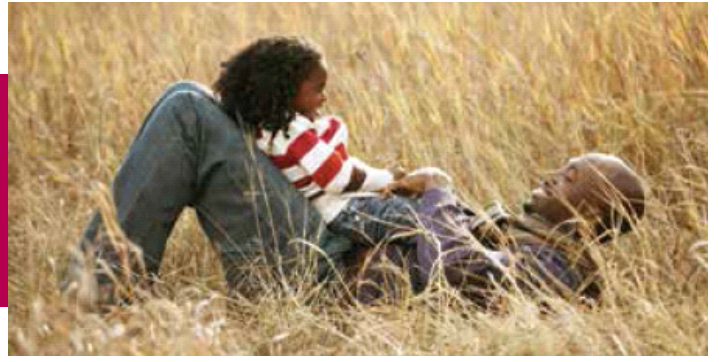


## Plan Highlights

# Voluntary Group Short Term Disability Insurance



### The Research Foundation for The State University of New York

#### COVERAGE

Disability income protection insurance provides a benefit for “short term” disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration.

#### ELIGIBILITY

Each Active Full-time Salaried Employee working 37.5 or more hours per week, and earning a minimum annual salary of \$15,000 per year, except any person working on a temporary or seasonal basis and each active Salaried Part-time employee working a minimum of 18.75 hours based on a 37.5 hour work week or regularly scheduled to work at least 20 hours per week based on a 40 hour work week excluding Hourly, Summer, Graduate and Undergraduate Employees.

#### BENEFIT AMOUNT

You may elect a weekly benefit in increments of \$100, from a minimum of \$100 up to a maximum benefit of \$2,000 per week, not to exceed 60% of your covered earnings (rounded to the next lower increment).

#### DAY BENEFITS BEGIN

Injury (accident) and Sickness (illness): benefits begin on the 8th consecutive day of disability;

or the day following the number of accumulated sick days applicable to the employee.

#### MAXIMUM BENEFIT DURATION

Benefits for one period of disability, will be paid up to a maximum of 26 weeks.

#### CONTRIBUTION REQUIREMENTS

Coverage is 100% employee paid.

#### RATES

See attached Rate Sheet.

#### FEATURES

- ▶ Maternity covered as any other illness
- ▶ Non-occupational coverage

#### LIMITATIONS

- ▶ \*Pre-Existing Condition Limitation - 3/12
- \*Pre-ex limitations also apply to benefit increases and late entrants  
\*Pre-Ex does not apply to those enrolling within 60 days of initial eligibility

#### EXCLUSIONS

Benefits will not be payable for any disability caused by: an intentionally self-inflicted injury; an act of war (declared or undeclared); commission of a felony; sickness covered by workers' compensation or other workers' disability law; injury occurring out of or in the course of work for wage or profit.

For a comprehensive list of exclusions, limitations, and any applicable benefit offsets, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

This Plan Highlights is a brief description of the key features of the RSL insurance plan. The availability of the benefits and features described may vary by state. It is not a certificate of insurance or evidence of coverage. Insurance is provided under group policy form LRS-6451, et al.

**First Reliance Standard Voluntary Plans  
Voluntary Group Short Term Disability Insurance  
Premium Table**

**Plan Holder: The Research Foundation for the State University of New York  
VPS # 2000014987**

**Scheduled Benefit:** Each eligible employee may elect an amount of insurance, in increments of \$100 from a minimum of \$100 to a maximum of \$2,000 per week up to 60% of covered earnings.

- ÿ You may select any benefit amount from \$100 up to your maximum weekly benefit.
- ÿ Locate your weekly earnings to determine your maximum weekly benefit amount.
- ÿ If your covered earnings fall between ranges, the lesser benefit amount will apply

