

USAbLe Life

Voluntary Term Life and Short Term Disability Insurance

Term Life Eligibility

If you are a member and work at least 40 hours per month, you are eligible to apply for member voluntary term life.

Dependents

Your Spouse

Your legal spouse is eligible to apply provided you are enrolled for coverage for yourself.

Your Domestic Partner

Your domestic partner is eligible to apply provided you are enrolled for coverage for yourself and your relationship meets the criteria found on the SEIU Local 503 Domestic Partner Affidavit (see page 16) or you have obtained a Certificate of Domestic Partnership from the State of Oregon.

Your Dependent Children

Your child under age 26 is eligible, provided you are enrolled for coverage, they are unmarried, not in a domestic partnership and who meets any of the following criteria:

1. You or your spouse's natural child, step child, adopted child or a child legally placed with you or your spouse for adoption; or
2. a child for whom you or your spouse have court appointed guardianship; or
3. a child for whom you or your spouse are required to provide coverage by a legal Qualified Medical Support Order.

If your spouse/partner or child cannot perform the normal activities of daily living a person of his or her age and gender on the date coverage would begin, his or her coverage will not begin until he or she is so able.

Member Term Life Insurance

Member voluntary term life insurance is available in the following amounts: \$10,000, \$20,000, \$30,000, \$40,000, \$50,000, \$60,000, \$70,000, \$80,000, \$90,000, \$100,000, \$110,000, \$120,000, \$130,000, \$140,000, \$150,000, \$160,000, \$170,000, \$180,000, \$190,000 or \$200,000

New Member - If you enroll within 90 days of becoming a SEIU Local 503 member you are guaranteed enrollment for the following amounts: \$10,000, \$20,000, \$30,000, \$40,000, \$50,000, \$60,000, \$70,000, \$80,000, \$90,000 or \$100,000

Open Enrollment - If you are currently enrolled in voluntary life you are able to increase by \$10,000 increments up to a maximum of \$100,000 of coverage.

All other enrollment during open enrollment requires satisfactory evidence of insurability and approval by USAbLe Life.

Spouse/Partner Term Life Insurance

Spouse/partner voluntary term life insurance is available in the following amounts: \$10,000, \$20,000, \$30,000, \$40,000, \$50,000, \$60,000, \$70,000, \$80,000, \$90,000, \$100,000, \$110,000, \$120,000, \$130,000, \$140,000, \$150,000, \$160,000, \$170,000, \$180,000, \$190,000 or \$200,000

New Member - If you enroll within 90 days of becoming a SEIU Local 503 member and you elect coverage for yourself your spouse/partner is guaranteed enrollment for the following life amounts: \$10,000, \$20,000, \$30,000 or \$40,000

Open Enrollment - If you are currently enrolled in voluntary life you are able to increase by \$10,000 increments up to a maximum of \$100,000 of coverage.

All other enrollment during open enrollment requires satisfactory evidence of insurability and approval by USAbLe Life.

Child Term Life Insurance

Child voluntary term life insurance is available in the following amounts: \$5,000 or \$10,000

New Member - If you enroll within 90 days of new SEIU Local 503 membership and you elect coverage for yourself your child(ren) are eligible for the following amounts: \$5,000 or \$10,000

Open Enrollment - If you are enrolled your child(ren) are guaranteed enrollment for the following amounts: \$5,000 or \$10,000

Enrollment outside of your initial 90 days of SEIU Local 503 membership or coverage above any guaranteed amount will require satisfactory evidence of insurability and approval by USAbLe Life.

USAbLe Life

Voluntary Term Life and Short Term Disability Insurance

Terminal Illness Benefit

If you are diagnosed by a physician as terminally ill with a life expectancy of 12 months or less, the accelerated payment benefit for terminal illness provides for 80% of the coverage amount in force or \$120,000, whichever is less, to be paid to the insured.

Any benefit paid under an Terminal Illness Benefit will reduce the voluntary term life Insurance death benefit and may be taxable. As with all tax matters, you should consult with a personal tax advisor to assess the impact of this benefit.

