

IT'S THAT TIME AGAIN!

PLEASE MAKE SURE YOU READ ALL THE INFORMATION REGARDING THE CHANGES IN OUR MEDICAL PLAN.

BECAUSE WE WILL NO LONGER BUNDLE/PACKAGE BENEFITS, EVERY EMPLOYEE WILL NEED TO FILL OUT A NEW BENEFIT ENROLLMENT AND CHANGE FORM.

EACH EMPLOYEE WILL MARK UNDER ITEM 2 WHAT YOU CHOOSE FOR YOURSELF.

TO THE RIGHT; IF YOU HAVE DEPENDENT COVERAGE YOU WILL NEED TO MARK WHAT YOU CHOOSE FOR YOUR DEPENDENT(S) COVERAGE.

(CHOOSE ONLY 1 PLAN FOR ALL DEPENDENTS)

PLEASE SEE DEPENDENT COSTS (PER MONTH) ON FOLLOWING SHEET.

THIS CHANGE WILL TAKE EFFECT ON JULY 1, 2011.

OPEN ENROLLMENT IS FROM MAY 1st THROUGH MAY 31st ONLY FOR THE NEW 11-12 FISCAL YEAR

RETURN TO PAYROLL DEPT BY MAY 31, 2011.

(INSURANCE TAKES EFFECT 7/1/11)

NOW IS THE TIME TO

- ADD A DEPENDENT (Pre-existing conditions may not be covered if no prior insurance coverage)
- REMOVE A DEPENDENT
- SIGN UP FOR SHORT TERM DISABILITY INSURANCE
- SIGN UP FOR VOLUNTARY LIFE/AD&D
- SIGN UP FOR AFLAC
- SIGN UP FOR FLEX

The only way you can add/delete a dependent from your medical plan any other time of the year would be if there was a "QUALIFYING EVENT": marriage, divorce, birth, death, spouse lost his/her insurance, etc. That has to be done within 31 days of the qualifying event. That would take effect on the first of the following month.

Email [bbreazeal@havas.k12.az.us](mailto:bbreazeal@havas.k12.az.us)(505-6929) or [sgranger@havas.k12.az.us](mailto:sgranger@havas.k12.az.us) (505-6930) if you have questions.

## LAKE HAVASU UNIFIED SCHOOL DISTRICT #1 EMPLOYEE BENEFIT TRUST

### What happened with The Trust during 2010-11?

Year-to-date school year, **monthly** claims (medical, dental, vision and prescription drug spend) averaged about \$417,000. This compares to \$516,000 for the same period during 2009-10.

Even though the paid loss history for the Trust has been lower than in 2009-10, with new benefits mandated by Health Care Reform, with the national medical trend increasing by 8%, combined with Arizona trending at 12 to 15%, in order to keep the LHUSD#1 employee benefit trust financially strong, the Trust's actuary recommended some increases to the plan's deductibles, co-pays, out-of-pocket maximum expenses, and dependent contributions. The EBT board of trustees approved the following changes, which will become effective **July 1, 2011**.

The schedule summary is as follows:

Individual Calendar Year Deductible:	\$1,150
Family Calendar Year Deductible:	\$3,450
Calendar Year Individual Out-of-Pocket maximum:	\$1,575
Calendar Year Family Out-of-Pocket maximum:	\$4,725
Lifetime Plan Maximum:	Unlimited
Chiropractic Care:	\$35.00 co-pay
Emergency Room:	\$200.00 co-pay
Office Visits (Primary):	\$35.00 co-pay
Office Visits (Specialist):	\$55.00 co-pay
Urgent Care:	\$35.00 co-pay
Generic Prescription Drugs:	\$5.00 co-pay (no change from 2010-11)
Brand Prescription Drugs:	\$35.00 co-pay
Non-Brand Prescription Drugs:	\$65.00 co-pay
Mail Order RX – 90 day supply:	\$15.00/\$105.00/\$195.00 co-pay
Wellness Colonoscopies:	\$100.00 co-pay (reduction from 2010-11)

Please note that the co-pay for wellness colonoscopies has been decreased from \$200.00 to \$100.00 to encourage members who may need this test to have it done. Additionally, the co-pay for generic drugs was not increased. EBT members have significantly increased their use of generics over the past few years. Thank you for remembering to ask your physician about the possibility of using a generic when a prescription is written. Don't forget that 27% of all prescriptions can be purchased for a copay of \$4.00 at many pharmacies (not through our plan), but **you have to ask**.

Because of Health Care Reform, the Trust will no longer "bundle/package" benefits. Effective July 1, 2011, an EBT member may sign up dependents for medical only, minus dental and vision, however they are not able to take dental and/or vision, minus medical. The options are;

- medical only;
- medical dental only;
- medical, vision only.
- Medical, dental and vision.

The EBT board of trustees voted to increase dependent premiums by 5%, also effective July 1, 2011. **Please see the attached contribution schedule.** A reminder that May is open enrollment to sign on or remove dependents from coverage.

The EBT Trust will be conducting an audit of eligible and enrolled dependent(s). You will be receiving communication from Gilsbar on this audit in the next few weeks. So please be on the lookout for it.

The EBT board previously approved changes to coverage for out-of-network non-emergency claims. During 2011-12, the EBT will pay 15% and the member will pay 85%. In 2012-13, the EBT member will be responsible for all out-of-network non-emergency charges. There is a \$3,000 deductible for out-of-network non-emergency charges. Expenses incurred for a bona fide emergency service will be paid under the in-network benefit allowances. Dependents living out-of-state are considered "out-of-network", except for emergency services.

An electronic version of the Blue Cross Blue Shield provider directory is available on the district website and is updated on a regular basis. Although the LHUSD#1 EBT is not insured by Blue Cross Blue Shield of Arizona, (BCBSAZ) our group pays a monthly access fee to utilize their "contracted providers" and to take advantage of the BCBSAZ discounts. However, these discounts are only available in Arizona.

Under Health Care Reform, as of July 1, 2011, new or existing employees who cover or might wish to cover a dependent child under the age of 19, who may not have had prior health insurance coverage, and therefore were not protected by HIPPA laws; said enrolled child will not be subject to pre-existing condition limitations.

Under Health Care Reform, a second regulation, adopted early by the EBT on July 1, 2010 allows an EBT member's dependent child to be covered until their 26<sup>th</sup> birthday. This includes non-students and married children. The exception is if the child is employed and their employer offers health insurance or the child's spouse is employed and that employer offers insurance coverage for spouses said child is not eligible to enroll in the LHSEBT. If a child has dropped off coverage previously, they would need to be re-enrolled during open enrollment, which takes place during the month of May of each year.

The employee benefit plan booklet is also available on the district web page.

