NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Offered by Life Insurance Company of North America

Employee-Paid
LONG TERM DISABILITY INSURANCE

Summary of Benefits

Prepared for: Old Dominion University

Eligibility:

All active, full-time Employees earning $15,000 and over annually over age 18 regularly working a minimum of 30 hours per week for the Policyholder.

Employee: You will be eligible for coverage immediately.

Available Coverage:

Gross Monthly Benefit	Maximum Gross Monthly Benefit	Benefit Waiting Period	Maximum Benefit Period
60% of your monthly covered earnings	$7,500	180 Days	Please refer to the “Duration” section below for more details.

Additional Features
Family Survivor Benefit – If you die while receiving benefits, we will pay a survivor benefit to your lawful spouse, eligible children, or estate. The plan will pay a single lump sum equal to 6 months of benefits.

Employee’s Monthly Cost of Coverage:

Monthly Rate Per $100 of Monthly Covered Earnings = $0.350

Actual per pay period premiums may differ slightly due to rounding.

How to Calculate Your Monthly Cost: (See rate chart for rate calculation per pay)

Step 1: Divide your annual salary by 12 to calculate your monthly earnings.

Step 2: Find the above Monthly rate.

Step 3: Multiply this rate by your monthly earnings, or $12,500, whichever is less.

Step 4: Divide the total by 100. The result is your Monthly cost.

Important Definitions and Policy Provisions:

Disability - “Disability” or “Disabled” means if solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation or you are unable to earn 80% or more of your covered earnings from working in your regular occupation. We will require proof of earnings and continued disability.

Covered Earnings - “Covered Earnings” means your wages or salary, not including overtime pay, bonuses, commissions, and other extra compensation.

When Benefits Begin - You must be continuously Disabled for 180 Days before benefits will be paid for a covered Disability.

How Long Benefits Last - Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit or until you no longer qualify for benefits, whichever occurs first. Should you remain Disabled, your benefits continue according to the following schedule, depending on your age at the time you become Disabled.

Age at Disability	Age 62 or younger	63	64	65	66	67	68	69+
Duration of Payments (months)	To age 65 or the date the 42nd monthly benefit is payable, if later.	36	30	24	21	18	15	12

When Coverage Takes Effect - Your coverage takes effect on the later of the policy’s effective date, the date you become eligible, the date we receive your completed enrollment form if required, or the date you authorize any necessary payroll deductions if applicable. If you’re not actively at work on the date your coverage would otherwise take effect, your coverage will take effect on the date you return to work. If you have to submit proof of good health, your coverage takes effect on the date we agree, in writing, to cover you.

Benefit Reductions, Conditions, Limitations and Exclusions:

Effects of Other Income Benefits – This plan is structured to prevent your total benefits and post-disability earnings from equaling or exceeding pre-disability earnings. Therefore, we reduce this plan's benefits by an amount equal to any Social Security retirement and/or disability benefits payable to you, your dependents, or a qualified third party on behalf of you or your dependents. Your disability benefits will not be reduced by any Social Security disability benefits you are not receiving as long as you cooperate fully in efforts to obtain them and agree to repay any overpayment when and if you do receive them. Disability benefits will be reduced by amounts received through other government programs, sick pay, employer funded retirement benefits, workers' compensation, franchise/group insurance, auto no-fault, and damages for wage loss. For details, see your outline of coverage, policy certificate, or your employer's summary plan description.

Earnings While Disabled – During the first 24 months that benefits are payable, benefits will be reduced if benefits plus income from employment exceeds 100% of pre-disability Covered Earnings. After that, benefits will be reduced by 50% of earnings from employment.

Limited Benefit Period – Disabilities caused by or contributed to by any one or more of the following conditions are subject to a lifetime limit of 24 months for outpatient treatment: Anxiety-disorders, delusional (paranoid) or depressive disorders, eating disorders, mental illness, somatoform disorders (including psychosomatic illnesses), Alcoholism, drug addiction or abuse. Benefits are payable during periods of hospital confinement for these conditions for hospitalizations lasting more than 14 consecutive days that occur before the 24-month lifetime outpatient limit is exhausted.

Pre-existing Condition Limitation – Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures), or for which a reasonable person would have consulted a physician during the 3 months just prior to the most recent effective date of insurance. Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for at least 12 months after your most recent effective date of insurance.

Termination of Disability Benefits – Your benefits will terminate when your Disability ceases, when your benefit duration period is exceeded, you earn more than your allowable Covered Earnings, or the date benefits end because you did not comply with the terms and conditions of the policy.

