20.50	$22.75	$34.00	$52.25	$97.75	$150.00	$288.50	$468.25

Dependent Children Premiums:

Benefit Amount	Premium
$2,000	$0.178
$4,000	$0.356
$6,000	$0.534
$8,000	$0.712
$10,000	$0.890

(One rate and benefit amount for all eligible children in family, regardless of number)

PREMIUM CALCULATION (Add your elections here):

Employee Premium	
Spouse Premium	
Dependent Children Premium	
Total Premium	

(Rates are calculated as of coverage effective date and are based on insured's age in relation to Plan anniversary date. Billed rates may be higher if, at application, the person is at the highest age in an age band).

Please read this important information:

- **You may not have coverage as both an employee and as a dependent.**
- **Only one insured spouse may cover the eligible dependent children.**

Rates are subject to change.

First Reliance Standard Life Insurance Company
Enrollment and Statement of Health for Group Insurance

Name of Employer	Location/Division	Bill Group
Citywide Association of Law Assistants of The Civil, Criminal and Family Courts in the City of New York		000001

Policy # and Class #	Policy # and Class #	Policy # and Class #	Policy # and Class #	Policy # and Class #
GL153793 / 1				

Application Type: ☐ Initial Eligibility/New Hire ☐ Late Applicant ☐ Other _____
☐ Increase ☐ Approved Annual Enrollment
☐ Change in Status: Nature of Change(s): _____

Date of Change: _____
If marriage, divorce or birth of a child, please provide copy of document.

Employee/Member Information – Always Complete

Submit completed Enrollment and Statement of Health form to:
EOIApplications@rsli.com or

First Reliance Standard
P.O. Box 7818
Philadelphia, PA 19101-7818

We do not accept faxed forms.

Name				Social Security Number
Gender	Date of Birth	Age	State of Birth	Date of Hire
Address		City	State	Zip
Phone Number	Occupation	Annual Compensation	Hours Worked Per Week	
Email Address				

Are you actively performing all the duties of your occupation or profession? ☐ Yes ☐ No

If "No," explain: _____

Spouse Information – Complete Only If Applying for Spouse Coverage

Spouse Name	Gender	Date of Birth	Age	State of Birth
Address	City	State	Zip	

Coverage Elected and Amounts

- When Life Insurance coverage includes accelerated death benefits: receipt of accelerated death benefits under Life Insurance may effect eligibility for public assistance programs and may be taxable

Coverage	Enroll or Decline[1]	Current Amount	Increase or Decrease	Total Amount Applied For	Monthly Premium
Group Term Supplemental Life Employee[2]	☐ Enroll ☐ Decline			$_____	See Premium Table
Group Term Life: Spouse[2,3]	☐ Enroll ☐ Decline			$_____	See Premium Table
Group Term Life: Dep. Children[3]	☐ Enroll ☐ Decline			$_____	See Premium Table

[1]"Enroll" authorizes employer to payroll deduct premiums.
[2]Statement of Health may be required.
[3]Coverage subject to election of employee coverage.

Employee/Member Name	Date of Birth

Health Questions

Answer all questions on this page for each person being underwritten for insurance. For any "Yes" answer, underline the condition and record details in the space provided on the next page. Failure to provide details of a condition will cause a delay in the review of your application.

	EMPLOYEE	SPOUSE
Enter height and weight.	Ht. __ft. ___in. Wt. _____ lbs	Ht. __ft. ___in. Wt. _____ lbs
1. In the past 10 years, have you or your spouse been treated for or diagnosed as having: heart, liver (biliary cirrhosis) or kidney disorder; an abnormal colonoscopy requiring follow-up; neurological disorder; diabetes; high blood pressure; thyroid disorder; stroke; transient ischemic attack (TIA); cancer and/or tumor malignant or benign; mental or nervous disorder; or been advised to have treatment for drug abuse (illegal or prescription drugs) or alcoholism?	☐ Yes ☐ No	☐ Yes ☐ No
2. In the past 10 years, have you or your spouse been diagnosed with or treated for: chronic pain; arthritis (lupus, rheumatoid or osteoarthritis); musculoskeletal (back, neck or muscle) condition; respiratory disorder including asthma, chronic obstructive pulmonary disease (COPD); or emphysema?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you or your spouse: (a) in the past year had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (thrush); or lymphadenopathy (enlarged or swollen glands)? or (b) in the past 10 years ever been diagnosed or treated for AIDS or AIDS-related complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No
4. In the past 10 years, have you or your spouse: (a) consulted with or been examined or treated by a physician, practitioner or specialist (include routine physicals only when there is an existing or newly diagnosed medical condition)? (b) been in a hospital or other facility for observation, diagnosis, treatment or an operation? or (c) been prescribed medication(s) (other than for colds, flu or allergies)?	☐ Yes ☐ No	☐ Yes ☐ No
5. Are you currently pregnant? In the past 10 years, have you or your spouse been diagnosed with: abnormal uterine bleeding; abnormal pap smear; abnormal mammogram requiring additional studies or with recommendation of breast biopsy?	☐ Yes ☐ No	☐ Yes ☐ No