### **Questions about Claims and Benefits...**

All questions concerning claims and benefits must be directed to our insurance administrator, Gilsbar, by telephone, or through their e-mail address, [www.mygilsbar.com](http://www.mygilsbar.com). The Gilsbar telephone number and address are located on your insurance card. For questions on prescription drug coverage, please contact Prescription Solutions at [www.prescriptionsolutions.com](http://www.prescriptionsolutions.com) or telephone 1-877-559-2955. The EBT pays Gilsbar and Prescription Solutions to answer all your medical and prescription questions. Shauna Granger and Bonnie Breazeal of the LHUSD #1 payroll department are the initial contacts for plan enrollment and changes. They cannot advise you on medical decisions or claims issues. If you do contact Gilsbar and are not satisfied with the answer you were given, or need further clarification, you may then contact the district's EBT consultants, David Stewart or Loren Martinez, from Webb & Greer Insurance Agency. Mr. Stewart may be reached at 480-889-0969 or e-mail address [dstewart@webbandgreer.com](mailto:dstewart@webbandgreer.com) and Ms. Martinez may be contacted at 480-889-0970 or e-mail address [lmartinez@webbandgreer.com](mailto:lmartinez@webbandgreer.com). Again, please contact Gilsbar initially, but feel free to call Mr. Stewart or Ms. Martinez if you still need assistance.

The open enrollment period to sign up for both the district's health insurance and flexible spending accounts is during the month of May. This is your time to make any changes to your coverage. For example, you may add or delete yourself or eligible dependents to/from the benefit plan without evidence of insurability. Please remember however, the changes you make during open enrollment are permanent for the following plan year unless you have a HIPAA qualified event (for more information, please refer to the EBT Insurance Booklet, which may be found on the district website [www.havas.k12.az.us](http://www.havas.k12.az.us)).

### **Women's Health and Cancer Rights Act...**

The Women's Health and Cancer Rights Act of 1998 was passed on October 21, 1998. Under the law, our health plan must provide medical and surgical benefits in connection with a mastectomy for certain reconstructive surgeries. This includes reconstruction of the breast on which the mastectomy was performed,

surgery on the other breast to produce a symmetrical appearance; and Prostheses and treatment for physical complications from all stages of mastectomy, including lymph edemas. The coverage is subject to the Plan's normal Medical Schedule of Benefits (i.e., deductibles, co-insurance and co-pays).

### **Our New and Continued Programs...**

During 2010-11, individuals covered by the District's health insurance were given the opportunity to obtain mammograms through Mobile On-Site Mammography (MOM). MOM will be scheduled again during the fall of 2011 and the spring of 2012, however payment for the mammograms will no longer be covered by Blue Cross Blue Shield of Arizona. Accordingly, the cost of the mammograms will be applied to the EBT member's wellness benefit. Please plan your schedule accordingly.

The district also offered health screenings and flu/pneumonia shots in 2010. This event was offered free of charge to covered EBT members. These events are also planned for the fall of 2011.

Special rates were once again offered to our members, through payroll deduction, by London Bridge Racquet and Fitness Club. The program will again be offered to LHUSD #1 employees during the 2011-12 school year. Please contact Bonnie Breazeal at 505-6929 or e-mail [bbreazeal@havasu.k12.az.us](mailto:bbreazeal@havasu.k12.az.us) for more information.

### **Wellness...**

Please join us in once again thanking Colleen Pankow for her efforts in creating the LHUSD #1 Employee Benefit Trust wellness newsletter. These newsletters are excellent tools for sharing tips for healthy living and for keeping EBT members up-to-date on the benefits that are available to them. Among the subjects reported by Colleen this year was the progress on the weight loss program that was offered to a small group of district employees who met certain criteria. Congratulations to this group for their diligence and the impressive amount of weight loss they have achieved year-to-date.

If you have any information, recipes, etc. that you would like to share with your fellow EBT members, please feel free to e-mail them to Colleen at [cpankow@havasu.k12.az.us](mailto:cpankow@havasu.k12.az.us).

The Employee Benefit Trust will continue to provide access to **eDocAmerica**, a service that provides on-line health decision support. Information on **eDocAmerica** is available on the district website at [www.havasu.k12.az.us](http://www.havasu.k12.az.us). It has been reported by the employees of the district that they have been able to avoid a doctor's office visit by contacting eDocAmerica and they have been comforted by a qualified "second opinion" from one of eDocAmerica's physicians on a planned procedure.

We would like to thank the insurance committee members from each school for their attendance at meetings during 2010-11 and for being the liaison between the Employee Benefit Trust and your site. The committee members share your concerns with the Trustees and are available to take suggestions and ideas to the meetings as well. We encourage each school to continue to work together to keep the District's employees healthy and fit.

### **Voluntary Programs...**

The district makes several voluntary (employee paid) programs available to employees. For more information, please contact Shauna or Bonnie in the payroll department. Information is also available on the district website. We encourage you to seriously consider the purchase of these products to ensure ease of mind, should an unexpected health event occur.

1. Additional life insurance for employees, as well as eligible spouses/children
2. Short Term Disability Insurance
3. AFLAC

In addition to the voluntary programs listed above, a flexible spending account is also available to LHUSD#1 employee benefit members. Information on this option is also available on the district web page.

**Looking to the future...**

Although covered Trust Members continue to do well in controlling health care expenditures, costs are increasing, including charges for doctor visits, prescription drugs, etc. Even though members of our staff are doing their best to maintain a healthy lifestyle, we are still affected by outside sources and health care will continue to cost more. Your assistance with our goal of keeping medical expenses down is very much appreciated.

**LHUSD#1 Employee Benefit Trust Board of Trustees:**

Cinda Ross (President)	Community Member
Mark Nexsen	Community Member
Kari Thompson	Employee Member
Ross Hobday	Governing Board Member
Colleen Pankow	Retiree

**Employee Benefit Trust Insurance Committee Members for 2010-11:**

Smoketree	Jeannie Phelps
Starline	Susan Read
Oro Grande	Rebecca Androzzi
Jamaica	Jana Koch
Nautilus	Tracey Kennedy
Havasupai	Marnetta Anderson
Thunderbolt	Kathleen Weber
LHHS/RTP	Audrey Berniklau
Transportation	Peggy Wallis
District Office	Mary Heronema



GILSBAR  
Group Number: S2595

BENEFIT ENROLLMENT AND CHANGE FORM

EMPLOYEE INFORMATION TO BE COMPLETED BY THE EMPLOYEE ONLY

2011-2012 OPEN ENROLLMENT

Social Security Number \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Marital Status  Single  Married  Widowed  Divorced Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex  M  F Hours Worked Per Week: \_\_\_\_\_  
 Telephone # Home(\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  Yes  No  
 ARE YOU MARRIED TO ANOTHER EMPLOYEE OF THE LAKE HAVASU SCHOOL DISTRICT?  Yes  No

- I waive the following coverage(s):  Medical/Dental/Vision Signature \_\_\_\_\_ Date \_\_\_\_\_  
 If you are waiving medical coverage you must sign and indicate your medical carrier: Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_
- EMPLOYEE OPTIONS (CHOOSE ONE)**  
 Medical Only  Employee only  Spouse  Child  Children  Family  
 Medical/Dental Only  Employee only  Spouse  Child  Children  Family  
 Medical/Vision Only  Employee only  Spouse  Child  Children  Family  
 Medical/Dental/Vision  Employee only  Spouse  Child  Children  Family
- BENEFICIARY:** \_\_\_\_\_ Relationship: \_\_\_\_\_  
 YOU ARE STILL ENTITLED TO LIFE INSURANCE WHEN WAIVING MEDICAL COVERAGE. ALL EMPLOYEES NEED TO FILL IN BENEFICIARY.
- LIST SPOUSE AND DEPENDENTS TO BE COVERED ON THE PLAN**