**Bi-Weekly Premiums**

| Weekly Earnings | Benefit Amount | Age 18-24 | Age 25-29 | Age 30-34 | Age 35-39 | Age 40-44 | Age 45-49 | Age 50-54 | Age 55-59 | Age 60-64 | Age 65-69 | Age 70+ |
|-----------------|----------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|---------|
| \$288           | \$100          | \$0.96    | \$1.12    | \$1.12    | \$1.12    | \$0.96    | \$1.04    | \$1.22    | \$1.43    | \$1.56    | \$1.69    | \$1.69  |
| \$333           | \$200          | \$1.92    | \$2.24    | \$2.24    | \$2.24    | \$1.92    | \$2.08    | \$2.44    | \$2.86    | \$3.12    | \$3.38    | \$3.38  |
| \$500           | \$300          | \$2.88    | \$3.36    | \$3.36    | \$3.36    | \$2.88    | \$3.12    | \$3.66    | \$4.29    | \$4.68    | \$5.07    | \$5.07  |
| \$667           | \$400          | \$3.84    | \$4.48    | \$4.48    | \$4.48    | \$3.84    | \$4.16    | \$4.88    | \$5.72    | \$6.24    | \$6.76    | \$6.76  |
| \$833           | \$500          | \$4.80    | \$5.60    | \$5.60    | \$5.60    | \$4.80    | \$5.20    | \$6.10    | \$7.15    | \$7.80    | \$8.45    | \$8.45  |
| \$1,000         | \$600          | \$5.76    | \$6.72    | \$6.72    | \$6.72    | \$5.76    | \$6.24    | \$7.32    | \$8.58    | \$9.36    | \$10.14   | \$10.14 |
| \$1,167         | \$700          | \$6.72    | \$7.84    | \$7.84    | \$7.84    | \$6.72    | \$7.28    | \$8.54    | \$10.01   | \$10.92   | \$11.83   | \$11.83 |
| \$1,333         | \$800          | \$7.68    | \$8.96    | \$8.96    | \$8.96    | \$7.68    | \$8.32    | \$9.76    | \$11.44   | \$12.48   | \$13.52   | \$13.52 |
| \$1,500         | \$900          | \$8.64    | \$10.08   | \$10.08   | \$10.08   | \$8.64    | \$9.36    | \$10.98   | \$12.87   | \$14.04   | \$15.21   | \$15.21 |
| \$1,667         | \$1,000        | \$9.60    | \$11.20   | \$11.20   | \$11.20   | \$9.60    | \$10.40   | \$12.20   | \$14.30   | \$15.60   | \$16.90   | \$16.90 |
| \$1,833         | \$1,100        | \$10.56   | \$12.32   | \$12.32   | \$12.32   | \$10.56   | \$11.44   | \$13.42   | \$15.73   | \$17.16   | \$18.59   | \$18.59 |
| \$2,000         | \$1,200        | \$11.52   | \$13.44   | \$13.44   | \$13.44   | \$11.52   | \$12.48   | \$14.64   | \$17.16   | \$18.72   | \$20.28   | \$20.28 |
| \$2,167         | \$1,300        | \$12.48   | \$14.56   | \$14.56   | \$14.56   | \$12.48   | \$13.52   | \$15.86   | \$18.59   | \$20.28   | \$21.97   | \$21.97 |
| \$2,333         | \$1,400        | \$13.44   | \$15.68   | \$15.68   | \$15.68   | \$13.44   | \$14.56   | \$17.08   | \$20.02   | \$21.84   | \$23.66   | \$23.66 |
| \$2,500         | \$1,500        | \$14.40   | \$16.80   | \$16.80   | \$16.80   | \$14.40   | \$15.60   | \$18.30   | \$21.45   | \$23.40   | \$25.35   | \$25.35 |
| \$2,667         | \$1,600        | \$15.36   | \$17.92   | \$17.92   | \$17.92   | \$15.36   | \$16.64   | \$19.52   | \$22.88   | \$24.96   | \$27.04   | \$27.04 |
| \$2,833         | \$1,700        | \$16.32   | \$19.04   | \$19.04   | \$19.04   | \$16.32   | \$17.68   | \$20.74   | \$24.31   | \$26.52   | \$28.73   | \$28.73 |
| \$3,000         | \$1,800        | \$17.28   | \$20.16   | \$20.16   | \$20.16   | \$17.28   | \$18.72   | \$21.96   | \$25.74   | \$28.08   | \$30.42   | \$30.42 |
| \$3,167         | \$1,900        | \$18.24   | \$21.28   | \$21.28   | \$21.28   | \$18.24   | \$19.76   | \$23.18   | \$27.17   | \$29.64   | \$32.11   | \$32.11 |
| \$3,333         | \$2,000        | \$19.20   | \$22.40   | \$22.40   | \$22.40   | \$19.20   | \$20.80   | \$24.40   | \$28.60   | \$31.20   | \$33.80   | \$33.80 |