Exclusions – This plan does not pay benefits for a Disability which results, directly or indirectly, from any of the following: • Suicide, attempted suicide, or intentionally self-inflicted injury while sane or insane. • war or any act of war, whether or not declared. • active participation in a riot; • commission of a felony; • the revocation, restriction or non-renewal of an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy.

In addition, the plan does not pay disability benefits any period of Disability during which you are incarcerated in a penal or corrections institution.

Terms and conditions of coverage for Long Term Disability insurance are set forth in Group Policy No. LK 008029. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, are contained in the Policy Certificate. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability and/or features may vary by state.

Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company, 51 Madison Avenue New York, NY 10010.

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Created on 08/2021.

INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

Return completed form to New York Life Group Benefit Solutions
P.O. Box 20310
Lehigh Valley, PA 18003-9924
Phone: 1-800-732-1603
Fax: 1-800-440-0856

Offered by Life Insurance Company of North America

Employer: Old Dominion University

ALL ABOUT YOU – THE EMPLOYEE

Your Name ______________ **Social Security #** __________ **Birthdate** __________
Address ______________ City __________ State _____ Zip __________
Work Phone __________ Home Phone __________ Employee ID # __________ Gender: ____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE

❑ I am currently married and my date of marriage is: __________

My Spouse's Information

Name ______________ **Social Security #** __________
Birthdate __________ Gender __________

Employee-Paid (Voluntary) Long-term Disability Insurance Policy # LK 008029		
Applicant	Review your available plan below before accepting or declining coverage.	
Employee	Benefit Percentage: 60%	❑ Accept Coverage
	Maximum Monthly Benefit Amount: $7,500	❑ Decline Coverage

***This is the maximum amount that you can choose under this plan.*

All coverage elected during this enrollment period will take effect on the latest of 09/01/2021, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.

Please see "Voluntary Product Costs" page for rate information per pay period.

Please turn to other side to complete enrollment process. Be sure to make a copy for your records.

SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to New York Life Group Benefit Solutions' approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by VA: Life Insurance Company of North America.

Pre-Existing Condition Limitation (applies to long-term disability insurance only): "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

Please Sign Here ☛ Signature ______________________________ Date ______________

Community Property Laws—If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary payment of benefits may be delayed or disputed unless your spouse provides their signature in the space provided below.

Spouse Signature ______________________________ Date _____/_____/_______

Employee Signature ______________________________ Date _____/_____/_______

Created on 08/2021.

Please see next page for rate information per pay period.

Voluntary product costs.

Prepared for the employees of Old Dominion University.

Voluntary Long Term Disability (LTD) Insurance

Long-term disability coverage pays benefits when you're disabled due to a covered injury or illness and are unable to work.

Your LTD plan covers 60% of monthly covered payroll to a maximum benefit of $7,500 per month.

Semi-Monthly Rates per elected amount		
Sample annual salary	Gross monthly benefit	Employee
$20,000	$1,000.00	$2.92
$27,000	$1,350.00	$3.94
$34,000	$1,700.00	$4.96
$41,000	$2,050.00	$5.98
$48,000	$2,400.00	$7.00
$55,000	$2,750.00	$8.02
$62,000	$3,100.00	$9.04
$69,000	$3,450.00	$10.06
$76,000	$3,800.00	$11.08
$83,000	$4,150.00	$12.10
$90,000	$4,500.00	$13.12
$97,000	$4,850.00	$14.15
$104,000	$5,200.00	$15.17

Semi-Monthly Rates per elected amount		
Sample annual salary	Gross monthly benefit	Employee
$111,000	$5,550.00	$16.19
$118,000	$5,900.00	$17.21
$125,000	$6,250.00	$18.23
$132,000	$6,600.00	$19.25
$139,000	$6,950.00	$20.27
$146,000	$7,300.00	$21.29
$153,000	$7,500.00	$21.88
$160,000	$7,500.00	$21.88
$167,000	$7,500.00	$21.88
$174,000	$7,500.00	$21.88
$181,000	$7,500.00	$21.88
$200,000	$7,500.00	$21.88

To calculate your LTD rate per pay period:

(Input Your Annual Salary) ________________ **x $0.0035 / 24 = $**________________

Group Benefit Solutions

Costs shown are for illustrative purposes only; actual per pay period deductions may differ due to rounding. Costs are subject to change based on age and program experience. Terms and conditions of coverage are set forth in your group policy. Refer to your Certificate of Insurance or Summary Plan Description for more information.