Last Name	First Name	MI	Relation	M/F	DOB	SSN	ADD	Terminate	Other Insurance
			Spouse						Y or N
									Y or N
									Y or N
									Y or N
									Y or N

- OTHER INSURANCE INFORMATION MUST BE COMPLETED:**  
 Is Spouse Employed?  Yes  No (if Yes Employer) \_\_\_\_\_  
 Other Insurance Co \_\_\_\_\_ Does Spouse have insurance coverage?  Yes  No Medical  Dental  
 Do Children have insurance coverage?  Yes  No Medical  Dental  
 Does Employee have other insurance coverage?  Yes  No Group/Policy# \_\_\_\_\_ Medicare?  A  B Eff Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby appoint my Employer as agent to receive all notices concerning premiums, coverage and termination and authorize my payroll deduction as required for coverage. I understand that any false or inaccurate information may result in the termination of coverage or nonpayment of benefits. I hereby authorize any provider of service to release to GILSBAR any information regarding diagnosis, treatment or prognosis for any person listed on this application.

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_  
 TO BE COMPLETED BY PAYROLL DEPARTMENT ONLY

New Hire Hire Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Ins. Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Classified \_\_\_\_\_ Certified \_\_\_\_\_ Salary \$ \_\_\_\_\_  
 Change Effective Date of Change: \_\_\_\_/\_\_\_\_/\_\_\_\_ Add Dependent(s)  Terminate Dependent(s)  Retiree  
 FMLA  LOA  Address \_\_\_\_\_ Termination of Insurance: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Sent to Gilsbar \_\_\_\_\_ Americas \_\_\_\_\_ Spreadsheet \_\_\_\_\_ IFAS \_\_\_\_\_ Life to Assurant \_\_\_\_\_ Spreadsheet \_\_\_\_\_ IFAS \_\_\_\_\_ Dept. Initials \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_





# L.H. Unified School District #1

*Employee Benefit Trust*

**DEPENDENT INSURANCE Rates Effective July 1, 2011**

Self-Funded	All Fulltime Eligible Employees				
BCBS Network Only	Medical Plan Only				
	Medical			LHS District	Employee
	Premiums *			Pays Per Mo	Pays Per Month
Employee	\$ 356.00			\$ 356.00	
Spouse Only	\$ 302.00				\$ 302.00
1 Child only	\$ 91.00				\$ 91.00
Children only	\$ 171.00				\$ 171.00
Family	\$ 355.00				\$ 355.00
Self-Funded	All Fulltime Eligible Employees				
BCBS Network Only	Medical/ Dental Plan Only				
Ameritas Network	Medical	Dental		LHS District	Employee
	Premiums *	Per Month		Pays Per Mo	Pays Per Month
Employee	\$ 391.00			\$ 391.00	
Spouse Only	\$ 302.00	\$ 42.00			\$ 344.00
1 Child only	\$ 91.00	\$ 35.00			\$ 126.00
Children only	\$ 171.00	\$ 58.00			\$ 229.00
Family	\$ 355.00	\$ 100.00			\$ 455.00
Self-Funded	All Fulltime Eligible Employees				
BCBS Network Only	Medical/Vision Plan Only				
Vision Care Direct Network	Medical		Vision	LHS District	Employee
	Premiums *		Per Month	Pays Per Mo	Pays Per Month
Employee	\$ 365.00			\$ 365.00	
Spouse Only	\$ 302.00		\$ 8.00		\$ 310.00
1 Child only	\$ 91.00		\$ 5.00		\$ 96.00
Children only	\$ 171.00		\$ 7.00		\$ 178.00
Family	\$ 355.00		\$ 18.00		\$ 373.00
Self-Funded	All Fulltime Eligible Employees				
BCBS Network	Medical/Dental/Vision Plan				
Ameritas Network	Medical	Dental	Vision	LHS District	Employee
Vision Care Direct Network	Premiums *	Per Month	Per Month	Pays Per Mo	Pays Per Month
Employee	\$ 400.00			\$ 400.00	
Spouse Only	\$ 302.00	\$ 42.00	\$ 8.00		\$ 352.00
1 Child only	\$ 91.00	\$ 35.00	\$ 5.00		\$ 131.00
Children only	\$ 171.00	\$ 58.00	\$ 7.00		\$ 236.00
Family	\$ 355.00	\$ 100.00	\$ 18.00		\$ 473.00

\* Employee & Dependent Life Premiums included.

5/1/2011



# Lake Havasu Public Schools Employee Benefit Plan



ASSURANT

Employee Benefits<sup>®</sup>

## Benefit Summary

### What can these benefits do for me?

The products in this benefit plan were selected with you and your family's well-being in mind. They're an important part of your compensation package. Please take the time to review the benefits carefully to be sure you select the ones that best fit your needs.

The products listed below are offered through Assurant Employee Benefits, one of the largest marketers of employee benefits in the United States. These products are backed by financial strength and stability you can count on. Assurant Employee Benefits is a part of Assurant Inc., a Fortune 500 company and a member of the S&P 500 Index.

You can learn more about these benefits and how to choose the coverage that's right for you on the following pages. Because these products are offered through your employer, premium rates may be more competitive than similar products you could buy as an individual.



### What benefits are available to me?

- **Life insurance** to protect your family, in case something happens to you.
- **Accidental Death and Dismemberment insurance.**
- **Short-Term Disability insurance** for protection against temporary loss of income should you be disabled for a short period of time.

### How do I enroll?

1. Review the information in this booklet to see which benefits suit your needs.
2. Attend your benefits enrollment meeting.
3. Complete your enrollment form.
4. Sign and give your form to program administrator.

Choosing to protect your family

## Life Insurance



ASSURANT  
Employee  
Benefits\*

### If something unexpected happens, how can I be sure my family will be all right?

No one wants to think about it. But an unexpected death can have devastating financial consequences for survivors – consequences that can linger long after the initial shock and grief. Adequate life insurance can help your family manage expenses and make a very difficult transition less painful.

### How do I know if I'm eligible to participate in this plan?

You're eligible to buy Life insurance through this plan if you are a full-time employee of the policyholder or an associated company. Full-time employment means you are working 30.0 hours or more per week. Temporary or seasonal workers are not eligible.

### How much coverage can I buy?

You can purchase up to 5 times your basic annual pay, in units of \$10,000, to a maximum of \$500,000; \$20,000 is the minimum you can purchase. You also can purchase coverage for your spouse and children (see "Can I buy coverage for my family?").

You can effectively double your protection by purchasing an equal amount of Accidental Death and Dismemberment (AD&D) coverage.

### What is AD&D?

AD&D pays an amount equal to your Life benefit if you die as a direct result of an accident. In addition, your AD&D coverage includes:

- A Higher Education Benefit that pays an additional \$3,000 per year for up to four consecutive years for eligible dependent students.
- An Automobile Accident Benefit that pays an additional 20% of the AD&D benefit, to a maximum of \$100,000 should you die as a result of a car accident while wearing a seatbelt.
- An Accidental Dismemberment benefit that pays 50% of the AD&D coverage for the loss of one hand, one foot or the sight of one eye; and 100% for the loss of two or more of the above.



