Pacific Educators
Insurance Services

- Please note that there are four pages to the brochure (not including this one)

- If you need help calculating your premium, please use our rate calculator (attached, or online) or give us a call at (800)722-3365.

- **If you would like to apply, the last page is the actual application that you can complete.**

  - You can complete the application and **submit it by email** by either clicking the button (outlook users), or if you use an online email provider (gmail, yahoo, hotmail, aol, etc.) you must save the pdf to a location on your computer (i.e. desktop or my documents folder). From there, open your email provider, attach the pdf, and email to wp@peinsurance.com. We will then send the document back to you for electronic signature (this is very fast and easy).

  OR

  - You can complete the application and then **print, sign and mail** to:

Pacific Educators
2808 E. Katella Ave., Suite 101
Orange, CA 92867

- If you have any questions, please do not hesitate to contact us directly (800) 722-3365 (or) wp@peinsurance.com

- For information on common examples of personal information collected from California residents and the purposes for which the categories of personal information will be used, please see the NOTICE AT COLLECTION FOR CALIFORNIA RESIDENTS **HERE** or attached to this pdf.

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 335 ORANGE CA
POSTAGE WILL BE PAID BY ADDRESSEE

PACIFIC EDUCATORS INC
PO BOX 1526
ORANGE CA 92856-9975

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

UTLA
SPONSORED

GROUP DISABILITY INCOME INSURANCE PLAN

Underwritten by:

Fidelity Security Life Insurance Company®
Kansas City, Missouri 64111

Fidelity Security Life Insurance Company® has been rated A (Excellent), based on an analysis of financial position and operating performance by A. M. Best Company, an independent analyst of the insurance industry. For the latest rating, access www.ambest.com

Administered by:

Pacific Educators
Insurance Services

2808 E. Katella Ave., Suite 101 • Orange, CA 92867
(800) 722-3365 • (714) 639-0962
www.PEinsurance.com Lic.#0429928

Policy Form No. M-4018 ®-365 Policy No.SD-20/SD-20A (08/2020)

UTLA
SPONSORED

IT CAN HAPPEN TO ANYONE

INJURY & SICKNESS DISABILITY INCOME INSURANCE PLAN

PAYS FULL BENEFITS
In addition to Sick Leave
Sub Differential Pay,
S.T.R.S. & P.E.R.S.

UTLASD20-082020

IT CAN HAPPEN TO ANYONE

CONSIDER THESE FACTS

When your paychecks stop, your bills keep going. Your income is a very important asset. It helps you cover all your routine living expenses. If you should become sick or injured and unable to earn your salary, how would you continue to meet your financial obligations? Disability Income Insurance provides you with benefits when you're unable to work due to a covered sickness or injury.

APPLY NOW, BECAUSE THE TIME TO PLAN FOR A DISABILITY IS BEFORE YOU REALLY NEED IT!

YOU CHOOSE YOUR BENEFIT

Because everyone's need for disability income insurance differs, you have a choice of monthly benefits and how long you want your benefits to continue. You may also choose between maternity and non-maternity coverage. Naturally, your premium varies with the plan and monthly benefit you choose.

The benefits you select for this coverage, combined with any other disability income insurance policy benefits for which you are currently insured or have an application pending must not exceed sixty percent of your monthly wage or salary. Select a plan and monthly benefit which best fits your needs!

THESE PLANS PAY YOU FULL BENEFITS IN ADDITION TO YOUR SICK LEAVE, SUBSTITUTE DIFFERENTIAL PAY, EXTENDED SICK LEAVE, S.T.R.S. AND P.E.R.S. DISABILITY, AND ANY OTHER DISABILITY PLANS FOR WHICH YOU MAY BECOME ELIGIBLE AFTER THE EFFECTIVE DATE OF YOUR CERTIFICATE.

In other words, these benefits do NOT reduce, coordinate, integrate or subtract from the above income or any disability plan for which you become eligible after the effective date of your certificate.

PAYS BENEFITS

12 MONTHS OF THE YEAR (Including summer vacation, off track and holidays)

MONTHLY BENEFIT

Find your annual salary in the salary chart below to determine your maximum eligible monthly disability benefit. You may choose the maximum, or any amount less than that. (Please note the benefit selected cannot be greater than 60% of your monthly income when combined with other disability insurance.)

