



Benefit Plans Office

Dear Worker,

Please find enclosed an enrollment form, an Evidence of Insurability form, and a summary of benefits for Optional Long Term Disability (LTD) coverage through WELS VEBA and Sun Life Assurance Company of Canada. **Please complete the below information as well as the enclosed Sun Life enrollment and Evidence of Insurability forms and return them to the WELS Benefit Plans Office:**

WELS Benefit Plans Office
2949 N. Mayfair Rd. Second Floor
Milwaukee, WI 53222

Note that you do not need to complete the section entitled "Employer Instructions" on the Cover Page of the Sun Life Evidence of Insurability Form. Upon receipt your application will be submitted to Sun Life for review. If your application is approved, optional LTD coverage will become effective at the time of approval.

You may keep the LTD summary of benefits for your information and records. Additional information is available on the Benefit Plans Office website at www.welsbpo.net. Questions may be directed to the Benefit Plans Office by e-mail to bpo@sab.wels.net or phone at 414-256-3860.

(Please complete the section below and return with your form)

Name: _____

Home Address: _____

Phone Number: _____ Marital Status: Married Single

Name of Employer/Sponsoring Organization: _____

Occupation: _____

Service Type: Pastor Teacher Layworker Hours Worked Per Week: _____

Who should be billed for this coverage?

Employer (Name if different than above): _____

Worker

HIGHLIGHTS OF LONG TERM DISABILITY BENEFITS



FOR EMPLOYEES OF **WELS VEBA Group Health Care Plan Policy 07528**

Welcome to Sun Life Assurance Company of Canada. We are pleased to provide you with Long Term Disability benefits. Below is an outline of the benefits now available to you through your employer.

Your LTD Benefits

Eligible Employees of Sponsoring Organizations.

- Covers accidents and sicknesses.
- Benefits are 66.67% of monthly earnings up to a maximum of \$5,000 per month.
- Benefits may begin after 90 days of absences due to a covered accident or sickness.
- Coverage \$100 or 15% Contributory.

Cost to You

Long Term Disability coverage is contributory, meaning that you are responsible for paying for all or a portion of the cost through payroll deduction. Your cost is determined by multiplying your monthly earnings by your monthly rate.

Example Monthly Earnings	Divided by 100	Multiplied by rate	Total cost	Example cost*
\$ 3,500	/ 100 = 35	x \$0.385	= \$13.48	\$ 13.48

Your Monthly Earnings	Divided by 100	Multiplied by rate	Total cost	Your cost*
\$	/ 100 =	x \$0.36	= \$	\$

***Contact your employer to confirm the portion of the cost for which you will be responsible.**

How to Enroll

Fill out the Long Term Disability enrollment form below. Be sure to sign, date, and return the form to your employer.

Name (First, middle initial, last)	<input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security No.	Date of Birth	Date of Hire
You must elect or refuse insurance coverage within 60 days of your date of eligibility.				Monthly Earnings
Long Term Disability (LTD) coverage. Check One: <input type="checkbox"/> I elect <input type="checkbox"/> I decline				\$
Important. You must read and sign. I understand that: <ul style="list-style-type: none"> • I am requesting LTD coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates. • My employer will deduct all or part of the premiums from my pay. • If I decline coverage now and want it at a later date, I will have to provide evidence of insurability (proof of good health) acceptable to Sun Life Assurance Company of Canada. • 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 a person to criminal and civil penalties. 				
Employee Signature				Today's Date

This summary flyer is intended to provide an overview of the benefits available from your employer and is not a complete description of plan provisions. Receipt of this flyer does not certify eligibility for benefits under the plan. When you become eligible for benefits under the plan, your employer will provide you with the Sun Life Assurance Company of Canada Group LTD booklet containing complete plan details.

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Sun Life Assurance Company of Canada

Evidence of Insurability Cover Page



Employer Instructions

Complete this cover page and provide it to the employee. The employee may complete the Evidence of Insurability (EOI) application either online or on paper:

- **Online at www.sunlife-usa.com/planmembers**

Our secure online system allows employees to provide all of the information needed for Evidence of Insurability in about 10 to 15 minutes. Following completion of the application, the employee receives confirmation by email. The employee then will receive notification of our decision by email or mail.

- **Printable EOI application**

If submitting the EOI application on paper, the applicant must include this Cover Page with his/her submission. Failure to include a completed Cover Page could delay the EOI process.