### Key Advantages of This Plan

- This plan is offered through your employer, so premium rates may be more competitive than similar products you could buy as an individual.
- Your premiums are paid through a convenient payroll deduction.
- If you enroll within 31 days of becoming eligible, you can purchase coverage without providing proof of good health, up to the Guarantee Issue amount.

**Assurant Employee Benefits**  
 5353 N. 16th Street, Suite 370  
 Phoenix, AZ 85016  
 T 602.908.0230 800.619.6996 F 602.263.0187

**VOLUNTARY LIFE MONTHLY PREMIUM DEDUCTION SCHEDULES FOR: Lake Havasu Employee Benefit Trust**

BENEFIT IN 000's	EMPLOYEE LIFE PREMIUMS												AGE				
	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	70-74	75+	76+	
\$30	1.40	1.40	1.80	1.80	2.40	3.60	6.00	10.20	17.20	25.20	41.60	81.80	123.20	123.20	123.20	1.04	
\$40	2.10	2.10	2.40	2.70	3.60	5.40	9.00	15.30	25.80	37.50	62.40	122.70	184.80	184.80	184.80	1.56	
\$50	2.80	2.80	3.20	3.60	4.80	7.20	12.00	20.40	34.40	50.00	83.20	163.60	246.40	246.40	246.40	2.08	
\$60	3.50	3.50	4.00	4.50	6.00	9.00	15.00	25.50	43.00	62.50	104.00	204.50	309.00	309.00	309.00	2.60	
\$70	4.20	4.20	4.80	5.40	7.20	10.80	18.00	30.60	51.60	75.00	124.80	245.40	369.60	369.60	369.60	3.12	
\$80	4.90	4.90	5.60	6.30	8.40	12.60	21.00	35.70	60.20	87.50	145.60	286.30	431.20	431.20	431.20	3.64	
\$90	5.60	5.60	6.40	7.20	9.60	14.40	24.00	40.80	68.80	100.00	166.40	327.20	492.80	492.80	492.80	4.16	
\$99	6.30	6.30	7.20	8.10	10.80	16.20	27.00	45.90	77.40	112.50	187.20	366.10	554.40	554.40	554.40	4.68	
\$100	7.00	7.00	8.00	9.00	12.00	18.00	30.00	51.00	86.00	125.00	208.00	409.00	616.00	616.00	616.00	5.20	
\$110	7.70	7.70	8.80	9.90	13.20	19.80	33.00	56.10	94.50	137.50	228.60	449.50	677.60	677.60	677.60	5.72	
\$120	8.40	8.40	9.60	10.80	14.40	21.60	36.00	61.20	103.20	150.00	249.60	490.00	739.20	739.20	739.20	6.24	
\$130	9.10	9.10	10.40	11.70	15.60	23.40	39.00	66.30	111.80	162.50	270.40	531.70	800.80	800.80	800.80	6.76	
\$140	9.80	9.80	11.20	12.60	16.80	25.20	42.00	71.40	120.40	175.00	291.20	572.60	862.40	862.40	862.40	7.28	
\$150	10.50	10.50	12.00	13.50	18.00	27.00	45.00	76.50	129.00	187.50	312.00	613.50	924.00	924.00	924.00	7.80	
\$160	11.20	11.20	12.80	14.40	19.20	28.80	48.00	81.60	137.60	200.00	332.80	654.40	985.60	985.60	985.60	8.32	
\$170	11.90	11.90	13.60	15.30	20.40	30.60	51.00	86.70	146.20	212.50	353.60	695.30	1047.20	1047.20	1047.20	8.84	
\$180	12.60	12.60	14.40	16.20	21.60	32.40	54.00	91.80	154.80	225.00	374.40	736.20	1108.80	1108.80	1108.80	9.36	
\$190	13.30	13.30	15.20	17.10	22.80	34.20	57.00	96.90	163.40	237.50	395.20	777.10	1170.40	1170.40	1170.40	9.88	
\$200	14.00	14.00	16.00	18.00	24.00	36.00	60.00	102.00	172.00	250.00	416.00	818.00	1232.00	1232.00	1232.00	10.40	
\$210	14.70	14.70	16.80	18.90	25.20	37.80	63.00	107.10	180.60	262.50	436.80	858.90	1293.60	1293.60	1293.60	10.92	
\$220	15.40	15.40	17.50	19.80	26.40	39.60	66.00	112.20	189.20	275.00	457.60	899.80	1355.20	1355.20	1355.20	11.44	
\$230	16.10	16.10	18.40	20.70	27.60	41.40	69.00	117.30	197.80	287.50	478.40	940.70	1416.80	1416.80	1416.80	11.96	
\$240	16.80	16.80	19.20	21.60	28.80	43.20	72.00	122.40	206.40	300.00	499.20	981.60	1478.40	1478.40	1478.40	12.48	
\$250	17.50	17.50	20.00	22.50	30.00	45.00	75.00	127.50	215.00	312.50	520.00	1022.50	1540.00	1540.00	1540.00	13.00	
\$260	18.20	18.20	20.80	23.40	31.20	46.80	78.00	132.60	223.60	325.00	540.80	1063.40	1601.60	1601.60	1601.60	13.52	
\$270	18.90	18.90	21.60	24.30	32.40	48.60	81.00	137.70	232.20	337.50	561.60	1104.30	1663.20	1663.20	1663.20	14.04	
\$280	19.60	19.60	22.40	25.20	33.60	50.40	84.00	142.80	240.80	350.00	582.40	1145.20	1724.80	1724.80	1724.80	14.56	
\$290	20.30	20.30	23.20	26.10	34.80	52.20	87.00	147.90	249.40	362.50	603.20	1186.10	1786.40	1786.40	1786.40	15.08	
\$300	21.00	21.00	24.00	27.00	36.00	54.00	90.00	153.00	258.00	375.00	624.00	1227.00	1848.00	1848.00	1848.00	15.60	
\$350	24.50	24.50	28.00	31.50	42.00	63.00	105.00	178.50	301.00	437.50	728.00	1431.50	2156.00	2156.00	2156.00	18.20	
\$400	28.00	28.00	32.00	36.00	48.00	72.00	120.00	204.00	344.00	500.00	832.00	1636.00	2464.00	2464.00	2464.00	20.80	
\$450	31.50	31.50	36.00	40.50	54.00	81.00	135.00	229.50	387.00	562.50	936.00	1840.50	2772.00	2772.00	2772.00	23.40	
\$500	35.00	35.00	40.00	45.00	60.00	90.00	150.00	255.00	430.00	625.00	1040.00	2045.00	3080.00	3080.00	3080.00	26.00	

The insurance policy or policies described in this document are underwritten by Union Security Insurance Company, a subsidiary of Assurant, Inc. Assurant Employee Benefits, a business unit of Assurant, Inc., markets life, disability and dental benefits plans as well as related products and services.