Employee/Member Primary Care Physician's Full Name	Office Phone Number
Address	
Spouse Primary Care Physician's Full Name	Office Phone Number
Address	

Employee/Member Name	Date of Birth

Details

Please provide all names used for medical records (if different than the names provided on this form):_____

_____

For each "Yes" response to a health question, please provide details below.

Question #	Illness or Nature of Injury	Date	Physician's Full Name and Address (if different than Primary)	Check One Employee or Spouse	

If you need more space, check here ☐. Complete, sign and date a separate sheet of paper and attach it to this page.

Read, Sign and Date Below

I understand and agree that:

- The information provided on this Enrollment and Statement of Health form is true and correct to the best of my knowledge and belief.
- The insurance requested will become effective in accordance with the individual effective date information in the Policy; any amount subject to evidence of insurability will not become effective until approved by First Reliance Standard and First Reliance Standard has the right to refuse my request. Coverage is subject to a minimum participation requirement at the employer level and if the minimum is not met, coverage may not be issued even though an enrollment form has been completed. An effective date is subject to eligibility requirements, satisfaction of service waiting period (if applicable) and payment of first premium when due. An effective date may be deferred for an employee not actively at work and enrolled dependents confined to a hospital or at home.
- Benefits are subject to terms and conditions of the Policy and Certificate.
- For age-banded rate plans, premiums increase as an employee (or spouse, if applicable) moves from one age band to the next.

I further understand and agree that if I am applying after the expiration of my initial eligibility period, all medical tests and costs for attending physician reports may be without expense to First Reliance Standard Life Insurance Company and I may be responsible for paying the expenses, if any.

I acknowledge receipt of the "Designation of Beneficiary" form and "Important Information Regarding Applications for Insurance" and "Notice Regarding Information Practices". If a Designation of Beneficiary form is not completed or one is not on file with the Plan Administrator, the provisions of the Policy will determine to whom benefits, if any, will be payable.

Please Note: Certain war risks are not assumed. In case of any doubt, contact First Reliance Standard for further explanation.

AUTHORIZATION: I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, organization, institution, person or the MIB, Inc. to release any information or record(s) on me or my health excluding psychotherapy notes and records relating to drug and alcohol treatment to be used in determining the acceptability of my application for insurance. I authorize any such information or record(s) to be released to First Reliance Standard Life Insurance Company, its reinsurers or authorized representatives. I also authorize First Reliance Standard or its reinsurers to make a brief report of my personal health information to the MIB. This authorization, or a photographic copy, shall be as binding as the original and valid for a period not exceeding twelve (12) months from this date. I understand that I (or my authorized representative) will be sent a copy of this Authorization upon request. I understand that I may revoke this Authorization at any time by writing to First Reliance Standard at its Administrative Office (address: 2001 Market Street, Suite 1500, Philadelphia, PA 19103-7090 Attn: Medical Underwriting). I understand that revocation is subject to the rights of any person who acted in reliance of this Authorization prior to First Reliance Standard receiving written notice of the revocation. I further understand that revocation of this Authorization will not apply to First Reliance Standard when the law provides for the right to contest the insurance coverage or a claim there under.

Please Note: During an approved enrollment, guaranteed issue amounts of insurance will not require a Statement of Health form provided the Enrollment form is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to insurance for yourself (and/or your spouse, if applicable); or b) during your present service with your employer or an affiliate, you (and/or your spouse, if applicable,) have not, with respect to insurance with First Reliance Standard or an affiliate: had an application withdrawn; been previously declined; had coverage postponed; or voluntarily terminated; or c) the enrollment period is not one with specific guaranteed issue/health acceptability rules.

Applicable to Health Insurance only: 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 shall also be subject to a civil penalty not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.

