Pacific Educators
Insurance Services

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

- **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.

PACIFIC EDUCATORS INC
PO BOX 1526
ORANGE CA 92856-9975

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 335 ORANGE CA

POSTAGE WILL BE PAID BY ADDRESSEE

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

UTLA SPONSORED

TERM LIFE INSURANCE BENEFITS TO $170,000.00

Policyholder:

Organizations and Associations Group Insurance Trust

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. ML-00031-I
®365
Policy No. FL-145
(03/2023)

UTLA SPONSORED

PROTECT YOUR LOVED ONES

AFFORDABLE GROUP
TERM LIFE INSURANCE PLAN

PROTECT YOUR FUTURE

UTLAFL145-032023

PROTECTION - IT'S WHAT LIFE INSURANCE IS ALL ABOUT

DON'T GAMBLE WITH YOUR FAMILY'S FUTURE.

Life insurance is the real answer to help safeguard financial security… think about it a minute. Suppose the worst happened … what if your family lost you tomorrow or next month – or even two years from now? Someday your family's future may depend on the benefits your life insurance provides. Will there be enough? Estimate how much money you spend each month. Be sure to include your mortgage or rent payments, car loan, medical expenses, utility bills, charge accounts and grocery bills. Add in the amount you save each month for future plans such as vacations and a good college education for your children. Now, divide the amount of your present life insurance by your monthly expenditure.

How many months would your family last on your current life insurance… very few I'll bet. More life insurance is a good solution to help safeguard their financial security. Get it the economical way through UTLA's Approved Plan.

Today, you and/or your spouse have the opportunity to purchase life insurance coverage under the UTLA Term Life Insurance Plan. Coverage is available for each of your eligible children.

With affordable premium rates, this coverage is too valuable to pass up! Important details are outlined in this brochure. Please take a few minutes to read about the special features this plan has to offer you and your family. Then complete the application attached and return in to the Insurance Administrator.

TAKE ADVANTAGE OF THIS VALUABLE OPPORTUNITY RIGHT NOW!

UTLA Associated Group Term Life Plan up to $170,000.00 of valuable protection.

plus...a lifetime benefit after age 70 without further cost to you

CONTINUATION OF COVERAGE

You may keep your coverage as long as you remain a UTLA member, pay your premiums and the Group Master Policy remains in force. At age 70, your coverage reduces to $500 for each unit of coverage with no further premiums due.

Spouse coverage terminates when member reaches age 70 or spouse's age 70, whichever occurs first; or when your spouse ceases to be a dependent spouse.

Child coverage terminates when he or she ceases to be an eligible dependent; reaches age 26; when the member's coverage terminates; or when the policy terminates.

FEATURES

GUARANTEED ISSUE BENEFIT FOR NEW EMPLOYEES!

For 120 days following initial date of active employment, new employees are guaranteed one unit of coverage without evidence of insurability. You must be actively at work on the effective date of your coverage and standard eligibility and policy provisions apply. That means you do not have to answer health question nos. 1, 2 & 3 on the application. However, if you are applying for more than one unit of coverage for you, or dependent coverage, or have been actively employed for more than 120 days, please complete the entire application.

EFFECTIVE DATE

Coverage will go into effect after the first payroll deduction is made following approval by the Company.

BENEFICIARY DESIGNATION

You designate your beneficiary. You may change beneficiaries at any time by giving written notice to the Insurance Company. You will be the beneficiary of your spouse's or children's insurance unless you designate otherwise.

LIMITATION

If an Insured commits suicide while sane or insane within one year from the effective date, the Company's obligation will be only to return the premiums paid.

More details

AFFORDABLE PREMIUMS

HELPING YOU SAVE WHILE PROTECTING THE ONES YOU LOVE

RATE SCHEDULE

Member or Spouse

Member's Age*	One Unit Life Insurance	Monthly Premium
Under Age 30	$17,000.00	$1.67
30-39	$14,000.00	$2.17
40-49	$10,000.00	$3.13
50-59	$10,000.00	$7.00
60-69**	$5,000.00	$8.00
70 & over **	$500.00	$0

Premiums shown above are for one unit of coverage for Member or spouse. Spouse's premium is based on Member's age when both are insured. Spouse's premium will be based on his/her individual age when the Member cannot be insured. Maximum of 10 units each.

For more units, just multiply the premium amount by the number of units you have selected.

* All Premiums and benefits are applicable at Member's age when insurance becomes effective and at his/her attained age on renewal anniversary due date.
** Rates shown for renewal purposes only.

CHILDREN'S COVERAGE

VERY AFFORDABLE! ONE PREMIUM COVERS ALL YOUR CHILDREN, NO MATTER HOW MANY.