Exclusions

If you are enrolled in the member voluntary term life you cannot be covered as a dependent under another member's policy. Voluntary term life insurance will not be paid for death resulting from suicide, intentionally self-inflicted injury, or any attempt to injure oneself, while sane or insane during the first year of coverage.

Age Increase Adjustments

SEIU Local 503 adjusts the monthly premium amount for you and your dependent term life coverages according to your birth year. The adjustment occurs the first of the month following your advancement to the next age bracket.

Conversion Privilege

When you terminate employment, your term life insurance will be continued without cost for 31 days. Within that period, you may convert your voluntary term life insurance benefit to a guaranteed individual permanent insurance policy. Application for conversion of group coverage must be made within 31 days of employment termination.

Portability Privilege

If you terminate employment prior to age 65 your voluntary term life insurance benefits can be ported. Spouse/partner and child life can be ported as well. You must apply within 31 days from the date your employment terminated. Coverage is guaranteed.

Short Term Disability Eligibility

A weekly benefit will be paid for a maximum of 26 weeks for a covered disability if you are unable to work because of a disabling off-the-job accidental bodily injury or illness. You do not have to be hospitalized or house-confined to be eligible for benefits. You need to

be certified by a physician as being unable to work, and under a physician's care. ***You must be actively at work on the effective date of insurance for your coverage to go into effect.***

Elimination Period

The elimination period for an off-the-job **accident** is 14 days, benefits begin on the 15th day of disability. Your disability must be verified by a treating physician who is licensed to practice medicine.

The elimination period for an for an off-the-job **illness** is 21 days, benefits begin on the 22nd day of continuous and total disability. Your disability must be verified by a treating physician who is licensed to practice medicine.

You may return up to 3 days during an elimination period without having to start the period over.

Definition of Disability

You will be considered Disabled if because of injury or sickness that prevents you from performing all of the material and substantial duties of your regular occupation or a reasonable employment offered to you by your employer.

Eligibility

If you are a member and work at least 80 hours per month, you are eligible to apply for member short term disability.

New Member - You may enroll for short term disability insurance within 90 days of becoming a new member without having to supply evidence of insurability.

Open Enrollment - You may enroll for short term disability Insurance during an annual open enrollment period without having to supply evidence of insurability.

You may enroll for short term disability insurance any time by answering the health questions on the Evidence of Insurability form. Coverage will be issued with the insurance company's approval. Coverage is effective when the insurance company has approved the coverage and premium payment begins.

Waiver of Premium

Applies to disability and begins when disabled and will continue until no longer disabled or until the maximum benefit period has been reached.

USable Life

Voluntary Term Life and Short Term Disability Insurance

Short Term Disability Insurance Benefit Amounts

Class 1: If your basic earnings are \$999 or less per month and you work a minimum of 80 hours per month. Your weekly benefit for any week during your disability is \$175.

Class 2: If your basic earnings are \$1,000-\$2,999 per month and you work a minimum of 80 hours per month. Your weekly benefit for any week during your disability is \$225.

Class 3: If your basic earnings are \$3,000-\$3,999 per month and you work a minimum of 80 hours per month. Your weekly benefit for any week during your disability is 66 2/3% of your salary, up to a maximum of \$300.

Class 4: If your basic earnings are \$4,000 or more and you work a minimum of 80 hours per month. Your weekly benefit for any week during your disability is 66 2/3% of your salary, up to a maximum of \$500.

Integration with Other Coverage

The benefit amount payable to an eligible member will be reduced by the sum of the benefits paid or payable from the following sources:

- State disability programs.
- Family social security benefits.
- Sick leave or salary continuation that exceeds 100% of your pre-disability earnings.
- Any governmental law or program including unemployment.
- Any loss of income benefits received from “no-fault” auto insurance, worker’s compensation, or similar legislation.
- Any group insurance plan sponsored by the employer.
- Minimum weekly benefit with integration is \$25 per week.