X _____ _____ Employee's/Member's Signature Date (required at all times)	X _____ _____ Spouse's Signature Date (required if spouse Statement of Health required)

CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE CIVIL, CRIMINAL AND FAMILY COURTS IN THE CITY OF NEW YORK
WELFARE TRUST FUND
SUPPLEMENTAL GROUP TERM LIFE INSURANCE ELECTION/REJECTION FORM

Please return this form to:
ADMINISTRATIVE SERVICES ONLY, INC.

☐ **YES, I WISH TO PURCHASE SUPPLEMENTAL INSURANCE COVERAGE AT THE AMOUNT INDICATED BELOW**

☐ **NO, I DO NOT WISH TO PURCHASE ANY ADDITIONAL SUPPLEMENTAL LIFE INSURANCE**

In any event, I understand that if I wish to purchase any additional Supplemental insurance, proof of insurability will be required.

MEMBER SOCIAL SECURITY NUMBER				DATE OF BIRTH
XXX-XX-				/ /
LAST NAME	FIRST NAME	MI	PHONE	
ADDRESS	APT NO.	CITY	STATE	ZIP

IF YOU HAVE ANY QUESTIONS WHEN SELECTING COVERAGE AMOUNT AND CALCULATING THE PREMIUM DUE, PLEASE CONTACT ASO AT 1-800-537-1238 EXT 9477.

	COVERAGE AMOUNT*	MONTHLY COST**		SEMI-ANNUAL BILLING CYCLE***		AMOUNT DUE FOR SUPPLEMENTAL LIFE INSURANCE****
MEMBER			X	6	=	
SPOUSE-coverage amount may not exceed 50% of coverage selected for Member Supplemental Life Insurances			X	6	=	
DEPENDENTS			X	6	=	
TOTAL			X	6	=	

*** Please Indicate Coverage Amount. Please refer to chart.**
**** Monthly Cost-Cost of Coverage Amount from your Age Bracket and Coverage Amount**
***** Billing Cycle-Premiums will be billed on a six month cycle.**
****** Amount Due for Supplemental Life Insurance- Monthly Cost x 6 Months**

SECTION IV MEMBER SIGNATURE

MEMBER'S SIGNATURE:_____ DATE:____/____/____

INSTRUCTIONS

Please review information regarding the Supplemental Term Life Insurance benefit options, enrollment requirements and chart of cost.

Complete and return the Supplemental Term Life Insurance Election/Rejection Form.

If electing Supplemental Term Life Insurance, DO NOT send payment now. ASO Brokerage Services Inc. will invoice you once they receive notice of approval of your purchase.

If electing Supplemental Term Life Insurance for YOURSELF, the beneficiary form for the basic group term life insurance will serve as the beneficiary designation form for the Supplemental life insurance.

If electing Supplemental Term Life Insurance for your SPOUSE, please complete the Spouse Supplemental Life Insurance Beneficiary Designation Form.

If electing Supplemental Term Life Insurance for DEPENDENT CHILDREN, there is one rate for all the children and the member is automatically the beneficiary.

IMPORTANT NOTICE

Information in this packet provides a brief general description, written in non-technical language, of the important provisions of the Group Term Life Insurance Policy and the Supplemental Term Life Insurance Policy as expressed in the Insurance Contract. If any conflict should arise between this notice and the Group Term Life Insurance Contract, the terms of the insurance contract will govern in all cases.

FREQUENTLY ASKED QUESTIONS

"When can I enroll for Supplemental Term Life Insurance coverage?"

You may choose to enroll starting upon your hire. Applications made beyond 30 days of your hire date and/or for amounts over $50,000 will require you to complete Evidence of Insurability forms.

"When will coverage go into effect?"

For your coverage to become effective, you must be actively at work during the enrollment period and on the effective date of your coverage. If your dependents are confined for medical treatment at home or elsewhere, their coverage will begin when confinement ends. Refer to the Booklet-Certificate for details.

"Can I increase my coverage in the future?"

Yes, you can increase your coverage up to your plan's maximum coverage amount. However, evidence of good health satisfactory to First Reliance Standard Life Insurance Company will be required as previously noted.

"How can I enroll?"

To enroll, simply complete the Election/Rejection Form. Then, return it as instructed. You will receive correspondence confirming the amount of your coverage.

Conversion to Individual Insurance Coverage- Upon termination of Employment, you may convert your coverage to an individual life Insurance policy, without having to provide evidence of good health.

Waiver of Premium- Payment of your premium can be waived if you meet all these conditions:
1) you are less than 60 years old when your disability begins,
2) you are totally disabled and unable to work for at least 9 continuous months, And
3) you continue to be totally disabled.