SALARY CHART

If Your Gross Annual Salary Is At Least...	Maximum Monthly Disability Benefit
$ 24,000.00	$ 1,200.00
$ 26,000.00	$ 1,300.00
$ 28,000.00	$ 1,400.00
$ 30,000.00	$ 1,500.00
$ 32,000.00	$ 1,600.00
$ 34,000.00	$ 1,700.00
$ 36,000.00	$ 1,800.00
$ 38,000.00	$ 1,900.00
$ 40,000.00	$ 2,000.00
$ 42,000.00	$ 2,100.00
$ 44,000.00	$ 2,200.00
$ 46,000.00	$ 2,300.00
$ 48,000.00	$ 2,400.00
$ 50,000.00	$ 2,500.00
$ 52,000.00	$ 2,600.00
$ 54,000.00	$ 2,700.00
$ 56,000.00	$ 2,800.00
$ 58,000.00	$ 2,900.00
$ 60,000.00	$ 3,000.00
$ 62,000.00	$ 3,100.00
$ 64,000.00	$ 3,200.00
$ 66,000.00	$ 3,300.00
$ 68,000.00	$ 3,400.00
$ 70,000.00	$ 3,500.00
$ 72,000.00	$ 3,600.00
$ 74,000.00	$ 3,700.00
$ 76,000.00	$ 3,800.00
$ 78,000.00	$ 3,900.00
$ 80,000.00 +	$ 4,000.00

Based on your monthly benefit amount, calculate your premium (cost) on the next page.

QUESTIONS & ANSWERS

WHO MAY APPLY?
All members, actively employed in the full-time duties (20 hours a week) of their occupation, may apply!

HOW ARE BENEFITS PAID?
Benefits are paid directly to you. All benefits you receive are yours to use as you please. Pay hospital, doctor or other miscellaneous medical expenses. Pay at-home expenses or continuing monthly bills. The choice is yours!

ARE MY BENEFITS TAXABLE?
No tax is payable on your monthly benefits as long as you, not your employer, pay the entire premium. If you use the premium under a pre-taxed section 125 plan, your benefits are taxable. Please consult your tax advisor.

WHAT IS MEANT BY SICKNESS?
Sickness means a bodily disorder; a disease; or Complications of Pregnancy. The Sickness must first begin while the coverage for the Insured is in force under the Policy. Sickness includes pregnancy and resulting childbirth if that option is selected and the pregnancy commences after the Insured's Effective Date.

DO I STILL PAY PREMIUMS WHEN I'M DISABLED?
No! After 6 months of total disability (and after your elimination period), your premium is waived for as long as you're disabled and benefits are payable.

WHAT ABOUT RECURRING CONDITIONS?
Maximum benefits are available, subject to a new elimination period, for the same recurring disability after 6 consecutive months of normal, active work.

HOW LONG CAN I KEEP MY COVERAGE?
Renew your coverage until retirement - provided you pay your premiums, remain a member, are gainfully employed and the group policy remains in force. This policy is renewable at the option of the company.

WHAT ISN'T COVERED?
Benefits are not payable for any injury, sickness or condition caused by or due to: war or acts of war declared or undeclared: military service of any country or international organization; normal pregnancy or childbirth (unless applying for maternity coverage); abortion, except to save the life of of the mother; illegal blood alcohol content; being under the influence of any narcotic, barbiturate or hallucinatory drug, unless administered under advice of a physician and taken in the prescribed dosage; suicide or any attempt at suicide while sane or insane; travel or flight in any kind of aircraft while participating in aviation training, or as a pilot, officer or other member of the crew; injury or sickness arising out of and in the course of any occupation for wage or profit.

Calculate your premium ▶

UTLA GROUP RATES

EXTEND YOUR INCOME WHEN DISABILITY STRIKES

PREMIUM

To determine your premium, choose the plan that has the waiting (elimination) period, the length of payment (1 or 2 years), and whether applying for maternity or non-maternity coverage. Based on the plan you selected and your current age, multiply the rate in the table below by the monthly benefit amount in $100 increments (see example). Premiums are based on your attained age on your effective date.

EXAMPLE: If applying for $2100/month benefit, multiply 21 x the rate shown in the table below.

NEED HELP CALCULATING YOUR PREMIUM?

Call Us at (800) 722-3365 or go to WWW.PEINSURANCE.COM and click on
Products, UTLA Members, and Disability Insurance to use our rate calculator.