Exclusions

Short term disability benefits will not be paid if your disability results directly or indirectly from:

- a. War, declared or undeclared, or any act of War except during a period of extended coverage under the terms of the Continuation During Military Leave provision;
- b. Intentionally self-inflicted injuries or Sickness, while sane or insane;
- c. Your active Participation in a Riot or an act of terrorism;
- d. Your attempt to commit or Your commission of a

felony under federal or state law, Your being engaged in an illegal occupation or activity, or commission of a crime for which You have been convicted;

- e. An injury arising out of, or in the course of, any work for wage or profit;
- f. Your attempted suicide, regardless of Your mental capacity;
- g. Sickness or Injury for which You are entitled to benefits under any Workers’ Compensation law, occupational disease law, compulsory benefit act or law or similar law, unless You are a partner or sole proprietor not covered by any of these acts or law;
- h. Active Military Service of any country, group of countries, governments or international authority;
- i. A Pre-Existing Condition, except as described in the provision Pre-Existing Conditions.

Short term disability benefits will not be paid for a period of disability when you are not under the appropriate care of a licensed physician practicing within the scope of his license.

Pre-existing Condition Limitation

Short term disability benefits are not payable for any disability caused by a pre-existing condition if the disability begins during the first 12 months of your coverage. A pre-existing condition is a sickness or injury for which you received any form of treatment, including prescription drugs, within 3 months prior to your effective date of short term disability coverage.

How to Enroll

New Member Enrollment

You must complete and submit a SEIU Local 503 Term Life and Disability Enrollment form within 90 days of new Union membership.

Open Enrollment

You must complete and submit a SEIU Local 503 Term Life and Disability Enrollment form.

Enrollment Change

Changes to your plan are allowed with a qualified status event and if the requested change is consistent with the qualifying event and within 31 days of the event. Contact Membership Advantages to verify if your qualifying status event is eligible for an enrollment change.

Member and Spouse Life Premium

(spouse premiums are calculated using member's age)

Member's Age	Monthly Rate Per \$10,000 of Coverage
Under 25	\$0.81
25-29	\$0.76
30-34	\$1.18
40-44	\$1.73
45-49	\$2.68
50-54	\$4.25
55-59	\$6.65
60-64	\$9.34
65-69	\$16.63
70-74	\$32.99
75 and over	\$67.96

Member Short Term Disability Premium

(classification based on gross monthly wages)

Salary Classification	Weekly Benefit	Monthly Rate
Class 1 (monthly salary \$999 and less)	\$175	\$6.60
Class 2 (monthly salary \$1,000 - \$2,999)	\$225	\$8.48
Class 3 (monthly salary \$3,000-\$3,999)	\$300	\$11.31
Class 4 (monthly salary \$4,000 and up)	\$500	\$18.85

Child Life Premium

(one rate covers all eligible children)

Child Coverage	\$5,000	\$10,000
Monthly Rate-All Ages	\$0.80	\$1.60

HOW TO CALCULATE YOUR MONTHLY PREMIUM

Step 1 - Determine Monthly Life Member Rate

Find the correct rate from the *Member and Spouse Life Premium* table, rate is based on the **member's** age. Rates are for \$10,000 of coverage. *Multiply rate by coverage amount elected. Example ~ member age 31 elects \$50,000 in coverage (\$50,000 ÷ \$10,000 = 5 x .88 = \$4.40 monthly)*

Step 2 - Determine Monthly Life Spouse Rate

Find the correct rate from the *Member and Spouse Life Premium* table, the rate is based on the **member's** age. Rates are for \$10,000 of coverage. *Multiply rate by coverage amount elected. Example ~ member age 31 elects \$40,000 in coverage (\$40,000 ÷ \$10,000 = 4 x .88 = \$3.52 monthly)*

Step 3 - Determine Child Life Premium

Find the correct rate from the *Child Life Premium* table.

Step 4 - Determine Member Short Term Disability Premiums

Elect the Weekly Benefit desired. The Salary Classification determines the maximum benefit that can be elected based on your monthly salary (a lower salary classification can be elected). Rates are based on monthly before taxes salary (gross wages).

Step 5 - Add all premiums together. This will determine your total monthly premium.