Employee/Dependent Information (To be completed by employer)

Employee Name (first, middle initial, last)		Group Policy Number 07528	
Social Security Number (last four digits)	Approval Requested for	<input type="checkbox"/> Employee <input type="checkbox"/> Dependent Child(ren):	<input type="checkbox"/> Spouse No. of Children:

Coverage(s) Subject to Evidence of Insurability (To be completed by employer)

Select coverage(s) for which EOI is required. Fill in Current Amount of coverage, or the Guaranteed Issue (GI) amount of the plan. Then fill in Requested Amount and Amount Subject to EOI. Sign and date here if employee is submitting the printable EOI form.

Life Insurance

	Current Amount of Coverage (or GI)	Requested Amount	Amount Subject to EOI
<input type="checkbox"/> Employee Basic	\$	\$	\$
<input type="checkbox"/> Employee Optional	\$	\$	\$
<input type="checkbox"/> Spouse Basic	\$	\$	\$
<input type="checkbox"/> Spouse Optional	\$	\$	\$
<input type="checkbox"/> Child Optional	\$	\$	\$

Other Coverages

<input type="checkbox"/> Short Term Disability
<input type="checkbox"/> Long Term Disability
<input type="checkbox"/> Buy-Up LTD: \$

Signature of person completing this cover page (Employer) X	Date
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Need help determining EOI? Please see your **Group Policy** and the **Administrator's Guide**.

Employee Instructions

Complete and submit either the **Online EOI Application** or the **Printable EOI Application**, but **not both**.

- **Online EOI Application**

1. Go to www.sunlife-usa.com/planmembers and click on Start under Evidence of Insurability
2. Follow the instructions on the web site. Enter height weight, date of birth and medical history for you and any dependents on this application. Use the information supplied by your employer above to complete the Coverage Information section of the online application. Your application will not be submitted until you click the Submit for Review button on the last screen.

- **Printable EOI Application**

1. Complete pages 1 and 2 of the EOI Application according to the instructions. You may type your answers into the fillable form and then print the document. Please remember to sign and date the form.
2. Mail or Fax the EOI Application and this Employer Cover Page to us:

MAIL TO: WELS Benefit Plans Office
2949 N. Mayfair Rd. Second Floor
Milwaukee, WI 53222-4392

-or- FAX TO: (414) 256-3879

Sun Life Assurance Company of Canada

Evidence of Insurability Application – Health Questionnaire



I Applicant Information (Please print clearly)

Complete and return pages 1 and 2 of this form, along with the employer cover page to:

WELS Benefit Plans Office
2949 N Mayfair Rd. 2nd Floor
Milwaukee, WI 53222-4392

Fax: (414) 256-3879

Your name (first, middle initial, last)		Name of your employer WELS VEBA Group Health Care Plan		Group policy no. 07528	
Your street address			City	State	Zip Code
Social Security number - -		Daytime phone number		E-mail address	

This Application is for: Employee Spouse Child Male Female

Name (if different than above)	Date of birth (m/d/y)	Height ft. in.	Weight lbs.
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II Health History (The information in sections II, III and IV is confidential and will not be shared with your employer)

Important: You must answer all questions. If you answer "Yes" to any question, please use the space in Section IV on page 2 to provide the details of your condition. Failure to provide the details of your condition will cause a delay in the review of your application.

1. In the past five years, have you:

- a. Had transplant surgery, other surgery, injuries or been treated in a hospital?..... Yes No
- b. Been treated for alcoholism or advised by a physician to change your drinking habits?. Yes No
- c. Used heroin, marijuana, cocaine, LSD, amphetamines, or any other narcotic? Yes No
- d. Been off work for more than five consecutive days due to illness or injury? Yes No
- e. Lost 20 lbs. or more over a 12 month period?..... Yes No

2. In the past five years, have you been diagnosed with, treated for or had any symptoms relating to any of the conditions listed below?