NO MATERNITY BENEFITS

All Premiums are 12 Times per Year	DISABILITY BENEFITS PAID UP TO ONE YEAR Rates Per $100 Monthly Benefit				DISABILITY BENEFITS PAID UP TO TWO YEARS Rates Per $100 Monthly Benefit			
Your Age	**Under 40** Monthly	**40 - 49** Monthly	**50 - 59** Monthly	**60 - 69*** Monthly	**Under 40** Monthly	**40 - 49** Monthly	**50 - 59** Monthly	**60 - 69*** Monthly
Waiting Period - **30 Calendar Days**	$0.72	$1.03	$1.65	$2.82	$1.05	$1.55	$2.53	$4.38
Waiting Period - **60 Calendar Days**	$0.51	$0.79	$1.32	$2.35	$0.87	$1.28	$2.17	$3.88

WITH MATERNITY BENEFITS

All Premiums are 12 Times per Year	DISABILITY BENEFITS PAID UP TO ONE YEAR Rates Per $100 Monthly Benefit						DISABILITY BENEFITS PAID UP TO TWO YEARS Rates Per $100 Monthly Benefi					
Your Age	**Under 30** Monthly	**30 - 34** Monthly	**35 - 39** Monthly	**40 - 49** Monthly	**50 - 59** Monthly	**60 - 69*** Monthly	**Under 30** Monthly	**30 - 34** Monthly	**35 - 39** Monthly	**40 - 49** Monthly	**50 - 59** Monthly	**60 - 69*** Monthly
Waiting Period - **30 Calendar Days**	$2.24	$1.38	$1.08	$1.03	$1.65	$2.82	$2.53	$1.70	$1.46	$1.55	$2.53	$4.38
Waiting Period - **60 Calendar Days**	$0.84	$0.68	$0.65	$0.79	$1.32	$2.35	$1.09	$0.93	$1.00	$1.28	$2.17	$3.88

* At age 70, the benefit period will reduce to 6 months. **Monthly premiums for age 70 and over are as follows:** 30 Day Plan - $2.41 per $100 unit. 60 Day Plan - $1.92 per $100 unit.

DEFINITION OF TOTAL DISABILITY

Total Disability or Totally Disabled means that because of injury or sickness, you cannot perform the material and substantial duties of your regular occupation; and must be under the care of a physician unless the physician certifies you do not need the regular care of a physician for such disabling condition. Loss of a professional or occupational license for any reason does not, in itself, constitute total disability.

PRE-NOTICE

Although your application is our main source of information, we at Fidelity Security Life Insurance Company® (FSL) may also collect or verify information pertaining to age, occupation, physical condition, health history and avocations by contacting various individuals or organizations by correspondence, telephone or personal contact. It may be necessary for us to share information we obtain with an individual or organization related to the medical or insurance industry or with an individual performing a function for us without your express written authorization.

Information regarding your insurability will be treated as confidential. FSL or its reinsurers may, however, make a brief report thereon to the MIB, LLC, a not-for-profit membership organization of 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 each company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. 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 Park, Suite 400, Braintree, Massachusetts 02184-8734.

Fidelity Security Life Insurance Company or its reinsurers may also release information from its file to other 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.

93-22714 Rev 1022

FAIR CREDIT REPORTING ACT NOTICE

With regard to your application, We may request a consumer report or an investigative consumer report. These reports contain information about your character, general reputation, mode of living and health. No adverse underwriting desicion will be made based on your sexual orientation. The information may have been obtained through interviews with you, your neighbors, friends and others who know you. We will give you the name and address of the consumer reporting agency so that you may request a copy of the report.

93-33631 Rev 0316

HOW TO APPLY

Fill out the application, detach, fold and mail today. Your answers to the general health questions will help determine your insurability. Please be sure the answers are correct and complete.

If this coverage replaces a similar plan, do not cancel current coverage until you have been approved for this plan.

Coverage becomes effective upon approval of your application by the Insurance Company and the first payroll deduction, provided you are actively at work on that day.

To file a claim, contact Pacific Educators, Inc. for a form which you and your doctor fill out. Return the form to the Insurance Company for prompt processing.

COMPLETE APPLICATION & MAIL
Postage is Paid!

APPLICATION TO FIDELITY SECURITY LIFE INSURANCE COMPANY® **For United Teachers Los Angeles Group Disability Income Insurance Plan**

Policy No. SD-20

Please indicate your choice of plan options.