To calculate your monthly premium, use the formula below:

Step 1 - Member Premium

$$\frac{\text{Desired Benefit}}{10,000} \times \text{Rate (from table above)} = \text{Monthly Premium}$$

Step 2 - Spouse Premium

$$\frac{\text{Desired Benefit}}{10,000} \times \text{Rate (from table above)} = \text{Monthly Premium}$$

Step 3 - Child Premium

$$\text{Desired Benefit} \times \text{Rate (from table above)} = \text{Monthly Premium}$$

Step 4 - Short Term Disability

$$\text{Desired Classification} \times \text{Rate (from table above)} = \text{Monthly Premium}$$

Add all premiums for monthly total:

$$\text{Total Monthly Premium}$$

For additional information or for assistance calculating premium call Membership Advantages at 503.772.6569.

This information is a brief description of important features of the plan. It is not a contract. Terms and conditions of the Term Life coverage are set forth on Group Policy Number 50059083. Terms and conditions of the Short Term Disability coverage are set forth on Group Policy Number 50059083. The availability of this offer may change. Please keep this material as a reference, and file it with your certificate, should you become insured. The plan may be amended from time to time or terminated in its entirety at any time by SEIU Local 503.

underwritten by
USAbLe Life



Term Life, Disability & Beneficiary Enrollment Form

Important notice: This form replaces all other enrollment forms on file and must be signed and dated to be valid. Group Life and Disability insurance is underwritten by USABLE Life, Group # 50059083.

Section 1 Member Information

This enrollment is for: New Member Open Enrollment Cancel Beneficiary Designation Only Change-Qualifying Event _____ Date of Event _____

Name	Date of Birth	Gender <input type="radio"/> M <input type="radio"/> F	E-mail
Social Security Number	Agency Employed	Home/Cell Phone	
Mailing Address	City/State	Zip	Work Phone
Marital Status	<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Domestic Partnership (per Certificate of Registered Domestic Partnership) <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> Domestic Partner (per Affidavit of Domestic Partnership) <i>If enrolling a domestic partner attach a completed SEIU Local 503 Affidavit of Domestic Partnership form.</i>		

How many hours per month do you work in your SEIU Local 503 represented position? _____

Free \$2,500 Member Term Life

Section 2 Voluntary Term Life Insurance (you must work at least 40 hours per month to enroll in life insurance)

Member Voluntary Term Life ^{1,4}

(Member term life benefit levels are \$10,000, \$20,000, \$30,000, \$40,000, \$50,000, \$60,000, \$70,000, \$80,000, \$90,000, \$100,000, \$110,000, \$120,000, \$130,000, \$140,000, \$150,000, \$160,000, \$170,000, \$180,000, \$190,000 or \$200,000)

\$10,000, \$20,000, \$30,000, \$40,000, \$50,000
 Other Amount (max. \$200,000) \$ _____

Child Voluntary Term Life ^{3,4}

\$5,000 or \$10,000

Child Name	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Spouse/Partner Voluntary Term Life ^{2,3,4}

(Spouse term life benefit levels are \$10,000, \$20,000, \$30,000, \$40,000, \$50,000, \$60,000, \$70,000, \$80,000, \$90,000, \$100,000, \$110,000, \$120,000, \$130,000, \$140,000, \$150,000, \$160,000, \$170,000, \$180,000, \$190,000 or \$200,000)

\$10,000, \$20,000, \$30,000, \$40,000
 Other Amount (max. \$200,000) \$ _____

Spouse/Partner Name	Date of Birth	Relationship
_____	_____	_____

¹Member Voluntary Term Life-new member (within 90 days of new SEIU membership) guaranteed up to \$100,000.

²Spouse Voluntary Term Life-new member (within 90 days of new SEIU membership) guaranteed up to \$40,000.

³You must be enrolled in voluntary member term life to apply for spouse/partner or child term life.

⁴You cannot be enrolled as a member and as a dependent on another member's voluntary term life policy.

Section 3 Voluntary Short Term Disability Insurance (you must work at least 80 hours per month to enroll in short term disability insurance)

Short Term Disability Insurance: \$ _____ Monthly Salary: Class 1 up to \$999 Class 2 \$1,000-\$2,999 Class 3 \$3,000-\$3,999 Class 4 \$4,000 and up
(current monthly salary)

Section 4 Beneficiary Designation (attach an additional sheet if more space is required. Additional sheet must be signed and dated to be valid)

You may choose a beneficiary(s) to receive life benefits. If no beneficiary survives, payment will be made in accordance with the terms of the policy. Unless designated otherwise, beneficiary designations for all life coverage will be the same. For Spouse/Partner and Child Term Life, you are the beneficiary.