- a. Dizzy spells, epilepsy, a nervous or neurological disorder, migraines or a mental disorder Yes No
- b. Asthma, bronchitis, emphysema, chronic cough, shortness of breath, Chronic Obstructive Pulmonary Disease (COPD) or lung disorder Yes No
- c. Abnormal blood pressure, chest pain, heart murmur, heart disease or heart attack Yes No
- d. Ulcer, liver disorder, colitis, diarrhea or any complaint of the digestive organs Yes No
- e. Arthritis, gout, rheumatism, back disorder, disc disease or joint or bone disorder Yes No
- f. Cancer, tumor, enlarged glands, enlarged lymph nodes or lupus Yes No
- g. Sugar in urine, diabetes, kidney or bladder disorder Yes No
- h. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV) Yes No
- i. Anemia, blood vessel disease, bleeding or any other blood disease or disorder Yes No
- j. Disorders of the eyes or ears Yes No
- k. Chronic fatigue or fibromyalgia Yes No

3. Are you currently pregnant?..... Yes No

Domiciliary State – Michigan

Continued on next page

III Activities

Important: If you answer “Yes” to any question, use the space in section IV to list each activity, how often you participate in it and the last time you participated in it.

Do you engage in any of the following activities?

- a. Skydiving Yes No
- b. Scuba diving..... Yes No
- c. Vehicle or boat racing Yes No
- d. Piloting an aircraft..... Yes No

IV Detail (Provide detail below about any “Yes” answer from sections II and III.)

Question number	Description/History of Condition (e.g. high blood pressure, recent BP reading etc.)	Date Condition Began	Duration of Condition/ Treatment	Treatment	Fully Recovered? <input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

If you need more room, check here and attach a separate sheet.

V Signature

Please read the Certification and sign and date the form below.

If an Authorization form is included in this package, please remember to sign and date all pages of the form and return it with your completed EOI Application.

Certification

I hereby certify, to the best of my knowledge and belief, that:

- The information I have provided in the Evidence of Insurability (EOI) Application is true, accurate and complete.
- I have read, or had read to me, the completed EOI Application, and understand that any false statements or misrepresentation made in it may result in a loss of coverage under the Group Insurance Policy.
- I have read or had read to me the Fraud Warning for my state on Page 3.

I also hereby confirm my understanding that:

- My EOI Application may be denied and I may be refused insurance if Sun Life Assurance Company of Canada (“The Company”) determines that I am not insurable. If The Company determines that I am not insurable, it will explain in writing the basis of its determination.
- I may ask The Company in writing to: (a) obtain certain information from the EOI Application file relating to me (a fee may be charged); (b) correct, amend or delete information in the EOI Application file relating to me (as permitted by applicable law); (c) file my own statement of facts if I believe any information in the EOI Application file relating to me is incorrect; and (d) provide me with a copy of my EOI Application.
- If I have any questions regarding my EOI Application, I can write to Sun Life Assurance Company of Canada, Group Medical Underwriting – SC 7190, 15 Rye Street, Portsmouth, NH 03801.

Signature of Employee X	Date signed
Signature of Spouse (If Application is for spouse) X	Date signed

Sun Life Assurance Company of Canada

Please read the applicable fraud warning before signing this form.

State Law requires us to notify you of the following:

Fraud Warning (for all states except those listed separately below): 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.

Fraud Warning – 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.

Fraud Warning – 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.

Fraud Warning – 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.

Fraud Warning – Oklahoma: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Fraud Warning – Virginia: 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.

Fraud Warning –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 include imprisonment, fines, and denial of insurance benefits.

WELS VEBA Long Term Disability Income Plan

Summary of Benefits*

Amount of Benefit

A disabled worker will receive a benefit amount equal to 66.67% of the worker's total compensation. Compensation is the sum of a worker's base salary, housing allowance (if any), and utilities allowance (if any).

Maximum Benefit

\$5,000/month

Minimum Benefit

15% of the monthly benefit or \$100, whichever is greater.

Elimination Period

90 continuous days. The elimination period is a waiting period during which no benefit is paid. On the 91st day of the disability, a worker may be eligible to receive benefits.

Premium Cost

For workers who are enrolled in the WELS VEBA Group Health Care Plan, the WELS VEBA Long Term Disability (LTD) Income Coverage is automatic and the cost for the LTD coverage is included in the cost for the WELS VEBA Group Health Care Plan.

The annual cost for the optional LTD coverage is calculated by multiplying the premium rate times the worker's annual compensation. The current premium rate is 0.36%. As such, the annual cost to cover a worker whose annual compensation is \$25,000 would be \$90.00 (.0036 x \$25,000 = \$90.00). Premium statements for the optional LTD coverage are sent on a quarterly basis to the payor (i.e., to either the individual worker or the respective Sponsoring Organization).

