Owner Only Benefits

Protect, Retire, Exit

National Postal Mail Handlers Union Local 310

Disability Insurance Sign Up Forms

Overview & General Instructions

1. **Postal (Central United Life Form) – must be completed / signed / dated**

2. **Application – must be completed / signed / dated**
    a. **Need Your Information (as Primary Insured)**
        i. **Name/Birthdate/Sex/Height/Weight/Social Security #**
    b. **Complete Address / Home Telephone / Employer / Date Employed / Hours Worked / Occupation / Monthly Income**
    c. **If working at least 27 hours – medical underwriting waived (***YOU DO NOT HAVE TO COMPLETE THE QUESTIONS BELOW THE "INSURANCE PLANS" BOX (questions below the "If Guaranteed Issue Requirements are met …" line)*
    d. **Your agent will need to sign as well**

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3. **Allotment Form (Firstnet)** *(if using payroll allotment)*
    a. **Complete Top Section (First Deduction: next payroll or future payroll date)**
    b. **Put Total Bi-Weekly Deduction (selection from Postal Form) on Central United Line**
    c. **Add Bi-Weekly Deduction + $2 FirstNet Transfer Fee**
    d. **Sign / Date / Enter Email Address**

4. **Bank Draft Form** *(if paying via bank draft and not payroll allotment)*
    a. **Check Central United Life Box** *(top of page)*
    b. **Enter Your Banking Account Information**
        i. **To – Your Bank Name**
        ii. **Account Title** *(account holder name)*
        iii. **Account # / Routing # / Date of Withdrawal / Account Type** *(your Policy # will not be available until processing)*
    c. **Sign the Form**
    *d. **FOR ALL BANK DRAFTS – VOIDED CHECK REQUIRED***

5. **Enter Deduction Amount in Postal Ease** *(if paying via payroll allotment)*
        i. **Use completed Firstnet for your personal account / routing numbers**

PLEASE NOTE: ALL SCRATCHOUTS MUST BE INITITALED

Postal (Central United Life)

Georgia

Name _____

On the acompanying benefit applications and this enrollment form, I have applied for certain benefits offered through the above group. It is my decision to receive the following through allotment / payroll deduction.

CDI10

Disability Plan (Occ 3) **ONE YEAR**

	Initial Election	*14/14 ELIM. Bi-Weekly Deduction*	*30/30 ELIM. Bi-Weekly Deduction*
$ 600 per month Benefit		$22.13	$17.42
$ 700 per month Benefit		$25.81	$20.32
$ 800 per month Benefit		$29.50	$23.22
$ 900 per month Benefit		$33.19	$26.13
$1000 per month Benefit		$36.88	$29.03
$1100 per month Benefit		$40.56	$31.93
$1200 per month Benefit		$44.25	$34.84
$1300 per month Benefit		$47.94	$37.74
$1400 per month Benefit		$51.63	$40.64
$1500 per month Benefit		$55.32	$43.55
$1600 per month Benefit		$59.00	$46.45
$1700 per month Benefit		$62.69	$49.35
$1800 per month Benefit		$66.38	$52.26
$1900 per month Benefit		$70.07	$55.16
$2000 per month Benefit		$73.75	$58.06

Other _____

Tower Worksheet: **Total Bi-Weekly:$_____** **Add $2.00 Fee =** **Total Allotment :$_____**

Authorized Signature : _____ Date: _____

CENTRAL UNITED LIFE INSURANCE COMPANY
10777 Northwest Freeway, Houston, Texas 77092

Application for Insurance

FRAUD: 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 be committing a fraudulent insurance act, which is a crime.

☐ Check if replacing or changing existing coverage in this company. **Policy Number** _____

PERSONS PROPOSED FOR INSURANCE								
Last Name	First	Middle	Relationship	Birthdate	Sex	Height	Weight	Social Security Number
			Primary Insured	/ /				
			Spouse AD&D only	/ /				
			Child AD&D only	/ /				
			Child AD&D only	/ /				
			Child AD&D only	/ /				

Address	City	State	Zip	Home Telephone ( )
Employer	Date Employed	Hours Worked/Wk (Full Time at least 27 hours per week)		
Occupation	Monthly Income $	Group Number		
Payor or Owner if other than Primary Insured	☐ Payor ☐ Owner	Social Security No. - -	Relationship to Primary Insured	
Beneficiary	Age	Relationship		

FOR THE PAST 30 DAYS: Have all proposed insureds been performing normal activities and been actively at work full time at their regular occupation? _____ Yes _____ No. If "No", explain: _____

USED TOBACCO in the past 12 months? Primary Insured _____ Yes _____ No Spouse _____ Yes _____ No

WILL THIS POLICY REPLACE OR CHANGE ANY: Existing Life or Health Insurance in this or any other company? _____ Yes _____ No.
If "Yes", complete replacement form where required.