	Name of Beneficiary	Social Security #	Date of Birth	Phone Number	Address	Relationship
Primary	_____	_____	_____	_____	_____	_____
Contingent	_____	_____	_____	_____	_____	_____

Section 5 Signature for Enrollment, Beneficiary Designation and Authorization for Payroll Deduction

I (we) request to be insured and authorize payroll deductions to cover the cost of coverage (if payroll deduction is available)*. Information in this application is given to obtain insurance, and the statements and answers are represented, to the best of my (our) knowledge and belief, to be true and complete. I (we) understand that (a) the insurance applied for shall not take effect until the application is approved and I will be notified of the insurance Effective Date; and (b) all insurance is subject to the eligibility provisions of the Policy; and (c) I must be Actively at Work (as defined in the Group Policy) to be insured. If I am not Actively at Work on the date my (our) coverage would become effective, my (our) coverage will not begin until the day I return to work.

Signature _____ Date _____

* Please read the information on the back of this form.

FOR SEIU USE ONLY

MEMBER DATE	CODE	DEDUCTION AMOUNT	AGENCY	EFFECTIVE DATE	Group # 50059083

Please keep a photocopy for your records and mail this original to: SEIU Local 503 at P.O. Box 12159, Salem, Oregon 97309, email to membershipadvantages@seiu503.org, or fax to 503-776-7341.

Revised for 2025 PY

Insurance will become effective the 1st of the month for which payroll deduction is taken. If the deduction is taken on the last day of the month, the insurance will become effective the 1st of the following month. *Payroll deduction may not be available through all employers. Contact your payroll department or the SEIU Local 503 Membership Advantages office if you have any questions. If payroll deduction is not available you will be required to self pay your premium.

Eligibility

To be eligible for coverage under this plan you must maintain your membership with SEIU Local 503. You must work at least 40 hours per month in your SEIU Local 503 represented position to purchase life insurance. You must work at least 80 hours per month in your SEIU Local 503 represented position to purchase short term disability insurance. You must be scheduled for the minimum required hours and actively working for your insurance to take effect.

Dependents eligible for coverage include spouse/partner and all unmarried dependent children under age 26. If enrolling a domestic partner attach a completed Affidavit of Domestic Partnership form or indicate on the front of this form that you have obtained a Certificate of Registered Domestic Partnership. If you are enrolled in the member voluntary term life you cannot be covered as a dependent under another member's policy.

If a dependent cannot perform the normal activities of a person of his or her age and sex on the date of his or her coverage would begin, his or her coverage will not begin until he or she is so able.

Enrollment and Premium Change

Enrollment elections can only be changed or canceled during an Open Enrollment period or with a qualified status event. You must notify SEIU Local 503 Membership Advantages office within 31 days of the qualified event to be eligible for the enrollment change. The amount of insurance and premium is subject to change as determined by the salary and age schedule as outlined in the benefit booklet and master policy issued by USABLE Life.

Termination of Coverage

Coverage under the term life plan ends when the participant fails to make the required monthly premium payment, or fails to meet the eligibility requirements and/or is no longer a member of SEIU Local 503.

If a plan participant retires or terminates employment, life insurance will be continued without cost for 31 days. Within that period, you may convert your voluntary term life Insurance to an individual guaranteed permanent policy. Application for conversion must be made within 31 days of retirement or employment termination. It is your responsibility to contact the SEIU Local 503 Membership Advantages office to request an application for conversion.

If a plan participant terminates employment prior to age 65, voluntary term life Insurance benefits can be ported. You must apply within 31 days from the date your employment terminated. It is your responsibility to contact the SEIU Local 503 Membership Advantages office to request an application for portability.

Benefit eligibility and termination provisions are detailed in the USABLE Life Benefit Booklet. The booklet is located on the SEIU Local 503 website at seiu503.org click on the Membership Advantages **page**. You can obtain a printed copy of the booklet by contacting the SEIU Local 503 Membership Advantages office at the number below.