The Waiver of Premium Benefit Terminates at age 65. This provision may vary by state. If any of the conditions above apply **YOU MUST CONTACT THE FUND OFFICE IMMEDIATELY**.

Accelerated Benefit Option- If terminally ill, you can get a partial payment of Your group term life insurance benefit. You can use this payment as you see fit. In the event of your death, your beneficiary will receive a benefit payout which has been reduced by the amount you receive. Receipt of accelerated death benefits may affect eligibility for public assistance programs and May be taxable. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

Portability of Group Insurance Coverage- Upon termination of Employment, you may continue a certain level of your Member and Dependent coverage, without having to provide evidence of good health

CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE CIVIL, CRIMINAL AND FAMILY COURTS IN THE CITY OF NEW YORK WELFARE TRUST FUND

***Member Supplemental Term Life Insurance Beneficiary Designation Form ***

Please complete & sign this form in ink. MAKE A COPY FOR YOUR RECORDS & RETURN THE SIGNED ORIGINAL TO:

Administrative Services Only, Inc.
PO Box 9005 Lynbrook, NY 11563

SECTION I MEMBER INFORMATION

LAST NAME | FIRST NAME | MI | SOC SEC NO. XXX-XX-☐☐☐☐ | DATE OF BIRTH

ADDRESS | APT NO. | CITY | STATE | ZIP

HOME PHONE | OFFICE PHONE

Please make your beneficiary designation(s) below. If you need more space, attach another sheet to this form.

You may designate more than one Primary or Contingent Beneficiary. If you do, make sure to indicate the percentage share each should receive. The total within each class (Primary and Contingent) must equal 100%. If you do not specify percentages, surviving beneficiaries within each class will share the proceeds equally. If you do not name a beneficiary, or if no beneficiaries are alive at the time of your death, proceeds will be payable to your estate.

SECTION II PRIMARY BENEFICIARY INFORMATION FOR MEMBER SUPPLEMENTAL LIFE INSURANCE

Please indicate who should receive your **Supplemental Term Life Insurance** Proceeds in the event of your death

FULL NAME – LAST, FIRST, MI	RELATIONSHIP (need not be a family member)	ADDRESS	DATE OF BIRTH	PHONE NUMBER	% SHARE OF PROCEEDS

SECTION III CONTINGENT BENEFICIARY INFORMATION FOR MEMBER SUPPLEMENTAL LIFE INSURANCE

Please indicate who should receive the **Supplemental Term Life Insurance** proceeds in the event that ALL of your Primary Beneficiaries are not living at the time of your death.

FULL NAME – LAST, FIRST, MI	RELATIONSHIP (need not be a family member)	ADDRESS	DATE OF BIRTH	PHONE NUMBER	% SHARE OF PROCEEDS

SECTION IV SIGN AND DATE THIS FORM FOR YOUR DESIGNATION TO BECOME EFFECTIVE MAKE A COPY FOR YOUR RECORDS AND RETURN THE SIGNED ORIGINAL

Member Signature _____ **Date** _____

THE SPOUSE OF THE PLAN MEMBER MUST COMPLETE THIS FORM ONLY IF SPOUSAL COVERAGE IS PURCHASED.

CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE CIVIL, CRIMINAL AND FAMILY COURTS IN THE CITY OF NEW YORK WELFARE TRUST FUND

***Spouse Supplemental Term Life Insurance Beneficiary Designation Form ***

Please complete & sign this form in ink. MAKE A COPY FOR YOUR RECORDS & RETURN THE SIGNED ORIGINAL TO:

Administrative Services Only, Inc.
PO Box 9005 Lynbrook, NY 11563

SECTION I MEMBER INFORMATION

LAST NAME	FIRST NAME	MI	SOC SEC NO.	DATE OF BIRTH
			XXX-XX-☐☐☐☐	

SECTION II SPOUSE INFORMATION

LAST NAME	FIRST NAME	MI	SOC SEC NO.	DATE OF BIRTH
			XXX-XX-☐☐☐☐	

Please make your beneficiary designation(s) below. If you need more space, attach another sheet to this form.

You may designate more than one Primary or Contingent Beneficiary. If you do, make sure to indicate the percentage share each should receive. The total within each class (Primary and Contingent) must equal 100%. If you do not specify percentages, surviving beneficiaries within each class will share the proceeds equally. If you do not name a beneficiary, or if no beneficiaries are alive at the time of your death, proceeds will be payable to your estate.

