

Enrollment Information

Please complete all required forms entirely, and submit to your employer to be reviewed, signed, and sent to FCMM for processing. Enrollment forms must be submitted to FCMM within 30 days of the eligible full-time hire date, unless otherwise documented on the Form 120: Employer Benefit Agreement. Once your enrollment is processed, you will receive a Welcome Email including the LTD Certificate and Life/AD&D Class Certificate.

Complete the following forms

- Form 101 - Enrollment Application (page 2)
- Limitations & Exclusions (page 3)
- Form 102 - Beneficiary Designation (page 4)
- Form 103 - Salary Worksheet (page 5)

Understand the terms

- *Eligible Class Full-time Hire Date*: The date you enter an eligible class, determined on your employer's Form 120: Employer Benefit Agreement.
- *Coverage Effective Date*: 1st of the month following the "Eligible Class Full-time Hire Date," unless otherwise documented on the Form 120: Employer Benefit Agreement.
- *Authorized Signature*: Employer signature (EX: treasurer, pastor, church administrator, etc.)
- *Open Enrollment Period*: Enrollment Applications may be submitted from October 15 to December 1 for a January 1 start date of benefits for newly eligible employees or changes to benefits.

Send completed forms electronically to FCMM to be approved within 30 days of eligible hire date, unless otherwise documented on the Form 120: Employer Benefit Agreement.

- Secure File Portal (preferred): <https://fcmmbenefits.leapfile.net/>
- Fax: 952.853.8474

Mail approved original enrollment forms

- FCMM Benefits & Retirement
901 East 78th Street
Minneapolis, MN 55420

Contact Client Services with questions

- Email (preferred): benefits@fcmmbenefits.org
- Phone: 1.800.995.5357



Underwritten by:

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

Evangelical Free Church of America
Administered by: FCMM Benefits & Retirement
901 East 78th Street, Minneapolis, MN 55420
Group Long Term Disability Insurance & Term Life/AD&D
Enrollment Form
Policy #930391/Div #001

Form 101: Enrollment Application

Employee Social Security Number _____ **Gender** M F **Date of Birth (mm/dd/yyyy)** ____ / ____ / ____

Employee First Name _____ **M.I.** _____ **Last Name** _____

Employee Home Street Address _____ **City** _____ **State** _____ **Zip Code** _____

Occupation / Job Title _____ **Phone Number** _____ **Email Address** _____

Eligible Class _____ **Full-time Hire Date** _____ **Total Annual Salary** \$ _____ **Salaried** **Hourly** **Hours Worked Per Week** _____

Long Term Disability Premium Payment Method:
 Staff Benefit - my employer pays 100% of my LTD premiums on this plan.
 Payroll Deduction - I pay 100% of my LTD premiums on this plan. I authorize my employer to deduct from my salary the necessary premium for this coverage. I understand my payroll deduction amount will change if my coverage or costs change.

Life/ AD&D Premium Payment Method:
 Staff Benefit - my employer pays 100% of my Life/AD&D premiums on this plan.
 Payroll Deduction - I pay 100% of my Life/AD&D premiums on this plan. I authorize my employer to deduct from my salary the necessary premium for this coverage. I understand my payroll deduction amount will change if my coverage or costs change.

No, I do not wish to participate in the Long Term Disability and Life/AD&D Insurance Benefit Plan at this time through payroll deduction. I understand I cannot enroll again until the Annual Open Enrollment, if I wish to elect this coverage in the future. Enrolling at a future date will include a pre-existing limitation on coverage.

I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off, or leave of absence on the date this insurance would otherwise become effective. I have read and understand the information in Form 138 - Coverage Overview, Limitations & Exclusions, benefit amounts, and offsets. My signature verifies the accuracy of information contained on this form.

Employee Signature: _____ Date: _____

Coverage Effective Date: ____ / 0 1 / ____ Authorized Signature: _____

Please be aware that your coverage may be impacted by certain limitations and exclusions including, but not limited to, the following:

Limitations and Exclusions

Delayed Effective Date:

Employee: Insurance will be delayed for employees not in active employment until the first of the month, coincident with or next, following the date they return to work. Regularly scheduled vacation time is considered active employment.