INSURANCE PLANS							Monthly Premium
DISABILITY Primary Insured Only		Monthly Ben.	Elim. Period	Benefit Period	Building Benef. Rider	50% Ben. Red. Unless % selected	
Occ. Class	Injury	$ _____	$ _____	$ 1 year (12 months)	☐	here _____	
☐ 1 ☐ 2 ☒ 3	Sickness	$ _____	$ _____	$ 1 year (12 months)			
RIDER	AD &D						
Primary Insured	$ _____						
Spouse	$ _____						
Children	$ _____						$ _____

If Guaranteed Issue requirements are met, medical underwriting will be waived.

1. **HAS ANY PROPOSED INSURED:** In the last 10 years been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) and/or tested positive for HIV (Human Immunodeficiency Virus)? _____ Yes _____No
2. **HAS ANY PROPOSED INSURED:** In the past 2 years had a driver's license suspended/revoked? _____ Yes (License # _____ State _____) _____ No.
3. **HAS ANY PROPOSED INSURED:** Consulted a Physician, received any medical treatment or been hospitalized or confined during the past 3 years? _____ Yes _____ No
4. **IS ANY PROPOSED INSURED** currently covered or eligible for Medicare? _____ Yes _____ No. If Yes, a "Guide to Health Insurance for People with Medicare" must be given to any proposed insured age 65 or over.
5. List the amount of any other individual disability insurance currently applied for or in force for the Primary Insured:
   $_____

Details of "Yes" answers. Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury/Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

Home Office Corrections and/or Additions Only

Authorization to Obtain and Release Information: I hereby AUTHORIZE any licensed physician, medical practitioner, pharmacy or pharmacy related facility, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB) consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Central United Life Insurance Company, its reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service Central United Life Insurance Company may engage, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Central United Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I AGREE that all answers given in this application are complete and true to the best of my knowledge and belief, and that this application is to be attached to and made a part of the policy. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of this Authorization. This Authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing. I ACKNOWLEDGE receipt of the Notice of Information Practices and the Medical Information Bureau Disclosure Notice.

I agree and understand that no insurance coverage will be in force until the effective date specified by the Company. No Agent or Broker is authorized to make or modify any policy or waive any of Central United's rights or requirements or waive the answer to any question in the application. No change to the policy will be valid until approved by an Officer of the Company which must be noted on or attached to the policy. The policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance. I hereby apply for insurance coverage to be issued solely and entirely in reliance upon the written answers to the foregoing questions and/or information obtained by the Company in its underwriting process. I and my agent certify that I have read or had read to me all the questions and answers in this completed application and such answers to the best of my (our) knowledge and belief are true and complete. I understand and agree that the falsity of any answer or statement in this application which materially affects the acceptance of the risk or hazard assumed by the Company may bar the right to any recovery under any policy(s) issued contracts, waive any Company rights or requirements or waive any information the Company requests.

AGENT'S STATEMENT: I, the undersigned agent, also certify that to the best of my knowledge, replacement ☐ is ☐ is not involved at this time.

Signed at _____ this _____ day of _____ 20 _____
City, State

X _____ X _____ X _____
Signature of Primary Insured (Parent if person to be insured is less than 15 years old) | Payor/Owner (if other than Proposed Insured) | Spouse

X _____ _____ _____ _____ % _____
Signature of Agent | Agent's Name (printed) | Agent No. | % Credit | State ID No.

NOTICE: ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO CENTRAL UNITED LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

BIWEEKLY ALLOTMENT SINGLE OR MULTIPLE COMPANY TRANSFERS FORM

FAX: 270-351-1239

First Citizens Bank
P.O. Box 988
Radcliff, KY 40159
Phone –800-351-1911

B4

EMPLOYEE INFORMATION

NAME OF PAYEE (last,first,middle initial)	DATE OF BIRTH	FIRST DEDUCTION
ADDRESS (street,route,P.O. Box, APO/FPO)	SOCIAL SECURITY NUMBER	TELEPHONE #
CITY STATE ZIP CODE	TYPE OF DEPOSITOR ACCOUNT ☒ SAVINGS	

If an allotment is currently on the routing number, you must do an increase to the existing allotment.