# Assurant Employee Benefits

5353 N. 16th Street, Suite 370  
Phoenix, AZ 85016  
T 602.308.0230 800.619.6996 F 602.263.0187

BENEFIT IN 000's	Spouse Life Premiums												
	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
\$5	0.35	0.35	0.40	0.45	0.50	0.60	1.50	2.55	4.30	6.25	10.40	20.45	30.80
\$10	0.70	0.70	0.80	0.90	1.20	1.80	3.00	5.10	8.60	12.50	20.80	40.80	61.60
\$15	1.05	1.05	1.20	1.35	1.80	2.70	4.50	7.65	12.90	18.75	31.20	61.35	92.40
\$20	1.40	1.40	1.60	1.80	2.40	3.60	6.00	10.20	17.20	25.00	41.80	81.80	123.20
\$25	1.75	1.75	2.00	2.25	3.00	4.50	7.50	12.75	21.50	31.25	52.00	102.25	154.00
\$30	2.10	2.10	2.40	2.70	3.60	5.40	9.00	15.30	25.80	37.50	62.40	122.70	184.80
\$35	2.45	2.45	2.80	3.15	4.20	6.30	10.50	17.85	30.10	44.75	72.80	143.15	215.60
\$40	2.80	2.80	3.20	3.60	4.80	7.20	12.00	20.40	34.40	50.00	83.20	163.60	248.40
\$45	3.15	3.15	3.60	4.05	5.40	8.10	13.50	22.95	38.70	56.25	93.60	184.05	277.20
\$50	3.50	3.50	4.00	4.50	6.00	9.00	15.00	25.50	43.00	62.50	104.00	204.50	308.00
\$55	4.20	4.20	4.80	5.40	7.20	10.80	18.00	30.60	51.60	76.50	124.80	246.40	369.60
\$60	4.90	4.90	5.60	6.30	8.40	12.60	21.00	35.70	60.20	87.50	145.60	288.30	431.20
\$65	5.60	5.60	6.40	7.20	9.60	14.40	24.00	40.80	68.80	100.00	166.40	327.20	492.80
\$70	6.30	6.30	7.20	8.10	10.80	16.20	27.00	45.90	77.40	112.50	187.20	368.10	554.40
\$75	7.00	7.00	8.00	9.00	12.00	18.00	30.00	51.00	86.00	125.00	208.00	409.00	616.00
\$80	7.70	7.70	8.80	9.90	13.20	19.80	33.00	56.10	94.60	137.50	228.60	449.60	677.60
\$85	8.40	8.40	9.60	10.80	14.40	21.60	36.00	61.20	103.20	150.00	249.60	490.80	738.20
\$90	9.10	9.10	10.40	11.70	15.60	23.40	39.00	66.30	111.90	162.50	270.40	531.70	800.60
\$95	9.80	9.80	11.20	12.60	16.80	25.20	42.00	71.40	120.40	175.00	291.20	572.60	862.40
\$100	10.50	10.50	12.00	13.50	18.00	27.00	45.00	76.50	129.00	187.50	312.00	613.60	924.00
\$105	11.20	11.20	12.80	14.40	19.20	28.80	48.00	81.60	137.60	200.00	332.80	654.40	985.60
\$110	11.90	11.90	13.60	15.30	20.40	30.60	51.00	86.70	146.20	212.50	353.60	695.20	1047.20
\$115	12.60	12.60	14.40	16.20	21.60	32.40	54.00	91.80	154.80	225.00	374.40	736.00	1108.80
\$120	13.30	13.30	15.20	17.10	22.80	34.20	57.00	98.90	163.40	237.50	395.20	777.10	1170.40
\$125	14.00	14.00	16.00	18.00	24.00	36.00	60.00	102.00	172.00	250.00	416.00	818.00	1232.00
\$130	14.70	14.70	16.80	18.90	25.20	37.80	63.00	107.10	180.60	262.50	436.80	859.60	1293.60
\$135	15.40	15.40	17.60	19.80	26.40	39.60	66.00	112.20	189.20	275.00	457.60	899.80	1355.20
\$140	16.10	16.10	18.40	20.70	27.60	41.40	69.00	117.30	197.80	287.50	478.40	940.70	1416.80
\$145	16.80	16.80	19.20	21.60	28.80	43.20	72.00	122.40	206.40	300.00	499.20	981.60	1478.40
\$150	17.50	17.50	20.00	22.50	30.00	45.00	75.00	127.50	215.00	312.50	520.00	1022.50	1540.00

CHILD AMOUNT	\$1,000	\$5,000	\$10,000
CHILD PREMIUM	0.18	0.91	1.82

Lake Havasu Public Schools Employee Benefit Plan



11/20/2008 09:31:39  
21075286/0.80/E639/M170/P20/C15.00/FO.00

**FRAUD STATEMENTS**

**Please read the following before completing the attached form.**

**If you live in the states of Arkansas or Louisiana, the following statement applies to you:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**If you live in the state of California, the following statement applies to you:** For your protection California law requires the following to appear on the form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**If you live in the state of Colorado, the following statement applies to you:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**If you live in the District of Columbia, the following statement applies to you:** **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**If you live in the state of Florida, the following statement applies to you:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**If you live in the state of Maryland, the following statement applies to you:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**If you live in the state of New Hampshire, the following statement applies to you:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**If you live in the state of New Jersey, the following statement applies to you:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**If you live in the state of Oregon, the following statement applies to you:** Any person who, with 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 be guilty of insurance fraud.

**If you live in the state of Virginia, the following statement applies to you:** Any person who, with 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.

**If you live in a state other than mentioned above, the following statement applies to you:** 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 subjects such person to criminal and civil penalties.

***To avoid unnecessary delays, be sure all parts of the Application are completed according to the instructions, and DO NOT SEPARATE the pages.***

**Voluntary Term Life Insurance Employee Application—  
Arizona**



**ASSURANT Employee  
Benefits**

*Please print.*

Desired effective date of request \_\_\_\_\_

**Failure to sign and date the application on page 3 and to accurately complete the questions on this application may affect the existence or amount of coverage. Please refer to your product brochure for available benefit amounts and maximums.**

Employer <b>LAKE HAVASU EMPLOYEE BENEFIT TRUST</b>		Policy/part no. <b>5380904</b>	Certificate no.
Insured's name (last, first, middle initial)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of birth (month, day, year)	Social Security number	Job title	
Date of hire (month, day, year)	Present salary \$ _____ per month/week/year _____ hours per week.		
Beneficiary's name (last, first, middle initial)		Relationship	

Have you used tobacco products regularly in the past 12 months?  Yes  No

**Employee coverage**

Amount elected \$ \_\_\_\_\_

Accidental Death and Dismemberment Insurance—equal to your amount of life insurance.  
(Coverage not elected will be assumed refused, even if not specifically refused.)

**If over the guaranteed issue amount or late entrant, complete all health questions on page 3.**

<p><b>Spouse coverage</b></p> <p>Name of the spouse _____</p> <p>Date of birth _____</p> <p>Amount elected \$ _____ (Amount cannot exceed 50% of the employee's amount.)</p> <p>Has your spouse used tobacco products regularly in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If over the guaranteed issue amount, complete all health questions on page 3.</b></p>	<p><b>Dependent/Child(ren) coverage</b> (If applying for dependent coverage, please complete below, amount cannot exceed 50% of the employee's amount.)</p> <p><input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000</p> <p>Child(ren)'s name(s)</p> <table border="1"> <thead> <tr> <th>Last (if different)</th> <th>First</th> <th>Date of birth</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Last (if different)	First	Date of birth	_____	_____	_____	_____	_____	_____	_____	_____	_____
Last (if different)	First	Date of birth											
_____	_____	_____											
_____	_____	_____											
_____	_____	_____											

**Refusal – Sign below ONLY if you are refusing coverage. If you wish to ENROLL, please sign on page 3.**

This is to certify that I have been given an opportunity to participate in the Voluntary Life plan but have declined this coverage. I fully understand that I will not be entitled to any benefits under this coverage. I further understand that if I desire to participate in the Voluntary Life plan at a later date, I must furnish, at my own expense, proof of good health satisfactory to Union Security Insurance Company and that I can be turned down for coverage on the basis of my health.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH QUESTIONS**

Please personally answer the following questions. If you answer "Yes," to any question, please provide details in REMARKS below. If you are applying for dependent coverage, please answer all questions for your eligible dependents.