Dependents: Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer disabled. This delay does not apply to newborn children while dependent insurance is in effect. "Totally disabled" means that, as a result of injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; is receiving or is entitled to receive any disability income from any source due to any sickness or injury; is receiving chemotherapy radiation therapy or dialysis treatment; or has a life threatening condition. Disabled children over the maximum child age may be eligible for benefits, please see your plan administrator for more details.

Exclusion for Suicide:

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

This Suicide Exclusion does not apply to Washington residents.

AD&D Benefit Exclusions

AD&D Benefits would not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders;
- Suicide, self-destruction while sane, or self-inflicted injury;
- War, declared or undeclared, or any act of war;
- Active participation in a riot;
- Attempt to commit or commission of a crime;
- The voluntary use of any prescription or non-prescription drug, poison, fume or any other chemical substance unless used according to the prescription or direction of the individual's doctor. This exclusion does not apply to the individual if the chemical substance is ethanol; or
- Intoxication. ("Intoxicated" means that the individual's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.)

Please see your Plan Administrator [or your Policy] for a complete listing of applicable limitations and exclusions.



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

Evangelical Free Church of America
 Administered by: FCMM Benefits & Retirement
 901 East 78th Street, Minneapolis, MN 55420
 Group Long Term Disability Insurance & Term Life/AD&D
Enrollment Form
 Policy #930391/Div #001

Form 102: Beneficiary Designation

Please complete the beneficiary information on this form. If you wish to change your beneficiary at any time please complete a new form. The form with the most recent signature date will replace all other elections or directions. Beneficiary designation will affect your LTD Survivor Benefit and Life/AD&D Insurance coverage.

Employee Social Security Number _____ **Gender** M F **Date of Birth (mm/dd/yyyy)** ____ / ____ / ____

Employee First Name _____ **M.I.** _____ **Last Name** _____

Phone Number _____ **Email Address** _____

(I) PRIMARY BENEFICIARIES (REQUIRED)

<u>Name (last name, first, middle initial):</u>	<u>Relation to You:</u>	<u>Benefit %:</u>
(1)		
(2)		

**Total of all Primary Beneficiary designations must equal 100%.*

(II) CONTINGENT BENEFICIARIES (REQUIRED)

If the beneficiary(ies) named above are not living, then pay:

<u>Name (last name, first, middle initial):</u>	<u>Relation to You:</u>	<u>Benefit %:</u>
(1)		
(2)		
(3)		
(4)		

**Total of all Contingent Beneficiary designations must equal 100%.*

I certify all statements I provided are true to the best of my knowledge and belief, and I understand a copy of this form will be made available to me at my request. I have read and understand the "Limitations and Exclusions" included with this enrollment form.

Employee Signature: _____ **Date:** _____

Form 103: Salary Worksheet


This form is to be used for initial eligible employee enrollments, as well as employee salary updates. Accurate and current salary information is necessary for our insurance carrier. In the event a claim is filed for the Long Term Disability benefit, up-to-date salary information is required. For those whose benefit is paid through payroll deduction, the insurance carrier will request information of after-tax payroll deduction at the time a claim is filed.

Employee Full Name	Employee Email Address
_____	_____
Employer Name	Employer Address
_____	_____
Employer Contact Name	Employer Email Address
_____	_____

Combined total of annual salary and housing allowance (if applicable) is considered for premium and benefit:

1. **Gross Annual Base Salary (Line 1)** \$ _____
 - a. Include: salary added for SS offset, salary added in lieu of health insurance, employee retirement salary deferral contributions, and employee payroll-deducted contributions to a HSA or FSA.
 - b. Do Not Include: housing allowance, reimbursements, employer retirement contributions, or other employer paid nontaxable benefits.
2. **Housing Allowance (Line 2)** \$ _____
 - a. Include: Designated housing allowance and/or fair rental value of housing provided by church for qualified pastoral staff.
3. **Total Annual Salary** \$ _____
 - a. Add gross annual base salary and housing allowance amount.