**First Reliance Standard Life Insurance Company  
Enrollment and Statement of Health for Group Insurance**

|  |                      |                      |                      |                      |
|--|----------------------|----------------------|----------------------|----------------------|
| Name of Employer<br>The Research Foundation for SUNY |                      | Location/Division    |                      | Bill Group<br>000001 |
| Policy # and Class #<br>VPS2000014987 / 1            | Policy # and Class # | Policy # and Class # | Policy # and Class # | Policy # and Class # |

Application Type:  Initial Eligibility/New Hire  Late Applicant  Other \_\_\_\_\_  
 Increase  Approved Annual Enrollment  
 Change in Status: Nature of Change(s): \_\_\_\_\_

Date of Change: \_\_\_\_\_  
 If marriage, domestic partnership, divorce, dissolution of a partnership or birth of a child, please provide copy of document.

**Employee/Member Information – Always Complete**

Submit completed Enrollment and Statement of Health form to:  
[EOIApplications@rsli.com](mailto:EOIApplications@rsli.com) or

**First Reliance Standard  
P.O. Box 7818  
Philadelphia, PA 19101-7818**

We do not accept faxed forms.

|               |               |                     |                                      |                       |     |
|---------------|---------------|---------------------|--------------------------------------|-----------------------|-----|
| Name          |               |                     | Social Security Number / Employee ID |                       |     |
| Gender        | Date of Birth | Age                 | State of Birth                       | Date of Hire          |     |
| Address       |               |                     | City                                 | State                 | Zip |
| Phone Number  | Occupation    | Annual Compensation |                                      | Hours Worked Per Week |     |
| Email Address |               |                     |                                      |                       |     |

Are you actively performing all the duties of your occupation or profession?  Yes  No

If "No," explain: \_\_\_\_\_

**Coverage Elected and Amounts**

- Receipt of accelerated death benefits under Life Insurance may affect eligibility for public assistance programs and may be taxable.
- Disability Insurance pre-existing conditions provision/limitation: if your disability is related to a pre-existing condition, benefits may be limited or no benefits may be payable depending on the length of your disability.

| Coverage                                   | Enroll or Decline <sup>1</sup>                                      | Current Amount | Increase or Decrease | Total Amount Applied For | Premium           |
|--|---|----------------|----------------------|--------------------------|-------------------|
| <b>Voluntary STD: Employee<sup>2</sup></b> | <input type="checkbox"/> Enroll<br><input type="checkbox"/> Decline |                |                      | \$_____per Week          | See Premium Table |

<sup>1</sup>"Enroll" authorizes employer to payroll deduct premiums.

<sup>2</sup>Statement of Health may be required.



|                      |               |
|----------------------|---------------|
| Employee/Member Name | Date of Birth |
|----------------------|---------------|

**Health Questions**

Answer all questions on this page for each person being underwritten for insurance. For any "Yes" answer, underline the condition and record details in the space provided on the next page. Failure to provide details of a condition will cause a delay in the review of your application.