SECTION III PRIMARY BENEFICIARY INFORMATION FOR SPOUSE SUPPLEMENTAL LIFE INSURANCE

Please indicate who should receive your **Supplemental Term Life Insurance** Proceeds in the event of your death.

FULL NAME – LAST, FIRST, MI	RELATIONSHIP (need not be a family member)	ADDRESS	PHONE NUMBER	% SHARE OF PROCEEDS

SECTION IV CONTINGENT BENEFICIARY INFORMATION FOR SPOUSE SUPPLEMENTAL LIFE INSURANCE

Please indicate who should receive the **Supplemental Term Life Insurance** proceeds in the event that ALL of your Primary Beneficiaries are not living at the time of your death.

FULL NAME – LAST, FIRST, MI	RELATIONSHIP (need not be a family member)	ADDRESS	PHONE NUMBER	% SHARE OF PROCEEDS

SECTION V SIGN AND DATE THIS FORM FOR YOUR DESIGNATION TO BECOME EFFECTIVE MAKE A COPY FOR YOUR RECORDS AND RETURN THE SIGNED ORIGINAL

Spouse Signature _____ **Date** _____

BENEFICIARY FORM INSTRUCTIONS

These instructions will assist you in properly completing the Primary and Contingent Beneficiary sections of the Beneficiary Designation Form. If you have any questions, please call Administrative Services Only, Inc. at 800-537-1238 ext 9477, 516-394-9477

* It is **very important** that you take the time now to designate who will receive the Group Life Insurance proceeds in the event of your death. If you do not do so, the benefit will go to your estate.
* In order to designate a beneficiary to receive any benefits payable in the event of your death, **you must sign and date the Beneficiary Designation Form on the reverse side of this notice and return it to the** Administrative Services Only, Inc. PO Box 9005, Lynbrook NY 11563.
* **IF YOUR SPOUSE IS ELECTING SUPPLEMENTAL/SUPPLEMENTAL LIFE, PLEASE COMPLETE AND RETURN THE BENEFICIARY DESIGNATION FORM FOR SPOUSE OF PLAN MEMBER IN ADDITION TO THE BENEFICIARY DESIGNATION FORM FOR PLAN MEMBERS.**
* **THE VALIDITY OF YOUR DESIGNATION UNDER THE LAW IS** YOUR **RESPONSIBILITY. BE PRECISE AND CLEAR**
* BEFORE MAKING BENEFICIARY DESIGNATIONS, YOU MAY WANT TO CONSULT WITH YOUR TAX OR LEGAL ADVISOR.
* **YOU MAY CHANGE A BENEFICIARY DESIGNATION** AT ANY TIME.
* **Please Note**: You cannot name your employer as a beneficiary for Group Life Insurance proceeds under the Group Policy.
* If a beneficiary is living at the time of the employee's death but dies before receiving full benefits, the remaining proceeds will be paid to the beneficiary's estate.

Proposed Beneficiary(ies)	Suggested Wording
1. Estate	Estate
2. One Beneficiary	Martha Doe, wife
3. More than one beneficiary in equal shares	Jane Doe, Mary Doe and Richard Doe, children, or survivor(s) of them, in equal share
4. Two beneficiaries, in succession	Primary: Martha Doe, wife; Contingent: Richard Doe, son (Richard will only receive proceeds if Martha Doe is not living at the time of employee's death.)
5. One Beneficiary followed by two beneficiaries in equal shares	Primary: Martha Doe, wife; Contingent: Jane Doe and Mary Doe, children in equal shares, or the survivor of them (Jane and Mary will only receive proceeds if Martha Doe is not living at the time of the employee's death.)
6. More than one Beneficiary in equal shares per descendent order	Jane Doe, Mary Doe and Richard Doe, or the survivor(s) of them, in equal shares. However, if any of my children predecease me and leave issue who survive me, the issue of the deceased child will receive their parents' share in equal shares.
7. One or more minor children.	John Smith, as custodian for Jane Doe, a minor under the Uniform Transfers to Minors Act (UTMA) so that proceeds can be paid before the child reaches the age of majority.
8. To a church or non-profit organization	Name and address of the beneficiary organization.
9. Beneficiaries shown in percentages	John Smith, brother – 40%, or in the event of his death, to my estate; Alan Smith, brother 60%, or in the event of his death, to my estate.
10. Trust under Last Will and Testament	Proceeds to be paid to the Trustee under my Last Will and Testament.
11. Existing Trust	Jane Doe, Trustee of the Doe Family Trust, dated 1/1/2001