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | <b>YES</b>               | <b>NO</b>                |
| 1. Applicant's height _____ Weight _____ Spouse's height _____ Weight _____<br>Have you or your dependents gained or lost 10 or more pounds during the past 12 months?<br>If "Yes," how much <input type="checkbox"/> Gained _____ <input type="checkbox"/> Lost _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you or your dependents within the past 5 years:   |                          |                          |
| a) Received or been advised to receive any medication, treatment, surgery, therapy, testing, observation or consultation by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium, health resort or any other health related facility?   | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Used any illegal drug?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past 5 years, have you or your dependents ever had, been treated for or been advised to seek treatment for persistent cough, fatigue or swollen glands, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, patches in mouth, skin lesions, prolonged night sweats, visual disturbance or recurring diarrhea, fever or infection?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you or your dependents ever had, been medically diagnosed, treated, or been advised to seek treatment for: arthritis; back, neck or joint disorder; asthma; emphysema or lung disorder; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental, nervous or eating disorder; seizures; acquired immune deficiency syndrome (AIDS) within the past 5 years or immune system disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
- "Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure.

Personal physician \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_  
NAME ADDRESS TELEPHONE NO.

Employee's address \_\_\_\_\_ Home phone ( \_\_\_\_\_ ) \_\_\_\_\_

**REMARKS AND ADDITIONAL INFORMATION FOR "YES" ANSWERS**  
 If you answered "Yes" to any medical questions above, please provide details below.

Ques. no.	First name	Description of illness, injury or pregnancy, medication and treatment	Duration (dates) & no. of episodes	Residual effects	Name and address of attending Physician or Hospital (include zip)

**IMPORTANT NOTICE TO APPLICANTS—PLEASE READ CAREFULLY**

**AUTHORIZATION TO RELEASE INFORMATION:** For underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, consumer reporting agency, employer, Medical Information Bureau or any other organization to give Union Security Insurance Company or its reinsurers ALL INFORMATION on my behalf, including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be insured. I give my permission to Union Security Insurance Company or its reinsurers to release any information to other life insurance companies as I may come in contact with.

I know that I and any authorized representative have a right to a copy of this authorization. A photocopy of this authorization will be as valid as the original. This authorization will be valid for two and one half years from the date shown below. For claim purposes, the authorization will remain valid for the term of coverage of the policy if health insurance, or the duration of the claim if non-health insurance. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

**MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I** 1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company. 2) Authorize any required deductions from my earnings. 3) Designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. 4) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. 5) Understand that I must be actively at work on the effective date, or coverage will be deferred until I return to work and that dependent coverage will not become effective while the dependent is in a hospital or similar facility. 6) Have read, understood and received a copy of this application and the NOTICE REGARDING THE MEDICAL INFORMATION PRACTICES AND AUTHORIZATION TO OBTAIN AND FURNISH INFORMATION.

**NOTICE:** For this group Insurance plan to become effective, a minimum number of employees must apply. Your coverage will not go into effect unless the minimum requirement is met.

Date \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Spouse's signature (if spousal coverage) \_\_\_\_\_

**NOTICE REGARDING MEDICAL INFORMATION BUREAU  
INSURANCE INFORMATION PRACTICES AND AUTHORIZATION TO OBTAIN AND FURNISH INFORMATION**

To properly underwrite applications and issue insurance policies on an equitable basis, we must obtain information about our proposed insured. The nature of the information we seek includes age, occupation, physical condition, health history, habits, avocations and other personal characteristics. This information will be collected from you and various sources, including health professionals and health facilities. Information regarding factors affecting insurability will be treated as confidential.

In addition, we may obtain an investigative consumer report from an insurance support organization. If a report is prepared, upon request to your agent, you have the right to be personally interviewed in connection with the investigation. Also, upon proper request to Union Security Insurance Company, you may obtain a copy of the report.

Further, we or our reinsurers may obtain a report from and make a report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another bureau member for life or health coverage, or a claim for benefits is submitted to such a company, the bureau, upon request, will supply information contained in its file.

Upon receipt of a request from you, the bureau will arrange disclosure of the information in its file. If the accuracy of the information is questioned, you may request that corrections be made by following the procedures set forth in the Fair Credit Reporting Act. The address of the Bureau's Information Office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112 (telephone 617.426.3660).

The information which we collect may, under certain circumstances, be disclosed to third parties without your specific authorization. However, be assured that disclosure will be strictly limited to that which is reasonably required. This authorization is not governed by HIPAA, however, when necessary, you may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

You have the right to gain access to and request correction of information contained in our files. However, we will not disclose information which relates to a claim or to a civil or criminal proceeding.

If you wish to receive a more detailed explanation of our information practices, including a description of access and correction rights as well as circumstances under which non-authorized disclosures or personal information may be made, please contact Senior Vice-President, Underwriting and Administration, 2323 Grand Boulevard, Kansas City, Missouri 64108.



**ASSURANT**  
Employee  
Benefits

## Voluntary Short-Term Disability

**Lake Havasu Employee Benefit Trust**  
announces income protection for its employees

Proposed Effective Date: 01/01/2009

If you were unable to work because of an injury or sickness, would you be financially prepared? Our Voluntary Short-Term Disability insurance can help protect your income in the event of disability by providing you a benefit for injuries and sicknesses that are not work related. Your employer is offering you the opportunity to purchase Short-Term Disability insurance through convenient payroll deduction.

The plan your employer has selected includes the following features:

### Eligibility

- ◆ You are eligible to participate in the plan if you are a full-time employee of the policyholder or an associated company,
  - whose annual pay is greater than or equal to \$12,000, and
  - who is at active work, and
  - who is working in the United States of America, except any temporary or seasonal worker.
  - Any other requirements set by your employer must also be met. "Full-time" means working at least 20 hours per week.

### Plan Features

- ◆ Weekly benefits are equal to 60% of basic covered weekly pay, to a maximum of \$1,000 per week.
- ◆ Benefits begin on the 30th day of disability for accident and the 30th day of disability due to sickness or pregnancy. Pregnancy is covered as any other disability. Benefits are payable to 22 weeks.
- ◆ Benefits are not subject to federal income tax when premiums are paid with after-tax dollars.
- ◆ You may qualify for disability benefits by meeting either an occupation test or an earnings test.
  - **Occupation Test**  
You may qualify under the occupation test if you are under the regular care and attendance of a doctor, and an injury, sickness or pregnancy prevents you from performing at least one of the material duties of your occupation.
  - **Earnings Test**  
You may qualify under the earnings test if an injury, sickness or pregnancy prevents you from earning more than 80% of your pre-disability pay.
- ◆ Any amount of coverage you elect is available on a **Guaranteed Issue** basis. This means that you do not have to answer any health questions to enroll in this plan.
- ◆ If you are eligible and choose not to enroll for coverage you are a late applicant under our plan and must wait to enroll during a subsequent annual enrollment period. The normal pre-existing conditions limitation will apply.