Elimination Period: ☐ 30 Day ☐ 60 Day Benefit Period: ☐ 1 Year ☐ 2 Years Maternity Benefits: ☐ Yes ☐ No

Monthly Benefit Desired: $_____; Number of $100 units _____ (6 to 40) X _____ (Rate per $100) = _____ (Premium)

Please Print or Type in Black Ink

NAME _____ (FIRST / MIDDLE / LAST) SOCIAL SECURITY NO. _____

ADDRESS _____ (STREET / CITY / STATE / ZIP)

BIRTHDATE_____ AGE _____ SEX _____ HEIGHT _____ ft._____ in. WEIGHT _____lbs. GROSS ANNUAL SALARY_____

1. Duties: _____ Are you actively performing the full-time duties of your occupation? ..... ☐ Yes ☐ No
2. Have you ever been advised that you've had: brain disorder, stroke, heart or circulatory disorder, pulmonary or lung disorder, internal cancer or malignancy (other than basal or squamous cell skin cancer), leukemia, diabetes, bladder or kidney disease, liver disease, or arthritis? ..... ☐ Yes ☐ No
3. During the past five years, have you had any condition requiring surgery, or the use of medication other than for flu or cold? ..... ☐ Yes ☐ No
4. During the past five years, have you had any condition requiring diet, physical therapy, chiropractic therapy, braces, crutches, or other corrective devices? ..... ☐ Yes ☐ No
5. During the past five years, have you been treated for any physical or mental condition, including anxiety, depression or excessive use of alcohol or drugs? ..... ☐ Yes ☐ No
6. (Females only) Have you ever been diagnosed with, treated for or taken medication for: reproductive organ disease or disorder, C-Section, pregnancy complications, or are you currently pregnant? ..... ☐ Yes ☐ No
7. If the answer to any question 2 thru 7 is "yes" please provide the information below. If needed, use a signed and dated separate sheet

DIAGNOSIS/MEDICATION	DATE	DURATION	DEGREE OF RECOVERY	NAME & ADDRESS OF DOCTOR / HOSPITAL

8. Do you carry any other individual or group disability insurance? ☐ Yes ☐ No If yes, will this policy replace any existing disability insurance? ☐ Yes ☐ No
   Company _____ Amount _____
9. Do you understand and agree that the monthly benefit herein applied for, together with all other individual and/or group disability income policies you have or are applying for, cannot exceed 60% of your wage or salary? ☐ I agree
10. Do you understand and agree that the insurance shall not become effective unless you are actively at work at your regular place of employment on the date it would otherwise become effective? ☐ I agree. Do you understand and agree that no indemnity for loss of time is payable during the elimination period applicable to the plan you select? ☐ I agree.

I understand that by applying for this group insurance that I am becoming a member of the Combined Association & Organization Group Insurance Trust. I understand that the insurance applied for shall become effective on the date specified by the Company only if this application is accepted by the Company and the first premium is paid prior to the death of any proposed insured. I represent that all statements and answers recorded on this application are true and complete as of the date I signed this application and made to obtain the insurance applied for. I understand any misstatements or omissions may be used as a basis for rescinding my coverage. This means all claims will be denied and the Company's liability will be limited to full refund of premium less any claims previously paid. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. I have received and read a copy of the Pre-Notice which describes how information is obtained and used by the Company. I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically-related facility, insurance company, its authorized representatives, Pharmacy Benefit Manager, MIB, LLC (MIB), IntelliScript or other organization or institution that has any records or knowledge of me or my physical or mental health, including significant history, findings, diagnoses and treatment or nonmedical information, such as driving records, any criminal activity or associations, hazardous sport or aviation activity, use of alcohol or drugs, and other applications of insurance, to give to the Company, its plan administrators, business associates, or its reinsurers, any such information for use to: 1) underwrite my applications for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. The Company or its authorized representatives may release to its plan administrators, business associates, other insurance companies, MIB, or others whom I authorize in writing, information covered by this authorization. I authorize the Company or its reinsurers to make a brief report of my personal health information to MIB. A photographic copy of this authorzation shall be as valid as the original. I agree this authorization shall be valid for 30 months from the date shown below. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to Fidelity Security Life Insurance Company® at P.O. Box 418131, Kansas City, MO 64111-8131, Attention: Privacy Officer. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand I will receive a signed copy of this authorization. For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

_____

DATE SIGNATURE OF APPLICANT PHONE # EMAIL

A-00999CA(01/23) Policy Form No. M-4018

Payroll Deduction Authorization: I hereby authorize the Payroll Department to deduct from my salary such amount for insurance premiums as may now or here after be payable by me, and transmit the deduction to UTLA. I further understand and agree that the Los Angeles City Board of Education or its representative acting under this authori za tion shall not be liable in any manner for failure or delay on its (his) part in making the deduction or payment herein authorized. This authorization shall remain in force until cancelled by written notice from UTLA or myself.

Date _____ Employee No. _____ Employee Signature _____

Agent's Signature (if present) _____ Date _____

Click to submit by Outlook Email - If you use an online email provider (Gmail, Yahoo, Hotmail, etc.) See page 1 for instructions

Click here to print, sign & mail to address on page 1