DISTRIBUTION OF ALLOTMENT

COMPANY NUMBER	AGENT CODE	COMPANY NAME	POLICY OR ACCOUNT NUMBER	FIRSTNET TRANSFER FEE	TOTAL
5580	000	Firstnet Transfer Fee	N/A	$2.00	$2.00
5535	000	Central United			
5519	000	Bank Transfer Checking Savings	Bank Account # / Bank Routing #		
				TOTAL	

NAME AND ADDRESS OF FINANCIAL INSTITUTION	ROUTING NUMBER	CHECK DIGIT
First Citizens Bank P.O. Box 988 Radcliff, KY 40159	083901655	0
	ACCOUNT # (USE SSN)+5580	5580

ALLOTMENT SAVINGS ACCOUNTS APPLICATION AND TRANSFER AUTHORIZATION

In consideration of the opening and maintenance of a savings account by First Citizens Bank, the depositor agrees that this account shall be subject to the bank's rules and regulations covering allotment savings account interest rates, statements and maintenance of this type account. Accounts inactive for 365 days may be assessed a dormant service charge.

Undersigned hereby authorizes First Citizens Bank to deduct from said account and transfer bi-weekly the amount listed above (including Firstnet Transfer Fee) or any lesser amount if the first amount is not available to Firstnet. First Citizens Bank will mail Electronic Funds Transfer disclosure, rules and regulations regarding this account. Quarterly statements and other disclosures will be made available to you at www.firstnetbillpay.com. If the email address given is invalid, omitted or email is returned to us, we will automatically mail all disclosures and quarterly statements to the address given above. The owners of the accounts, by signing below consent to receive all required statements and disclosures, for example change-in-terms notices, Regulation E notice, error resolution procedures, electronically from First Citizens Bank.

Under penalties of perjury, I certify that (1) TIN provided on this form is true, correct and complete, and (2) that I am not subject to backup withholding either because (a) I have not been notified that I am subject to backup withholding as a result of failure to report all interest or dividends, or (b) IRS has notified me that I am no longer subject to backup withholding. CERTIFICATION INSTRUCTIONS: You must cross out item (a) above if the IRS notified you that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return.

Account Holder Email Address

Agent name (PLEASE PRINT)
T. Spence White

Customer Signature

DATE

Please check the box beside the name of your insurance company.

☐ American States ☐ Central United Life ☐ First Unum ☐ Sun America
☐ Gold Cross Burial Association ☐ Investors Consolidated ☐ Unilife
☐ Loyal American ☐ Manhattan Life ☐ Unum ☐ Family Life

INDEMNIFICATION AGREEMENT

To: Financial Institution named on this form.

In consideration of your compliance with the request and authorization of the depositor:

THE COMPANY REFERENCED ABOVE AGREES THAT:

1. It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any debit drawn by the company referenced above to its own order in the account of such person, or from any liability to any such person or to any owner or beneficiary of any policy issued by the company referenced above in respect of which such a debit is drawn by the company referenced above, provided there are sufficient funds in such account to pay the same upon presentation, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture of a policy the premiums on which is sought to be collected by the company referenced above by such debit; and,
2. It will refund to you any amount erroneously paid by you to the company referenced above on such debit if claim for the amount of such erroneous payment is made by you within twelve months from the date of the debit on which such erroneous payment was made.

President

AUTHORIZATION TO HONOR DEBITS DRAWN BY COMPANY REFERENCED ABOVE

To: _____
(Print Name and Address of Financial Institution where Account is maintained)

As a convenience to me, I hereby request and authorize you to pay and charge to my account debits drawn on my account by and payable to the order of – the company referenced above - provided there are sufficient collected funds in said account to pay the same upon presentation. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such debit. This arrangement shall terminate immediately upon the closing of my account with you or upon receipt by you of notice of my bankruptcy. I agree that your treatment of and rights in respect to each such debit shall be the same as if it were signed by me. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance.

Account Title: _____

Account Number: _____

ABA Routing Number: _____

Date of Withdrawal: _____
(Cannot select the 29th, 30th, or 31st)

Account Type: ☐ Checking ☐ Savings

Policy Number: _____

Signature(s) X_____

X_____

PLEASE ATTACH A VOIDED CHECK

Return the completed form to:
P.O. Box 925688
Houston, Texas 77292-5688

Comments:

_____

_____

MANHATTAN

National Postal Mail Handlers Union Local 310

Individual Disability Benefits

Contact Information

For Enrollment / Questions / Claims

Spencer White
770.833.3220
swhite@owneronlybenefits.com
www.owneronlybenefits.com/npmhulocal310

For Additional Claims Assistance

800.662.5099 (Whitten & Associates)