The plan may be amended from time to time or terminated in its entirety at any time by SEIU Local 503.

SEIU Local 503
PO Box 12159
Salem, Oregon 97309-0159
1.844.503.SEIU (7348)



PO Box 1650 | Little Rock | AR | 72203

Group Term Life – Group Accidental Death & Dismemberment – Group Disability Income

STATEMENT OF INSURABILITY

SECTION 1 – COMPLETED BY EMPLOYER			
Group Name SEIU LOCAL 503		Group Number 50059083	Telephone # (Include Area Code) ()
Amount of Insurance Applying For: Employee Life: \$ Dependent Life: \$ Disability: \$ Other: \$			Date of Hire
			Employee's Annual Salary

SECTION 2 – COMPLETED BY EMPLOYEE				■ Voluntary Group Term Life		■ Amount Over Guarantee Issue		■ Late Enrollee	
Name (First, MI, Last)					Social Security No.				
Home Address			City		State	Zip		County	
Date of Birth	Birth State or Country	Gender	Height (ft-in.)	Weight (lbs.)	Work Phone ()		Home Phone ()		

Spouse & Children Information – Complete if applying for dependent's coverage.

Person Proposed For Insurance Show First, Middle, Last Name	Occupation	Date of Birth & Place				Height	Weight	Marital Status	Sex
		Month	Day	Year	State or Country				
(Spouse)									
(Child)									
(Child)									
(Child)									
(Child)									

Spouse's Social Security No: Spouse's Work Telephone #: ()

SECTION 3 – INSURABILITY QUESTIONNAIRE		Yes	No
1. Has anyone to be covered used any tobacco or nicotine products in the past year?		<input type="checkbox"/>	<input type="checkbox"/>
2. Does anyone to be covered have scheduled, or been advised to have any consultation, diagnostic tests, medical or surgical procedures, or is anyone awaiting results? (annual wellness exams, routine mammogram, pap smear, prostate exam, or colonoscopy recommended due to age only are excluded)		<input type="checkbox"/>	<input type="checkbox"/>
3. Has anyone to be covered been hospitalized for any reason during the past five (5) years?		<input type="checkbox"/>	<input type="checkbox"/>
4. Has anyone to be covered consulted a member of the medical profession in the past one (1) year for any reason?		<input type="checkbox"/>	<input type="checkbox"/>
5. Within the past five (5) years, has anyone to be covered been diagnosed or treated by a member of the medical profession for any of the conditions listed below? Please check all that apply.			
<input type="checkbox"/> Cancer, cancer related disease or benign tumor? <input type="checkbox"/> Bladder, urinary system or reproductive organs disorder? <input type="checkbox"/> Heart or Circulatory System disease/disorder, or had a Stroke? <input type="checkbox"/> COPD, Emphysema, Asthma, Chronic Bronchitis or other Lung disease/disorder? <input type="checkbox"/> Blood or Bone Marrow, Lymphatic, Endocrine or Immune System disease/disorder? <input type="checkbox"/> Ulcer, stomach, Intestines, Pancreas, Liver or other Digestive System disease/disorder? <input type="checkbox"/> Kidney disease or diabetes? <input type="checkbox"/> Nervous System or Brain disease/disorder? <input type="checkbox"/> Emotional disorder, eating disorder or mental health problems? <input type="checkbox"/> Arthritis, back, bone or joint disorder or injuries?			
6. Within the past ten (10) years, has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, Human Immunodeficiency Virus ("HIV"), or other sickness or condition derived from such infection?		<input type="checkbox"/>	<input type="checkbox"/>
7. Within the past five (5) years, has anyone to be covered been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure) or high cholesterol? If yes, list name of person(s), medications taken, medication dosage, last two blood pressure readings, and/or last two cholesterol readings in Section 4.		<input type="checkbox"/>	<input type="checkbox"/>
8. Is anyone to be covered currently taking medication(s)? If yes, list name of person, reasons, medications and dosage in Section 4.		<input type="checkbox"/>	<input type="checkbox"/>
9. Within the past five (5) years, has anyone to be covered been diagnosed with, treated or counseled by a licensed medical professional for, or taken medication for alcohol or substance abuse, or been convicted of DUI, or currently confined to a penal institution?		<input type="checkbox"/>	<input type="checkbox"/>
10a. Are you now pregnant? <input type="radio"/> Yes <input type="radio"/> No	10b. Within the past five (5) years, have you had an ectopic pregnancy, problem pregnancy, miscarriage, problem delivery, therapeutic abortion, or Cesarean section that was diagnosed or treated by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you actively at work on the date of this application and have you been actively at work for the 31 days prior to such date? If no, give full details in Section 4.		<input type="checkbox"/>	<input type="checkbox"/>
12. Names, addresses, and phone numbers of the personal physicians of all applicants:			