|   | EMPLOYEE   |
|---|--|
| <b>Enter height and weight.</b>   | Ht. __ft. __in.<br>Wt. _____ lbs                         |
| 1. In the past 10 years, have you been treated for or diagnosed as having: heart, liver (hepatitis or biliary cirrhosis) or kidney disorder; an abnormal colonoscopy requiring follow-up; neurological disorder; diabetes; high blood pressure; thyroid disorder; stroke; transient ischemic attack (TIA); cancer and/or tumor malignant or benign; mental or nervous disorder; or been advised to have treatment for drug abuse (illegal or prescription drugs) or alcoholism? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. In the past 10 years, have you been diagnosed with or treated for: chronic pain; arthritis (lupus, rheumatoid or osteoarthritis); musculoskeletal (back, neck or muscle) condition; respiratory disorder including asthma, chronic obstructive pulmonary disease (COPD); cystic fibrosis or emphysema?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you: (a) in the past year had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (thrush); or lymphadenopathy (enlarged or swollen glands)? or (b) in the past 10 years ever been diagnosed or treated for AIDS or AIDS-related complex (ARC)?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. In the past 10 years, have you: (a) consulted with or been examined or treated by a physician, practitioner or specialist (include routine physicals only when there is an existing or newly diagnosed medical condition)? (b) been in a hospital or other facility for observation, diagnosis, treatment or an operation? or (c) been prescribed medication(s) (other than for colds, flu or allergies)?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Are you currently pregnant? In the past 10 years, have you been diagnosed with: abnormal uterine bleeding; abnormal pap smear; abnormal mammogram requiring additional studies or with recommendation of breast biopsy?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. In the past 10 years, have you been diagnosed or treated for Alzheimer's Disease, dementia, Parkinson's or motor neuron diseases?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

|  |                     |
|--|---------------------|
| Employee/Member Primary Care Physician's Full Name | Office Phone Number |
| Address  |                     |

|                      |               |
|----------------------|---------------|
| Employee/Member Name | Date of Birth |
|----------------------|---------------|

**Details**

Please provide all names used for medical records (if different than the names provided on this form): \_\_\_\_\_  
 \_\_\_\_\_

For each "Yes" response to a health question, please provide details below.

| Question # | Illness or Nature of Injury | Date | Physician's Full Name and Address<br>(if different than Primary) |
|------------|-----------------------------|------|--|
|            |                             |      |  |
|            |                             |      |  |
|            |                             |      |  |
|            |                             |      |  |

If you need more space, check here . Complete, sign and date a separate sheet of paper and attach it to this page.

**Read, Sign and Date Below**

I understand and agree that:

- The information provided on this Enrollment and Statement of Health form is true and correct to the best of my knowledge and belief.
- The insurance requested will become effective in accordance with the individual effective date information in the Policy and Certificate; any amount subject to evidence of insurability will not become effective until approved by First Reliance Standard and First Reliance Standard has the right to refuse my request. Coverage is subject to a minimum participation requirement at the employer level and if the minimum is not met, coverage may not be issued even though an enrollment form has been completed. An effective date is subject to eligibility requirements, satisfaction of service waiting period (if applicable) and payment of first premium when due. An effective date may be deferred for an employee not actively at work and enrolled dependents confined to a hospital or at home.
- Benefits are subject to terms and conditions of the Policy and Certificate.
- For age-banded rate plans, premiums increase as an employee moves from one age band to the next.

**I further understand and agree that if I am applying after the expiration of my initial eligibility period, all medical tests and costs for attending physician reports may be without expense to First Reliance Standard Life Insurance Company and I may be responsible for paying the expenses, if any.**

I acknowledge receipt of "Important Information Regarding Applications for Insurance" and "Notice Regarding Information Practices".

**Please Note:** Certain war risks are not assumed. In case of any doubt, contact First Reliance Standard for further explanation.

**AUTHORIZATION:** I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, organization, institution, person or the MIB, LLC. to release any information or record(s) on me or my health excluding psychotherapy notes and records relating to drug and alcohol treatment to be used in determining the acceptability of my application for insurance. I authorize any such information or record(s) to be released to First Reliance Standard Life Insurance Company, its reinsurers or authorized representatives. I also authorize First Reliance Standard or its reinsurers to make a brief report of my personal health information to the MIB. This authorization, or a photographic copy, shall be as binding as the original and valid for a period not exceeding twelve (12) months from this date. I understand that I (or my authorized representative) will be sent a copy of this Authorization upon request. I understand that I may revoke this Authorization at any time by writing to First Reliance Standard at its Administrative Office (address: 1700 Market St, Suite 1200, Philadelphia, PA 19103-3938 Attn: Medical Underwriting). I understand that revocation is subject to the rights of any person who acted in reliance of this Authorization prior to First Reliance Standard receiving written notice of the revocation. I further understand that revocation of this Authorization will not apply to First Reliance Standard when the law provides for the right to contest the insurance coverage or a claim there under.