Enrollment Period

Workers who are enrolled in the WELS VEBA Group Health Care Plan need not enroll in the WELS VEBA Long Term Disability Income plan since the LTD coverage is automatic for such individuals.

Workers who are not enrolled in the WELS VEBA Group Health Care Plan can enroll in the LTD plan without providing any evidence of medical insurability within 60 days from the date they become eligible for this coverage. After 60 days from the eligibility date, the worker will need to provide evidence of medical insurability when applying for the LTD coverage. Workers who are not enrolled in the WELS VEBA Group Health Care Plan may not obtain or keep the LTD coverage unless their calling/hiring body provides WELS VEBA Group Health Care Plan coverage for other workers.

Definition of Disability

A Total Disability means the Employee, because of Injury or Sickness, is unable to perform the Material and Substantial Duties of his or her Own Occupation. A Partial Disability means the Employee, because of Injury or Sickness, is unable to perform the Material and Substantial Duties of his or her Own Occupation and the Employee has Disability Earnings of less than 80% of his or her Indexed Total Monthly Earnings.

Reductions in Benefit

A disabled worker's benefit will be reduced by any Social Security benefits which are received by the worker, any retirement benefits received from the Employer sponsored retirement program, any benefits received from Worker's Compensation, and benefits received under occupational disease law, or any other similar benefit, and any other group LTD plan which is maintained by the respective Sponsoring Organization.

For Workers Who Have Opted Out of Social Security

There will be NO Social Security reduction of benefits for workers who have opted out of Social Security.

For Workers Who Maintain an Additional Individual LTD Plan

There will be no reduction in benefits for benefit amounts which are received from an additional individual LTD plan. A worker may collect a benefit from both an individual LTD plan and the WELS VEBA Long Term Disability Income plan.

* If there is ever a discrepancy between this Summary of Benefits and the provisions of the coverage as stated in the certificate booklet, the certificate booklet shall take precedence.



Are you covered?

How would you pay your bills and support your family if you become disabled from an illness or injury? If you're like most people, you have insurance to protect your car, your home, and your health, but have you protected your ability to earn a living? Many people do not consider how their standard of living would change if they were unable to work. What if it happened to you?

Ask yourself how you would handle these issues.

Family resources?

Savings, investment income or another family member's income may cover some household bills.

Workers' compensation?

Since this covers only job-related disabilities, you may not want to count on this. You are more likely to become disabled from an injury or illness unrelated to your job.

Health insurance?

While health insurance covers your medical bills, it doesn't replace your lost income.

Social Security?

Social Security pays disability benefits only when your illness or injury is expected to last at least one year. To qualify, you must be unable to perform *any* substantial, gainful work. Benefits begin only after a waiting period of five continuous months.

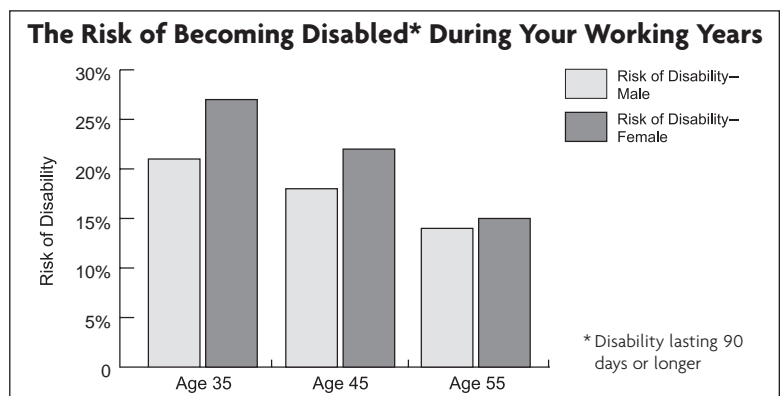
Should you rely on these sources to protect you?

Consider that your odds of becoming disabled during your working years are far greater than dying. And the financial impact of a disability can be devastating. Almost half (48%) of all home foreclosures are due to a serious medical condition.¹

If you are like most Americans, you cannot afford to be out sick or injured for an extended period of time.

That's why your employer is offering Sun Life Assurance Company of Canada LTD coverage that replaces a portion of your income while you're disabled. Enroll today for peace of mind.

For more information, please contact your employer.



Source: "Disability Insurance: A Missing Piece in the Financial Security Puzzle," America's Health Insurance Plans and Society of Actuaries, 2004

¹ The JHA Disability Fact Book, 2003/2004 Edition

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