SECTION 4 – GIVE DETAILS TO “YES” ANSWERS TO QUESTIONS 2 THROUGH 10 INCLUDE DATES OF TREATMENT:

■ **Separate Sheet Attached**

Ques. No. & Individual	Illness/Reason for Checkup or Medication & Dosage or Doctor's Treatment/Consultation	Date & Duration	Full Name, Complete Address, and Telephone Number of Doctors & Hospitals

NOTICE FOR PROPOSED INSURED

IMPORTANT NOTICE FOR DISABILITY COVERAGE

Acceptance of your application for disability income insurance will be based upon the information contained in the Statement of Insurability, including the medical information disclosed and information obtained from your medical providers. Your insurance coverage may not be issued as applied for. If not, an "Exclusion of Coverage Amendment" will be attached to your certificate of coverage.

PLEASE READ YOUR CERTIFICATE OF COVERAGE CAREFULLY UPON ITS RECEIPT.

IMPORTANT NOTICE CONCERNING YOUR EFFECTIVE DATE

1. Insurance will not be effective until the application is approved by USABLE Life.
2. Insurance will not be effective if there has been a change in the health of the proposed insured(s) after the date of the application and prior to the effective date.
3. For benefits sheltered under a Section 125 Cafeteria plan: To satisfy premium deduction requirements of your employer and dating requirements of the Section 125 Plan, your coverage will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) of the Section 125 agreement or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In signing below, I authorize any hospital, physician, medical practitioner, clinic, pharmacy, pharmacy benefits manager, medically related facility, insurance company, DMV, MIB, Inc., and any consumer reporting agency to release any information regarding me or my past or present health to USABLE Life, its reinsurers and legal representatives for the purpose of evaluating this Enrollment Form for insurance. Information subject to this authorization includes facts about my physical and mental health, advice or treatment; prescriptions; hazardous activities, driving record; age; occupation; income; and my use of alcohol, drugs, and tobacco. This information will be used to determine eligibility for insurance. This authorization does not authorize the release of genetic screening or testing results.

I also authorize USABLE Life or its reinsurers to disclose all such information to any physician, or any other insurance company in order to evaluate a claim or an application for insurance. I authorize USABLE Life, its reinsurers, and its legal representatives to make a brief report of my/our personal health information to MIB, Inc. All sources except MIB, Inc. may give these facts to any insurance support organization authorized by USABLE Life to collect and transmit them.

This authorization shall remain valid for a period of two years from the issue date of the coverage. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to me or my representative upon request to USABLE Life.

I understand that this authorization may be revoked at any time. Such revocation must be in writing, and will not be effective until USABLE Life and the provider of the information receive it. My revocation will not be effective with respect to disclosures made by a covered entity in reliance on this authorization before it was revoked.

Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

If an investigative consumer report is made, I can choose to be interviewed and to receive a copy of the report upon request.

I understand that any insurance will not take effect unless and until USABLE Life approves this enrollment request. If coverage is not issued as requested, I authorize USABLE Life to issue reduced benefits and adjust premiums to match the coverage issued. I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am requesting allows for alternate methods to pay insurance premiums).

I have read and understand this form in its entirety and the notices, authorizations, and certifications contained within.

