



The Standard™
Positively different.

SPECIAL NOTICE FOR GROUP LTD INSURANCE

***Open Enrollment for January 1, 2006 Effective Date
County of El Paso***

******DO NOT MISS THIS OPPORTUNITY!!!******

This is a one-time open enrollment offering of Long Term Disability Insurance by your employer. You may enroll during this open enrollment period WITHOUT being subject to Evidence of Insurability requirements. If you do not elect coverage during this specific enrollment period, then you will be considered a late enrollee, subject to medical underwriting approval on all amounts.

LTD insurance provides coverage for your most valuable asset – your ability to earn an income.



Voluntary Long Term Disability Insurance

Standard Insurance Company has developed this document to provide you with information about the optional insurance coverage you may select through your *employer*. Written in non-technical language, this is not intended as a complete description of the coverage. If you have additional questions, please refer to the Voluntary Long Term Disability (LTD) Employee Brochure included in your packet or check with your human resources representative.

Employer Plan Effective Date

A minimum number of eligible employees must apply and qualify for the proposed plan before Voluntary LTD coverage can become effective. This level of participation has been agreed upon by your *employer* and The Standard.

Eligibility

To become insured, you must be:

- A regular, full-time employee of the County of El Paso, excluding temporary or seasonal employees, full time members of the armed forces, leased employees or independent contractors
- *Actively at work* at least 30 hours each week
- A citizen or resident of the United States or Canada

Employee Coverage Effective Date

Please contact your human resources representative for more information regarding the following requirements that must be satisfied for your insurance to become effective. You must satisfy:

- Eligibility requirements
- An *eligibility waiting period*
- An *active work* requirement. This means that if you are not *actively at work* on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete 1 day of *active work* as an eligible employee.

Benefit Amount

Your monthly benefit is 60% of your insured *predisability earnings* reduced by *deductible income*. Please contact your human resources representative for additional information regarding what is included in *predisability earnings*.

Plan Maximum Monthly Benefit: \$5,000

Plan Minimum Monthly Benefit: \$100

Benefit Waiting Period

If your claim for Long Term Disability benefits is approved by The Standard, benefits become payable after you have been continuously *disabled* for 90 days and remain continuously *disabled*. Benefits are not payable during the *benefit waiting period*.

Rates

If you have questions regarding how to determine your earnings, please contact your human resources representative.

Age as of 1/1/2006	Rate
<25	\$0.249
25-29	\$0.249
30-34	\$0.274
35-39	\$0.319
40-44	\$0.440
45-49	\$0.641
50-54	\$0.930
55-59	\$1.249
60-64	\$1.355
65-69	\$1.444
70+	\$1.652

To calculate your monthly payroll deduction, use the formula indicated below:

1. Enter your average monthly income, not to exceed 8,333, on Line 1. Line 1: _____
2. Select your rate from the rate table and divide this by 100. Line 2: _____
3. Multiply Line 1 by the amount shown on Line 2. Line 3: _____

The amount shown on Line 3 is your estimated monthly payroll deduction.

If you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage. The information presented above is controlled by the *group policy* and does not modify it in any way. The controlling provisions are in the *group policy* issued by Standard Insurance Company

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT	Your Name (Last, First, Middle)		Group Name County of El Paso		Group Number(s)	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation	
DISABILITY	Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements. Long Term Disability <input type="checkbox"/> Voluntary LTD					
	Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply. <input type="checkbox"/> Name Change Former name _____ <input type="checkbox"/> Other _____					
SIGNATURE	I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.					
	Member/Employee Signature Required				Date (Mo/Day/Yr)	
Human Resources Department - Complete this section. Retain form for your records.						
Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr	