



# **Protector Platinum<sup>SM</sup> Guarantee Issue Disability Income Insurance**

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**Prepared for:**

Valued Reznick Group Client  
The Reznick Group

**Presented by:**

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Winston-Salem, NC 27101

**Open Enrollment**

Ends on December 1, 2011

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# Why disability income insurance is so important

Disability income insurance is designed for one purpose: to help provide financial security in the event a long-term illness or accident prevents you from earning your usual income.

## Disability Happens

Disabling events happen much more frequently than most of us like to think and the financial and emotional toll can be devastating. The sad reality is that every ninety seconds someone files for bankruptcy in the wake of a serious illness.<sup>1</sup>

## Life with Protector Platinum<sup>SM</sup>

We will not dwell on what could happen without insurance because:

**with** Protector Platinum disability income insurance, you can help protect your future earnings should disability strike.

**with** Protector Platinum disability income insurance, while you recuperate, a steady stream of monthly income can help offset the mounting financial strain associated with loss of income combined with unanticipated expenses.


## Trust The Standard

The Standard ranks among the leading individual disability insurance carriers in the nation. You can be confident that we're financially strong, our disability products are high in quality and we can pay what we promise – now and in the future.

In the event you become disabled and need to make a disability claim, you'll discover our exceptional service. Our claims representatives exceed the industry average in courtesy, willingness to help, ability to answer questions and timeliness of responses.<sup>2</sup> Our goal is to give you the kind of expert, friendly service we wish for ourselves and our families.

1. The American Journal of Medicine, Vol 122, No 8, August 2009

2. 2008 research by independent insurance consultants JHA.

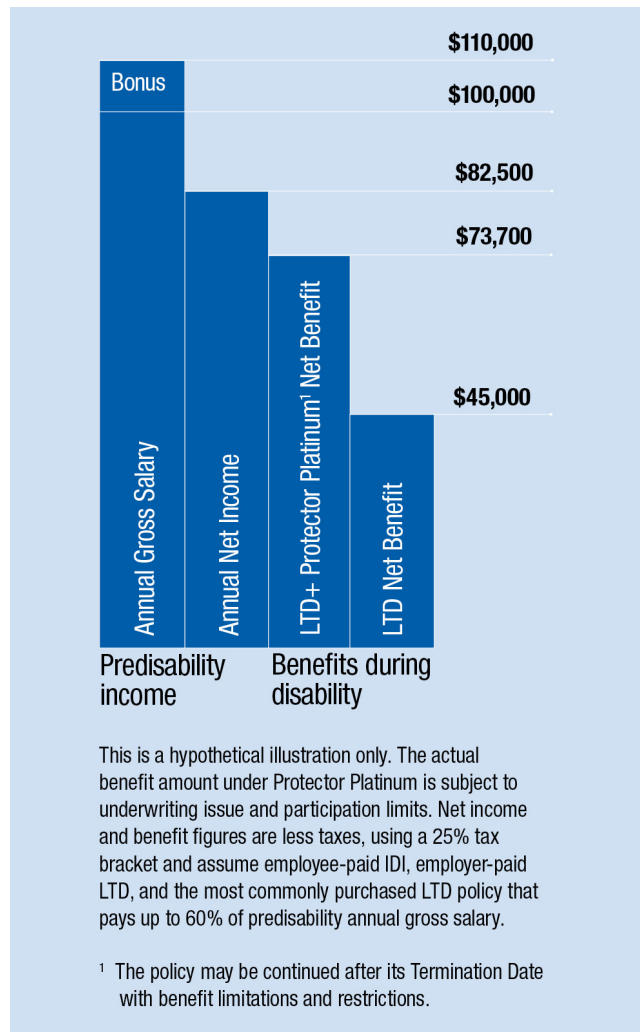
Important information  
when you already have LTD 


# Optimal protection for your income

Combining individual disability income insurance with LTD provides optimal protection from financial loss in the event of a disability.

Protector Platinum has advantages that include coverage of incentive pay, portability (you can take your coverage with you should you change employers), and when policy premiums are employee-paid, IDI benefits are tax-free to you.

What does this mean in numbers? The illustration below shows the different levels of disability income insurance coverage with LTD and LTD combined with Protector Platinum. Insurance protection assumes an annual salary of \$100,000 plus a \$10,000 bonus.



Turn the page to see your personal guarantee issue disability income insurance coverage options 

# Calculations using your income

## LTD alone

<b>Valued Reznick Group Client</b>	Age 40
Gross Monthly Earnings	\$ 7,000
After-tax monthly earnings <sup>1</sup>	\$ 5,250
Gross monthly LTD benefit	\$ 4,200
<b>After-tax monthly LTD benefit</b> (Assuming 60% net monthly income)	<b>\$ 3,150</b>

1. Assuming 25% tax rate

With this offer through The Reznick Group, you are eligible to purchase an additional **\$1,400** of monthly disability income insurance.

## LTD combined with Protector Platinum

After-tax LTD benefit <sup>1</sup>	\$ 3,150
Monthly tax-free <sup>2</sup> benefit with Protector Platinum Guarantee Issue	+ \$ 1,400
<b>Total monthly after-tax benefit when you need it most</b> (This represents 87% of net monthly income)	<b>= \$ 4,550</b>

1. Assuming 25% tax rate  
2. Assuming employee-paid premiums

## Protect yourself and your loved ones with this special The Reznick Group opportunity

- You are guaranteed to be eligible for coverage without consideration of your medical status.\*
- Your plan includes discounted rates you cannot obtain on your own.

\* You must meet financial and occupation eligibility requirements. Coverage is subject to The Standard's Issue and Participation Limits.

See the next page for a description of the offer from  
The Reznick Group



## Plan Design and Premiums

Benefit Waiting Period: 90 Days

Maximum Benefit Period: To Age 67

Noncancelable Policy Rider

12/12 Pre-Existing Conditions Limitation

Discounted Monthly Premium, if  
you have not used tobacco in the  
past 12 months \$ 38.01

Discounted Monthly Premium, if  
you have used tobacco in the  
past 12 months \$ 47.51

### How to enroll

Many answers have been pre-filled in the attached application. Please review all information for accuracy. Your completed and signed application will become a permanent part of your policy. Incomplete or missing information may result in a delay issuing your policy.

- If you need to make a correction, place your initials next to the change. As with any contract, changes with masking ink cannot be accepted.
- Please use blue or black ink.
- Don't forget to sign your application. Your signature is required in the following areas of the application packet (if included):
  - Page two of the Short Form Application
  - Authorization to Obtain and Disclose Personal Information
  - Annual Benefit Increase Agreement
  - Acknowledgement of Receipt
  - Notice to Applicant Regarding Replacement of Accident and Sickness Insurance
  - Catastrophic Application Supplement

Whether you wish to accept or decline this offer, please complete the attached The Reznick Group *Payroll Deduction Authorization form* for The Reznick Group's employee files. A Declination of Coverage statement is listed at the bottom of that form should you choose not to participate.

**Open enrollment is available until December 1, 2011**

# The Reznick Group

## Payroll Deduction Authorization

### Disability Insurance Income Protection Plan

Administered by Standard Insurance Company

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I have applied for coverage under the **The Reznick Group** Insurance Income Protection Plan, administered by Standard Insurance Company. I authorize **The Reznick Group**, or any of its subsidiaries, to deduct funds from my wages to cover my contribution toward the cost of insurance premiums and/or payments due to Standard Insurance Company for disability income insurance coverage under the **The Reznick Group** Disability Insurance Income Protection Plan. The pay period deductions for the disability income insurance coverage will be:

#### Pay Period Deduction 26 Periods

	<b>Non-Smoker</b>	<b>Smoker</b>
Basic Plan Benefits:	17.54	21.93
Check <u>One</u> :	Non-Smoker <input type="checkbox"/>	Smoker <input type="checkbox"/>

The disability coverage under the **The Reznick Group** Disability Insurance Income Protection Plan will become effective on **February 1, 2012**. This coverage is contingent on the approval of my application for disability income insurance coverage and the completion of any policy delivery requirements. I understand that I must be insurable under Standard Insurance Company's underwriting rules on the effective date and the actual coverage provided will be limited by Standard Insurance Company's eligibility rules on that date, including any other disability income insurance now in force or pending issue with Standard Insurance Company.

If the **The Reznick Group** Disability Insurance Income Protection Plan ends or no longer applies to my insurance coverage, premiums shall become payable according to the provisions in the applicable policy. In that event, I understand I must notify Standard Insurance Company if I wish to continue payment of premiums, and the failure to continue the payment of premiums may cause the policy to lapse. **I understand that I may cancel this Payroll Deduction Authorization at any time by written notice to The Reznick Group.**

_____	_____	Valued Reznick Group Client
<b>Date</b>	<b>Signature</b>	<b>Print Name</b>

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### Declination of Coverage

I acknowledge that I have been given the opportunity to participate in the **The Reznick Group** Disability Insurance Income Protection Plan. The benefits of the **The Reznick Group** Disability Insurance Income Protection Plan have been clearly and thoroughly explained to me and I decline to participate in this plan at this time. **I understand that if I decide at a later date to participate in the The Reznick Group Disability Insurance Income Protection Plan, I will be required to re-apply for coverage, and I will have to satisfy any and all evidence of insurability requirements that may exist at that time.**

_____	_____	Valued Reznick Group Client
<b>Date</b>	<b>Signature</b>	<b>Print Name</b>

**Proposed Insured**

Client, Valued Reznick Group Male  
 1. Full Name (Last, First, Middle) 2. Sex 3. Social Security Number  
 4. Home Address 10/19/1970 City State Zip Code  
 5. Date of Birth 6. State of Birth 7. Length of US Residence 8. Email (optional)

**Insurance Applied For**

9. Plan Type & Features: **A. Disability Income**  
 BASIC MONTHLY BENEFIT \$ 1,400  
 WAITING PERIOD 90 DAYS  
 BENEFIT PERIOD To Age 67  
 NONCANCELABLE  
 OWN OCCUPATION  
 24-MO REGULAR OCCUPATION  
 FUTURE PURCHASE OPTION  
 \$ \_\_\_\_\_ POOL AMOUNT  
 CATASTROPHIC \$ \_\_\_\_\_  
 INDEXED COST OF LIVING:  3% /  6%  
 MENTAL DISORDER/SUBSTANCE ABUSE LIMITATION  
 PRE-EXISTING CONDITIONS EXCLUSION  
 ERISA  
 OTHER \_\_\_\_\_

10. Occupation Class: 5A (Available classes: 5A, 4A, 4P, 3A, 3P, 2A, 2P, A, B)  
 11. Premium Mode: \_\_\_\_\_ List Bill-monthly. (List bill plan number, if known: \_\_\_\_\_)  Other \_\_\_\_\_

12. Other Coverage: Explain all YES answers in the table below. Do not include the insurance you are applying for with this application.  
 a. Have you applied for any disability insurance in the last 12 months? .....  YES  NO  
 b. Is there any other individual or group disability insurance currently in force or pending on you?.....  YES  NO  
 c. Have you filed a claim for or received any disability insurance benefits in the last 3 months?.....  YES  NO  
 If YES please explain: \_\_\_\_\_

COMPANY OR SOURCE:	TYPE OF COVERAGE*	IF GROUP INSURANCE:		MONTHLY AMOUNT:	BENEFIT PERIOD:	WAITING PERIOD:	WILL THIS COVERAGE BE REPLACED OR REDUCED?
		WHO PAYS PREMIUM?	BENEFIT CAP MAXIMUM?				
Hartford	G	ER	60%	10000	SSNRA	90	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							<input type="checkbox"/> YES <input type="checkbox"/> NO
							<input type="checkbox"/> YES <input type="checkbox"/> NO

\*USE TYPE CODES: I - INDIVIDUAL; G - GROUP; X - ASSOCIATION; OE - OVERHEAD EXPENSE; O - OTHER

**General Information**

13. Current Primary Occupation (Include professional designation, specialty or degree.) The Reznick Group  
 14. Years in Current Primary Occupation 7700 Old Georgetown Road Suite 400 Bethesda, MD  
 15. Years with Current Employer 20814  
 16. Current Employer 17. Employer Address City, State Zip Code

18. For the period of time starting **180 days prior to and including the date of this application:**  
 Have you been continuously at work on a full time basis performing all the duties of your occupation without limitation due to an injury or sickness?.....  YES  NO  
 If NO, please explain: \_\_\_\_\_

19. Have you used tobacco or nicotine in any form in the last 5 years? If yes, circle types below and complete table.....  YES  NO

	HOW LONG:	AMT PER DAY:	DATE LAST USED:
A. CIGARETTES	_____	_____	_____
B. CIGAR	_____	_____	_____
C. PIPE	_____	_____	_____
D. SMOKELESS	_____	_____	_____
E. GUM, PATCH, OTHER	_____	_____	_____

Proposed Insured (print): Valued Reznick Group Client

**Agreement**

I, THE UNDERSIGNED, AGREE TO THE FOLLOWING: This application includes pages 1 and 2 and all signed application supplements and amendments. In this application, "you" and "your" mean the proposed insured unless otherwise specified. I understand that Standard Insurance Company (Standard) will rely on the information I have provided in this application in considering the proposed insured's eligibility for insurance and for various premium rates. This application will not be effective unless signed and dated by the proposed insured and owner, if different. **No insurance will be in force until: (a) the date a policy has been issued, delivered to and accepted by the owner; and (b) the first full premium is paid while all answers in this application remain true and complete.** The only exceptions are as outlined in a written agreement between Standard and the employer as payor for the policy. Premium will be calculated to begin on the Policy Effective Date. No sales representative is authorized to judge insurability or change any of Standard's requirements. No corrections or amendments to this application may be made without the owner's written consent. We may require that any disability policy listed in answer to Question 12 be permanently terminated or reduced. Standard will rely on the information in this answer in determining the amount, if any, of disability insurance it will issue. If such insurance is not terminated or reduced as required by Standard, any policy issued and accepted pursuant to this application may be rescinded and all premiums returned. If any insurance applied for is intended to replace other insurance in force with Standard, the Standard policy(s) being replaced will end the moment the insurance applied for becomes effective. I have read this application. I understand that if any answers are false, incorrect or untrue, Standard may have the right to deny benefits or rescind my insurance policy. I REPRESENT that: All answers in this application are true and complete and correctly recorded; and that any and all answers I have provided to any Standard representative are recorded in this application. I signed this application in the city and state and on the date shown below.

If Proposed Insured is Owner of the Policy:

Provided there are no corrections or amendments made by Standard to this application, I AUTHORIZE my employer to accept delivery of the policy on my behalf; and I UNDERSTAND AND AGREE that my employer will then deliver the policy to me.

NOTE: A person commits a fraudulent act when that person knowingly files an application for insurance which either contains materially false information or conceals material information with intent to mislead.

\_\_\_\_\_  
Signed at \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_  
SIGNATURE OF PROPOSED INSURED CITY STATE DATE

If Policyowner is Other Than Proposed Insured:

\_\_\_\_\_  
Signed at \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_  
SIGNATURE OF POLICYOWNER CITY STATE DATE

Valued Reznick Group Client  
\_\_\_\_\_  
PRINT NAME AND TITLE OF POLICYOWNER POLICYOWNER'S TAX ID NUMBER

\_\_\_\_\_  
POLICYOWNER'S ADDRESS CITY, STATE ZIP CODE EMAIL ADDRESS (OPTIONAL)

I declare and affirm that: (1) any answers provided to me by the proposed insured have been truly and accurately recorded on this application; and (2) no changes, additions or alterations of any kind have been made to this form after it was signed by the proposed insured and owner, if different.

\_\_\_\_\_  
Signed at \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_  
SIGNATURE OF SOLICITING PRODUCER CITY STATE DATE

**Standard Insurance Company**

Individual Disability Insurance Underwriting  
1100 SW Sixth Avenue Portland OR 97204-1093

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**Disclosure Notice - Information Practices  
(Nonmedical)**

Standard Insurance Company (Standard) is committed to maintaining the confidentiality of your personal information. In order to offer and administer insurance products, Standard must obtain and review a certain amount and type of personal information about you. In general, we may seek information about your age, occupation, income and finances. This personal information is obtained and disclosed by us in order to evaluate your insurability and determine appropriate premium rates; to support our normal business practices; and to provide quality service in administering policies.

**Sources of Information**

You and your application for insurance are our primary sources of personal information. We, or our insurance representative, may call you for a personal history interview (PHI) to obtain supplementary information or to confirm information you provide on the application. With your written authorization, we may also collect or verify personal information by contacting: insurance producers, insurance or reinsurance companies, and the MIB, Inc. (see below); employers, and personal and business associates.

**Disclosure of Information**

In the course of conducting our business, there are circumstances in which we may disclose to others the information we collect about you. These disclosures are only made with your authorization, or as permitted or required by law. Such disclosures may be to the MIB, Inc., reinsurers; organizations that perform services or functions on our behalf or to serve you, and to regulatory, law enforcement and governmental authorities. Standard or its reinsurers may also release information in its file to other insurance companies to whom you have applied or may apply for life or health insurance or to whom a claim for benefits may be submitted. When information is disclosed to another party to perform services or functions on our behalf, we expect them to adhere to procedures and practices that maintain the confidentiality of your personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable federal and state privacy laws.

**Review and Correction of Information**

In general, you have a right to learn the nature and substance of any personal information about you in our files. You also have a right to obtain a copy of that information, subject to limited restrictions. To access information about you, send a signed, written request to the address at the top of this page. If you believe that any information about you is inaccurate, you may notify us in writing of any correction, amendment, or deletion that you believe should be made. We will carefully review your request and, where appropriate, make the necessary change.

**MIB, Inc. (Medical Information Bureau)**

Standard, or its reinsurers, may make a brief report to the MIB, Inc., formerly known as Medical Information Bureau. MIB, Inc. is a not-for-profit membership organization of insurance companies that 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 the company with the information in its file. At your request, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek 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 Park, Suite 400, Braintree, Massachusetts 02184-8734. The telephone number is 866-692-6901 (TTY 866-346-3642). Information for consumers about MIB, Inc. may be obtained on its website at [www.mib.com](http://www.mib.com).

**Additional Information**

We hope this information helps you understand how and why we obtain information about you. To obtain a more detailed explanation of your rights and our information practices, please contact Standard Insurance Company, Individual Disability Insurance Underwriting, 1100 SW Sixth Ave., Portland, OR 97204-1093.

**Standard Insurance Company**

Individual Disability Insurance Underwriting  
1100 SW Sixth Avenue Portland OR 97204-1093

**Authorization to Obtain and Disclose  
Personal (Nonmedical) Information**

**Types of Personal Information Collected**

I understand that it is necessary for Standard Insurance Company (Standard) to collect and review personal information about me in order to offer and administer insurance products. I understand that personal information may include information about my age, occupation, other insurance, income and finances. I also understand that personal information does not include any information related to my physical or mental condition, medical history or medical treatment.

**Authorization to Obtain Personal Information**

I authorize any insurance or reinsurance company, insurance sales representative, employer, MIB, Inc. (Medical Information Bureau) and any other person, organization or institution having records or knowledge of me, to release personal information about me, as described above, to Standard, its reinsurers, and any insurance support organization acting on behalf of Standard.

**Authorization to Use Personal Information**

I authorize Standard to use personal information obtained about me for the purposes of determining eligibility for insurance and reinsurance and determining appropriate premium rates, evaluating claims for insurance benefits, and conducting other legally permissible activities that relate to my application and insurance coverage.

**Authorization to Disclose Personal Information**

I authorize Standard to disclose any personal information about me to Standard's reinsurers, MIB, Inc., other insurance companies to whom I have applied or may apply for insurance, and to organizations or persons, including insurance sales representatives, performing business services for Standard related to my application and policy administration. No other disclosure may be made without my further authorization except to the extent necessary for the conduct of Standard's business or as permitted or required by law.

**Expiration and Revocation**

I understand that I have the right to revoke this Authorization at any time by sending a written request for revocation to Standard Insurance Company, Attention: Individual Disability Insurance Underwriting, 1100 SW Sixth Avenue, Portland, Oregon 97204. Revocation of this Authorization, or failure to sign this Authorization, will impair Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage. I realize that if I do revoke this Authorization it will not affect any use or disclosure of information prior to the receipt of my revocation and that any action taken before Standard receives my written revocation will be valid.

This Authorization will expire automatically twenty-four (24) months following the date of my signature below.

I acknowledge that I have read and received a copy of the Disclosure Notice-Information Practices. A copy of this Authorization will be provided to me, or my authorized representative, upon request. A photocopy or facsimile of this Authorization is as valid as the original. Any alteration made to this Authorization will render it invalid and unacceptable by Standard.

\_\_\_\_\_  
Signature of (Proposed) Insured

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

\_\_\_\_\_  
Valued Reznick Group Client  
Name (please print)

Standard Insurance Company  
Individual Division  
1100 SW Sixth Avenue, Portland, OR 97204-1093

**Annual Benefit Increase Agreement  
(Voluntary Guarantee Issue)**

Valued Reznick Group Client \_\_\_\_\_

Proposed Insured (please print)

**I UNDERSTAND AND AGREE** that the insurance applied for is being offered as part of a Guaranteed Standard Issue Program (the "Program"), and any insurance policy issued to me as part of the Program will be subject to the terms agreed to between Standard Insurance Company ("Standard") and my employer. During the life of the Program these terms include the opportunity to elect to increase my policy's Basic Monthly Benefit on any Program anniversary for which I am eligible for such an increase based on census information submitted by my employer, which increases will be available on a guaranteed standard issue basis.

**I FURTHER UNDERSTAND AND AGREE that** any such increase must be authorized by my employer, and my employer must provide verification of earnings supporting such an increase. Any such increase is subject to a minimum qualifying amount and may not exceed the Guaranteed Issue limit approved by Standard. I understand and acknowledge that I may decline to increase my Basic Monthly Benefit on any Program anniversary for which I am eligible for such an increase, and no further increases will be available under the Program on a guaranteed standard issue basis after such a decline.

\_\_\_\_\_  
Signature of Proposed Insured

Signed at \_\_\_\_\_ on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ .  
City, State Date

\_\_\_\_\_  
Signature of Owner (if other than Proposed Insured)

Signed at \_\_\_\_\_ on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ .  
City, State Date