Insurance products marketed by Assurant Employee Benefits are underwritten by Union Security Insurance Company.

- ◆ This plan includes a Quality of Care Benefit which provides services and support initiatives targeted at helping you return to better health and a Managed Rehabilitation Benefit which provides assistance and incentives to participate in a vocational rehabilitation plan should you become disabled.
- ◆ There is a pre-existing conditions limitation. A pre-existing condition is one for which you have seen a medical practitioner or taken medication in the 6 months prior to your coverage effective date. We will not pay benefits for any disability resulting directly or indirectly from a pre-existing condition unless the disability begins after 12 consecutive months during which you are continuously insured under this plan.
- ◆ Your benefit may be reduced by disability benefits from retirement or government plans, other group disability plans, no-fault benefits, and return-to-work earnings. If your benefit is reduced, a minimum weekly benefit of \$25 applies.
- ◆ The greater of 10 employees or 35% of all eligible employees must enroll in the plan before this group policy can be issued.

We will not pay benefits for any time you are confined to any facility because you were convicted of a crime or public offense. We will not pay benefits for any part of a period of disability during which you are receiving benefits under any Workers' Compensation Act or a similar law. We will not pay benefits for any disability caused by war or any act of war, whether declared or not; intentionally self-inflicted injury; while sane or insane; taking part in or the result of taking part in committing an assault or felony; an injury that arises out of or occurs in the course of any occupation for pay or profit; or a sickness that entitles you to benefits under any Workers' Compensation Act or a similar law. We will also not pay benefits if your employer, the policyholder, or an associated company has offered you the opportunity to return to limited work while you are disabled; you are functionally capable of performing the limited work which is offered; and you do not return to work when and as scheduled.

This coverage has limitations and exclusions. We do not pay for disabilities resulting from a pre-existing condition or a related condition. For complete details, please contact your company's benefits representative or refer to your benefit booklet. This highlight sheet provides a brief description of coverage. In the event that a discrepancy exists, the policy provisions will prevail. We can cancel the policy after giving the policyholder 31 days written notice.

## Voluntary Short-Term Disability Premium Calculation Worksheet For Lake Havasu Employee Benefit Trust

You may elect 60% of your covered weekly earnings to a maximum of \$1,000 per week. Your weekly earnings amount is your basic weekly pay. Overtime pay or other compensation that is not considered as basic income should not be included. To calculate your approximate Short-Term Disability monthly premium, follow these steps:

- |  |    |  |
|--|----|--|
| <b>Step 1</b> Enter your basic weekly pay (divide your annual pay by 52) rounded to the nearest dollar.  | 1. |  |
| <b>Step 2</b> Multiply the amount in Step 1 by 60% and enter the result (rounded to the next higher dollar). This is your weekly benefit. Do not enter more than \$1,000.  | 2. |  |
| <b>Step 3</b> Divide the amount in Step 2 by 10 and enter that amount.   | 3. |  |
| <b>Step 4</b> Enter the rate for your age from the chart below. The rate is determined by your age and will be reevaluated on each subsequent coverage policy anniversary. | 4. |  |
| <b>Step 5</b> Multiply the amount in Step 3 by the amount in Step 4 and then enter it here. This is your approximate monthly premium.                                      | 5. |  |

AGE	MONTHLY RATE PER \$10 OF WEEKLY BENEFIT
thru 39	0.484
40 - 49	0.314
50 - 59	0.388
60+	0.487

**Example:** The following is a calculation for an employee earning \$27,250 annually who is 46 years of age:

- Step 1** \$27,250 divided by 52 = \$524.04, which rounds to \$524.
- Step 2** \$524 times .60 = \$314.40. When rounded to the next higher dollar, the amount is \$315.
- Step 3** \$315 divided by 10 = \$31.50.
- Step 4** 0.314 – The rate from the table above for an employee age 46.
- Step 5** \$31.50 times 0.314 = \$9.89, which is the approximate monthly premium.

**Important:** This worksheet is provided to help you calculate your approximate monthly premium. Should you enroll for coverage, your actual premium will be calculated based on information provided to Assurant Employee Benefits at point of enrollment.

The insurance policy or policies described in this document are underwritten by Union Security Insurance Company, a subsidiary of Assurant, Inc. Assurant Employee Benefits, a business unit of Assurant, Inc., markets life, disability and dental benefits plans as well as related products and services.

**ISSUE**

Employee name		Employer Lake Havasu Employee Benefit Trust
Group policy/participant no. 5380904	Account no.	Cert. no.

BENEFICIARIES				
Last name	First	MI	Relationship*	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
				<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

If beneficiary is not related to you, please provide Date of Birth, Social Security Number, and full address.

1) Give FULL names and relationships of each beneficiary. 2) Beneficiaries elected will apply to all employee Life coverages. 3) If primary/secondary election is not noted, the beneficiary will be considered primary. 4) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary beneficiaries survive you, the proceeds will be paid in equal shares to the surviving secondary beneficiaries. 5) If your designation does not fit in the above arrangement, please contact Union Security Insurance Company for the appropriate forms.

**MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:**

(1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company. (3) Authorize any required deductions from my earnings. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured. (7) Understand that the short term disability plan/long term disability plan includes limitations, exclusions and a pre-existing conditions provision that may affect my entitlement to benefits. When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

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 subjects such person to criminal and civil penalties.

Employee's signature \_\_\_\_\_ Date \_\_\_\_\_

**Employee Application**

Please print clearly in blue or black ink.

ISSUE



**Check one – Employer Use**

- Initial Employee       New Employee       Change

**EMPLOYEE INFORMATION**—Failure to accurately complete the questions on this application may affect the existence or amount of coverage. Please correct any errors in the information listed below.

Employee name (last, first, initial)			Employer Lake Havasu Employee Benefit Trust			Employment location				
Group policy/participant no. 5380904			Account # or Bill Group Name		Cert. no.		Employee SSN	Employee birthdate		
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Job title or position		Employee hire date		No. hours Per week		Earnings \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly <input type="checkbox"/> Other _____		Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Children <input type="checkbox"/> Yes <input type="checkbox"/> No
Address			City		State		Zip			

**ELECTIONS ARE NOT VALID WITHOUT A SIGNATURE AT THE END OF THIS APPLICATION.**  
**DEPENDENT INFORMATION**—Required if Dependent coverage applies

Name (Last Name, First Name)	Date of Birth	Gender	Relationship

**NOTE** — Coverage not elected will be assumed refused even if not specifically refused

**Employee Choice Life, Short Term Disability Benefits** – You may select the benefit(s) below. If you enroll, you will pay all or a portion of the premium.