Insurance Fraud Warning – Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

EMPLOYEE'S SIGNATURE

DATE OF APPLICATION (MONTH, DAY, YEAR)

SIGNED AT (CITY AND STATE)

AGENT'S SIGNATURE

DATE OF APPLICATION (MONTH, DAY, YEAR)

SIGNED AT (CITY AND STATE)



PO Box 1650 | Little Rock | AR | 72203

NOTICE FOR PROPOSED INSURED

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report upon request.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO THE CHIEF UNDERWRITER, P.O. Box 1650, Little Rock, AR 72203

Federal Fair Credit Reporting Act Notice

In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to the Company.

Medical Information Bureau Disclosure Notice

Information regarding your insurability will be treated as confidential. US Able Life or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

US Able Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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**SEIU LOCAL 503
MEMBERSHIP ADVANTAGES
AFFIDAVIT OF DOMESTIC PARTNERSHIP**

SECTION ONE - AFFIRMATION OF DOMESTIC PARTNERSHIP

- (1) Are each eighteen (18) years of age or older.
- (2) Share a close personal relationship and are responsible for each other's common welfare.
- (3) Are each other's sole domestic partner.
- (4) Are not married to anyone nor have had another domestic partner within the prior six months.
- (5) Are not related by blood closer than would bar marriage in the State of Oregon.
- (6) Have jointly shared the same regular and permanent residence for at least six (6) months immediately preceding the date of this affidavit with the intent to continue doing so indefinitely.
- (7) Have signed a domestic partner declaration (applicable in jurisdictions, which provides for domestic partner declarations).
- (8) Are jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household. Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost. If requested I would be able to provide at least three of the following as verification of our joint responsibility.
 - (a) Joint mortgage or lease.
 - (b) Designation of the domestic partner as primary beneficiary for a life insurance or a retirement contract.
 - (c) Designation of the domestic partner as primary beneficiary in the employee's will.
 - (d) Durable power of attorney for health care or financial management.
 - (e) Joint ownership of a motor vehicle, a joint checking account, or a joint credit account.
 - (f) A relationship or cohabitation contract which obligates each of the parties to provide support for the other party.

SECTION TWO - DECLARATION OF MEMBER

- (1) I understand that my domestic partner is eligible for enrollment:
 - (a) Within 90 days of my becoming a new member of SEIU Local 503.
 - (b) During an open enrollment period.
 - (c) Within 31 days of meeting the criteria listed in Section One.
- (2) I understand that children of my domestic partner are eligible if they meet the requirement for an eligible dependent as defined by USABLE Life, and/or ARAG Group.
- (3) I understand that this affidavit shall be terminated upon the death of my domestic partner or by a change in circumstance attested to in this Affidavit.
- (4) I agree to file a Statement of Termination of Domestic Partnership with the SEIU Local 503 Membership Advantages office within 30 days of any change to circumstances attested to in this Affidavit.
- (5) After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed with the SEIU Local 503 Membership Advantages until such time as the conditions of Section One above have been met.

SECTION THREE - DECLARATION OF PARTNERS

- (1) We understand that the information contained in the Affidavit relates to eligibility for benefits under the SEIU Local 503 life and/or legal insurance program. Any other use of this information will be subject to disclosure only upon either of our written authorization or as required by law.
- (2) We understand that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of willful falsification of information contained in this Affidavit of Domestic Partnership.
- (3) We understand that in addition to the eligibility requirements of SEIU Local 503 Membership Advantages program for domestic partner coverage, there are terms and conditions of coverage set forth in the Service Agreement of each insurance plan offered through SEIU Local 503, plans which we agree to be bound.
- (4) We understand willful falsification of information contained in this Affidavit will result in termination of enrollment pursuant to this agreement by the SEIU Local 503 Membership Advantages program.

We certify under penalty of perjury under the laws of the State of Oregon, that the foregoing is true and accurate to the best of our knowledge

Signature of Member _____

Print Name _____

Signature of Domestic Partner _____

Print Name _____

Date _____

This affidavit of domestic partnership is for SEIU Local 503 life and/or legal insurance enrollment only and must be received by the SEIU Local 503 Membership Advantages office to be valid.

Mail completed enrollment forms and domestic partner affidavit to SEIU Local 503, PO Box 12159, Salem, OR 97309-0159 or e-mail to membershipadvantages@seiu503.org.

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