**Please Note:** During an approved enrollment, guaranteed issue amounts of insurance will not require a Statement of Health form provided the Enrollment form is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to insurance for yourself; or b) during your present service with your employer or an affiliate, you have not, with respect to insurance with First Reliance Standard or an affiliate: had an application withdrawn; been previously declined; had coverage postponed; or voluntarily terminated; or c) the enrollment period is not one with specific guaranteed issue/health acceptability rules.

**Applicable to Health Insurance only:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars (\$5,000) and the stated value of the claim for each such violation.

|  |       |
|--|-------|
| X _____  | _____ |
| Employee's/Member's Signature<br>(required at all times) | Date  |

## Important Information Regarding Applications for Insurance

The information provided on the Enrollment and Statement of Health form will be used in determining the insurability of a person proposed for insurance. Responsible parties completing and submitting a Statement of Health form are required to be made aware of the following statements concerning the consequences of insurance fraud. The lack of an applicable statement shall not constitute a defense against penalties.

**ARKANSAS and LOUISIANA** — 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. **COLORADO** — 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. **FLORIDA** — 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. **KENTUCKY** — Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. **MAINE** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **MARYLAND** — 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. **NEW JERSEY** — Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **NEW MEXICO** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. **NEW YORK** (health insurance only) — 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **OHIO** — 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 is guilty of insurance fraud. **PENNSYLVANIA** — 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. **RHODE ISLAND** — 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. **TENNESSEE, VIRGINIA, WASHINGTON** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **WASHINGTON, DC** — **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.

**KEEP THIS INFORMATION PAGE FOR YOUR RECORDS.**



Home Office: New York, New York  
Administrative Office: Philadelphia, Pennsylvania

## NOTICE REGARDING INFORMATION PRACTICES

In considering this Application, First Reliance Standard Life Insurance Company ("we", "us" or "our") collects certain information about all proposed insureds ("you" or "your"). The precise information varies according to the amount and type of coverage you apply for. Generally, we seek information about you: (1) age; (2) occupation; (3) physical condition; (4) medical history; (5) hobbies; and (6) other relevant activities.

You are the most important source of information, but we may also verify or collect information on you or your family from: (1) physicians; (2) other health care providers; (3) employers; (4) other insurers to which you have applied; (5) consumer investigative organizations; and (6) the MIB, LLC.

The MIB is a not-for-profit organization of life insurance companies which operates an information exchange for its members. This information may alert us to a need for further investigation, but under MIB rules such information cannot be used: (1) either wholly or in part to increase the premium for insurance; or (2) to deny issuance of insurance.

We may collect information by: (1) phone; (2) correspondence; or (3) personal contact.

Information will be treated as confidential. First Reliance Standard Life Insurance Company or its reinsurers may, however, with your authorization make a brief report to the MIB. 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, the MIB, upon request, will supply such company with the information in its file. The information supplied to other member companies may alert them to a need for further investigation.

In some circumstances, however, information may be released to third parties without your authorization (with the exception of the MIB). These include persons or organizations who are: (1) performing business functions for us; (2) conducting actuarial or scientific studies or audits; or (3) our reinsurers. We or our reinsurers may also release information to other life insurance companies to whom you apply for life or health insurance coverage, or to whom a claim for benefits is submitted. Please be assured that although such disclosures may occur, they are not always or even often made. When a disclosure is necessary, only as much information as is reasonably necessary to achieve the intended purpose will be disclosed.

You have the right to acquire and, if necessary, correct any personal information we or the MIB collect. Upon written request to us, we will within 30 days of receipt: (1) inform you of the nature and substance of the recorded information; (2) permit personal viewing and copying of the information in our possession; (3) disclose the identities of those persons such information has been disclosed to within the last two years; and (4) provide you with procedures for correction, amendment or deletion of the recorded information. Medical information will be disclosed to a physician that you choose. You may write to us for a fuller explanation of our information practices.

You may also contact the MIB via its website ([www.mib.com](http://www.mib.com)) or by telephone to arrange for disclosure of any information it may have on you. The MIB's toll-free telephone number is 866-692-6901. If you question the accuracy of information in the MIB's file, you may contact the MIB in writing and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

## KEEP THIS NOTICE FOR YOUR RECORDS.



Home Office: New York, NY