- | Accept                   | Refuse                   | Coverage                               |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Employee Voluntary Life - Amount _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Employee Matching AD&D                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Spouse Voluntary Life - Amount _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Child Voluntary Life - Amount _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Short Term Disability - Amount _____   |

**ISSUE**

Employee name		Employer Lake Havasu Employee Benefit Trust	
Group policy/participant no. 5380904	Account no.	Cert. no.	

**BENEFICIARIES**

Last name	First	MI	Relationship*	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
				<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

If beneficiary is not related to you, please provide Date of Birth, Social Security Number, and full address.

1) Give FULL names and relationships of each beneficiary. 2) Beneficiaries elected will apply to all employee Life coverages. 3) If primary/secondary election is not noted, the beneficiary will be considered primary. 4) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary beneficiaries survive you, the proceeds will be paid in equal shares to the surviving secondary beneficiaries. 5) If your designation does not fit in the above arrangement, please contact Union Security Insurance Company for the appropriate forms.

**MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:**

(1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company. (3) Authorize any required deductions from my earnings. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured. (7) Understand that the short term disability plan/long term disability plan includes limitations, exclusions and a pre-existing conditions provision that may affect my entitlement to benefits. When necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

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Employee's signature \_\_\_\_\_ Date \_\_\_\_\_

<b>Lake Havasu Schools Employee Benefit Trust</b> <b>AMERITAS DENTAL PLAN</b>		
<b>Benefit Type</b>		
New Plan effective 1-1-2010		
<b>PPO Network-Ameritas</b>	<b>In Network Providers</b>	<b>Out-of-Network Providers</b>
Type 1 Preventive Coverage	100% MAC	70%* URC
Type 2 Basic Coverage	80%* MAC	60%* URC
Type 3 Major Coverage	50%* MAC	40%* URC
Periodontal Coverage	80%* MAC	60%* URC
Endodontic Coverage	80%* URC	80%* URC
Annual Deductible (Individual/Family)	\$50 / \$150 Type 2 & 3 Combined	\$50 / \$150 Type 1, 2 & 3 Combined
<b>Ann Maximum: Per Person</b>	<b>\$2,000</b>	<b>\$1,000</b>
Type 1 Waiting Period		None
Type 2 Waiting Period		6 Month
Type 3 Waiting Period		12 Month
Orthodontia Coverage	\$1,000 LTM	No Coverage
Orthodontia Waiting Period		12 Months

\* Annual Deductible applies.

MAC- Maximum Allowable Charge on negotiated fees

UCR-Usual Customary and Reasonable Charges by zip code

# Ameritas Dental Page 17

may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

**EXPENSES INCURRED.** An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

**LIMITATIONS.** Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for Type 2 Procedures in the first 6 months the person is covered under this plan; unless the Member is covered on January 1, 2010.
2. for Type 3 Procedures in the first 12 months the person is covered under this plan; unless the Member is covered on January 1, 2010.
3. for Type 4 Procedures in the first 6 months the person is covered under this plan; unless the Member is covered on January 1, 2010.
4. in the first 12 months that a person is covered if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.
5. a. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the covered person is covered under this plan. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth, unless the covered person is covered on January 1, 2010. For those Members covered on January 1, 2010, see b.
  - b. Limitation a. will be waived for those Members whose coverage was effective on January 1, 2010 and
    - i. the person has the tooth extracted while covered under the prior plan; and
    - ii. has a dental prosthesis or prosthetic crown installed to replace the extracted tooth while covered under our plan;  
  
but such extraction and installation must take place within a twelve-month period; and
    - iii. the dental prosthesis or prosthetic crown noted above must be an initial placement.
6. for appliances, restorations, or procedures to:
  - a. alter vertical dimension;
  - b. restore or maintain occlusion; or
  - c. splint or replace tooth structure lost as a result of abrasion or attrition.
7. for any procedure begun after the covered person's coverage under this plan terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Member's coverage under this plan terminates.



### Lake Havasu Schools Employee Benefit Trust

Healthy Eye Exam	\$12	Member Payment	12 Months
Lenses	Single Vision	\$5	Member Payment 12 Months
	Bifocal	\$20	Member Payment 12 Months
	Trifocal	\$10	Member Payment 12 Months
	Progressives	\$10	Plus difference between retail price of trifocal & progressive
Tints	\$0		12 Months
Frame	\$100	Allowance	12 Months
Contact Lenses	\$100	Allowance	12 Months
	\$350	Non-Cosmetic	12 months

Group Number **S2595** Claims Administrator: (888) 215-9841  
 Gilsbar, Inc., P.O. Box 956, Covington, LA 70434

## Find a Doctor

- GUNNAR Provider
- Safety Provider
- Prio Provider
- Vision Provider
- LASIK Provider
- Discount Provider

	Doctor	Organization	City	Phone	Distance
	<u>Graff, Bruce V., O.D.</u>	<u>Bruce V. Graff, OD</u>	Lake Havasu City	928.855.5899	2.19 mi.
	<u>Adams, Stuart B., O.D.</u>	<u>Havasu Eye Center</u>	Lake Havasu City	928.680.1144	2.19 mi.
	<u>Sobchuk, Tania, O.D.</u>	<u>Lake Havasu Family Eyecare</u>	Lake Havasu City	928.855.5026	2.19 mi.
	<u>Vetter, Brooke, O.D.</u>	<u>Lake Havasu Family Eyecare</u>	Lake Havasu City	928.855.5026	2.19 mi.

[New Search](#)



LAKE HAVASU UNIFIED SCHOOL DISTRICT NO. 1

FLEXIBLE SPENDING ACCOUNT OPEN ENROLLMENT
DUE TO PAYROLL BY JULY 15, 2011
PARTICIPATION AGREEMENT PLAN YEAR 7-1-2011 TO 6-30-2012

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: (\_\_\_\_) \_\_\_\_\_ Work Ph: (\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I agree, until such time as I notify my employer in writing of an eligible change in family status, or such time when my employer no longer offers this program, to the terms and conditions of the flexible spending account as defined in the plan document. My employer and I agree that my pay will be reduced annually by the amount specified by me for the benefit option(s) I select under the plan on a pretax basis.

This election is for the Plan Year 2011/2012. However, if I were to leave employment prior to the end of this Plan Year, my Plan Year would end as of my termination date. I understand I can only be reimbursed for services rendered during this Plan Year.

I understand this agreement cannot be amended before the next annual election absent of a qualifying change in my family circumstances or the termination of this plan.

In addition, I understand that money left in the account at the end of the eligibility period for this plan year, not used for eligible expense reimbursement, will be forfeited.

The amount of my annual election for the 2011/12 Plan Year for each option selected is set forth below. I understand that the amounts I have chosen will be divided by 18 pays.

Plan Year Election Amount

Health Care Reimbursement Election
(Not to exceed \$3,500.) \$ \_\_\_\_\_

Dependent Day Care Reimbursement Election
(Not to exceed \$5,000, or \$2,500 if married and filing separate tax returns) \$ \_\_\_\_\_

SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

RETURN TO DISTRICT OFFICE/ PAYROLL BY JULY 15, 2011.

=====

PAYROLL USE ONLY

Approved by Payroll

Amount per pay period

\_\_\_\_\_

\_\_\_\_\_



ENROLLMENT AND CHANGE FORMS ARE ATTACHED.