Employer Information [INITIAL ENROLLMENT ONLY]

 This section must be completed by the EMPLOYER per the Form 120: Employer Benefit Agreement

Date of recently updated Form 120: Employer Benefit Agreement: _____
 Changes may only be made once a year during open enrollment and submitted by November 15

LTD Employee Benefit Class: # _____	Life/AD&D Employee Benefit Class: # _____	Life/AD&D Coverage Amount (by class):
		_____ \$10,000
		_____ \$50,000

Premium Payment Calculations

<u>Long Term Disability</u>	<u>Life/AD&D Insurance</u>
.008 (rate) x total annual salary = annual cost / 4 = Cost per quarter	\$10,000 Coverage = \$3.00/month = \$9/quarter
If total annual salary exceeds \$170,000,	\$50,000 Coverage = \$15/month = \$45/quarter
use \$170,000 as your total annual salary in the calculation	

For questions regarding this form, contact FCMM Client Services at (800)995-5357 or benefits@fcmmbenefits.org.

Update Form Submission:

Employer, please submit this completed form to FCMM by mail, secure file exchange, or fax.

Mail:
 FCMM Benefits & Retirement
 901 East 78th
 Street, Minneapolis, MN 55420

Secure File Exchange:
<https://fcmmbenefits.leapfile.net/>

Fax:
 (952)853-8474

For FCMM Office Use Only

FCMM Depositor #: _____ Received Date: _____ Processed by: _____ Processed Date: _____

Form 138: Coverage Overview

GROUP LONG TERM DISABILITY PLAN HIGHLIGHTS

Employee Disability Insurance

- Pays 60% of your monthly earnings to a maximum monthly benefit of \$8,500
- 90 Day Elimination Period before disability benefit payments begin
- Maximum Benefit Duration lasts up to your Social Security Normal Retirement Age
- Definition of Disability is based on your inability to perform the duties of your own- occupation for the first 3 years of a disability
- Additional disability benefits of up to \$1,000/month may be available to you for up to 2 years if you are cognitively disabled or unable to perform two or more Activities of Daily Living (ADLs)
- Employees working at least 25 hours per week may be eligible for the plan

Spouse Long Term Disability Rider

- Pays a benefit if your spouse is cognitively disabled or unable to perform two or more Activities of Daily Living (ADLs)
- Pays a \$1,500 monthly benefit after a 60-day elimination period up to 2 year lifetime maximum payment period

Additional Plan Features

- **Conversion** – you may convert your coverage to an individual policy and take it with you if your employment ends
- **Survivor Benefit** – if you pass away while receiving a long term disability benefit, Unum will pay your eligible survivor a lump sum benefit equal to 3 months of your gross disability payment
- **Rehabilitation and Return to Work Assistance Program** – depending on your disability, Unum may create a program tailored to your needs that could assist you in returning to work. This program pays an additional disability benefit of 10% of your gross disability payment to a maximum benefit of \$1,000 per month. You may also qualify for child care reimbursement of \$250 per child, per month, not to exceed \$1,000 per month while participating in this program

GROUP LIFE/AD&D PLAN HIGHLIGHTS

Employee Life and AD&D Insurance

- Employees working at least 25 hours per week may be eligible for the plan
- Benefit Age Reduction:
 - \$10,000 under age 70, \$6,500 ages 70 – 75, and \$5,000 ages 75+
 - \$50,000 under age 70, \$32,500 ages 70-75, and \$25,000 age 75+
- Guarantee Issue coverage – you will not have to answer any medical questions

Additional Plan Features:

- **Waiver of Premium** - If you become disabled (as defined by your plan) and are no longer able to work, your premium payments will be waived during this period of disability.
- **Survivor Support** counsel included
- **Portability** - If you retire, reduce your hours or leave your Employer, you can take this coverage with you according to the terms of the contract.

VALUE ADD SERVICES (Additional Information Available at: fcmmbenefits.org)

Travel Assistance Benefit

Employees and family are covered while traveling (100 or more miles from home), with crisis management, guaranteed hospital admissions, critical care monitoring, emergency medical evacuation, etc.

Employee Assistance Program

Unum's Life Balance program is there to assist employees with everyday home, personal and family issues. They provide full access to counseling, information, resources for wellness and free will preparation services.

Will Preparation

Unum's Life Balance program is there to assist employees with everyday home, personal and family issues. They provide full access to counseling, information, resources for wellness and free will preparation services.

** This is not a contract – Please refer to your contract for policy details **