New York Life Group Benefit Solutions products and services are provided by Life Insurance Company of North America and New York Life Group Insurance Company of NY, subsidiaries of New York Life Insurance Company. Policy forms: Disability -TL-004700 et al., Term Life -TL-004700 et al. and Accident -GA-00-1000.00 et al. Life Insurance Company of North America is not authorized in NY and does not conduct business in NY. This material is not intended for use with residents of New Mexico.

New York Life Insurance Company

51 Madison Avenue
New York, NY 10010

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EVIDE NCE OF INSUR ABILITY FORM

Life Insurance Company of North America (LINA)
(herein called the Insurance Company)
For info and customer service call 1-866-607-2360

PO Box 20310
Lehigh Valley, PA 18003

- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

Important: Please enter all dates in mm/dd/yyyy format.

Return form to: New York address above, Fax 1-800-440-0856, Email: bethlehemmail@newyorklife.com

Employer Use: (Mandatory Data Needed) In order to process this form, the employer must complete this information.

Employer: Old Dominion University **Policy(s)** LTD: LK008029

Class: ________ **Location:** ____________ **Date of Hire:** ____________ **Annual Salary:** ____________ **Verified By:** __________

Reason for Request: (i.e. New Hire, Late Entrant, Initial/Ongoing Enrollment, etc.) ______________________________

		LTD: LK008029
DISABILITY AMOUNT TO BE UNDERWRITTEN		

EMPLOYEE SECTION

Employee Name (first, middle, last) ______________________ Social Security # ____________

Address ______________________ City ____________ State ______ Zip ________

Phone ____________ ID # ____________ Birthdate ____________ Gender: ☐ M ☐ F

IMPORTANT
Please complete each section that follows. Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee info in this section if you are applying for Disability Insurance more than 31 days of becoming eligible due to a life status change or during an ongoing enrollment event.

Height and Weight Information

Employee Height ____ft.____in. Weight ______lbs.

PHYSICIAN SECTION

Employee Physician Name ______________________ **Phone Number** ______________

Street Address ______________________ City ____________ State ________ Zip ________

SECTION A: Please indicate your answers for each question in this section by checking the Yes or No box for the question.

Within the last 5 years has the proposed insured been: diagnosed with any of these conditions; told by a medical professional he/she has or may have any of the conditions; or been treated by a medical professional for any of the conditions shown below?	**Employee**	
	Yes	**No**
A. High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?		
B. Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?		
C. Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?		
D. Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?		
E. Human Immunodeficiency Virus infection, Acquired Immune Deficiency Syndrome, or any other condition affecting the immune system or lymph nodes?		
F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?		
G. Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?		
H. Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?		
I. Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?		
J. Alcohol or drug abuse or dependency?		
K. Any condition affecting hearing or vision, including any loss of sight or hearing, or dizziness or Vertigo?		
L. Carpal Tunnel Syndrome; neck, back, knee or joint condition, strain, sprain or other type of injury?		
M. Any bone, joint, or muscle condition persisting for, or having been treated for, 6 months or longer?		
N. Fibromyalgia, chronic pain, Chronic Fatigue, Irritable Bowel Syndrome (IBS), Multiple Sclerosis, or Temporomandibular Joint (TMJ) Disease?		
O. Received any form of physical therapy; been seen by a chiropractor or other non-MD medical practitioner or therapist for any reason?		

If you answered "Yes" to any questions above, please provide details in the table below.

Name ______________________________ Social Security #______________________________

SECTION B: Please indicate your answers for each question in this section by checking the Yes or No box for the question.	Employee	
Within the last 5 years has the proposed insured been:	**Yes**	**No**
A. Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?		
B. Smoked cigarettes:		
1. For how many years has the proposed insured smoked?		
2. Approximately how many cigarettes are, or were, smoked on average per day?		
3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking?		
C. Used any controlled or illegal drug or other substance?		
D. Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?		
E. Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?		
F. Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?		

If you answered "Yes" to any questions above, please provide details in the table below.

Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.

Name of Employee	*Medical Condition*	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

AGREEMENTS AND AUTHORIZATION

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

(1) This request will be a part of the policy that provides the insurance.
(2) I may need to provide more medical info.
(3) I may need to take medical tests and report the results to the Insurance Company.
(4) I must report any change in my health that happens before the insurance is effective.
(5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

Authorization. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original. I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request. I understand that the info will be used to assess my request for insurance. I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law. I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

Pre-Existing Condition Limitation: "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance. I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

Caution: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Sign Here ______________________________ ______________

Employee's Signature *Month/Day/Year*

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.