Only $1.00 Monthly PER UNIT
Age 14 days to 6 months $500.00
Age 6 months to 26 years . . . . . .1 unit $2,500.00 each child

All unmarried dependent children 6 months to age 26 may be covered...up to a maximum of 4 units each.

QUESTIONS & ANSWERS

Q: WHO MAY APPLY?

A: All actively employed members and his or her spouse under age 60 and their dependent children 14 days to 26 years.

Q: WHY IS TERM INSURANCE A GOOD VALUE FOR ME?

A: Term insurance is "pure protection". Your premium provides life insurance at an affordable cost since none of your premium goes toward building cash values.

Q: WHAT HAPPENS IF I QUIT TEACHING, MAY I CONTINUE MY COVERAGE?

A: Yes! You may convert your UTLA Approved Group Term Life Plan to an individual policy of permanent insurance then being offered for conversion.

Coverage will continue as long as the group policy remains in force, you pay your premiums, and you remain a member of the policy holder.

If an insured commits suicide, while sane, or insane within one year from his or her effective date, the insurance company's only obligation will be to return the premiums paid.

PRE-NOTICE

Although your application is our main source of information, we at Fidelity Security Life Insurance Company(R) (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 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 decision 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. Upon request, 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

QUESTIONS? Call 1-800-722-3365
COMPLETE APPLICATION & MAIL
Postage is Paid!

APPLICATION TO FIDELITY SECURITY LIFE INSURANCE COMPANY® • Home Office: Kansas City, Missouri 64111

Policy No. FL-145
075-4521

Monthly Premium Amounts: Member $ _____ Spouse $ _____ Children $ _____

Please Print or Type in Black Ink

1. Full Name _____ _____
first middle last employee #

2. Residence Address _____ _____
no. & street city state zip home phone

3. Full Name of Beneficiary _____ Address _____
Phone # _____ Date of Birth _____ SS# _____ Relationship _____

4. I hereby apply for: Member (Maximum 10 units) # _____ units Original Date Employed _____
Spouse (Maximum 10 units # _____ units Business Phone _____
My Children (Maximum 4 units) # _____ units Home E-mail Address _____

5. Member's Place of Birth _____ Occupation _____
Member's Birth Date _____ Age _____ Sex _____ Ht. _____ Wt. _____ Soc. Sec. # _____

6. Are you actively employed as of this date? ..... Yes ☐ No ☐
7. Check box if you wish to cover eligible dependents: if yes, list names, birth dates below ..... Yes ☐ No ☐

RELATIONSHIP	NAME	BIRTH DATE	AGE	SEX	HT.	WT.
Spouse						
Child						
Child						

Spouse's Place of Birth _____ Occupation _____ Spouse's Soc. Sec. # _____

1. Have you or any dependent ever had or been advised that you had a brain disorder, nervous or mental disorder, heart or circulatory disorder, respiratory or lung disorder, cancer, leukemia or diabetes? ..... Yes ☐ No ☐
2. Has any person to be covered been diagnosed by or received treatment from a licensed physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ..... Yes ☐ No ☐
3. During the past five years, have you or any dependents had any medical, surgical or psychiatric advice or treatment, or have you had any condition requiring the use of medication, diet or physical therapy? ..... Yes ☐ No ☐
4. Do you or any dependent have any impairments, deformity, disease or limitation of physical activity other than stated above? ..... Yes ☐ No ☐

If "Yes" to any part of Questions 1, 2, 3 or 4 give details below

Name of Person	Condition & Treatment	Date — Duration	Degree of Recovery	Name of Doctor and/or Hospital

Information in this application is given to obtain insurance, and the statements and answers are represented, to be true and accur ate as of the date I signed this application. I understand the following: (a) any false statement or material misrepresentation in the application may result in claim denial or rescission of coverage, and that if c overage is rescinded the company's only obligation for that person will be to refund all premiums paid; (b) if the application is declined and coverage not issued, Fidelity Security Life Insurance Comapny's (FSL) only obligation will be to return any premium paid. I understand that the insurance applied for will not become effective unless and until the first premium has been paid during the lifetime of the insured and; or its reinsurers unconditionally approves and accepts this application.

I have received and read a copy of the Pre-Notice which describes how information is obtained and used by Fidelity Security Life Insurance Company (FSL). I authorize any licensed physician, medical practitioner, hospital, clinic, or 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 dependents' physical or mental health, including significant history, findings, diagnoses and treatment or nonmedical information, such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications of insurance, to give to FSL, 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 FSL. FSL 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 FSL or its reinsurers to make a brief report of my personal health information to MIB. A photographic copy of this authorization 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 64141-8131, Attention: Privacy Officer. I understand that any information that is disclosed puruant 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, FSL 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 copy of this authorization. California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signed this _____ day of _____, Year _____

_____ _____ _____
Signature of Proposed Insured Signature of Spouse if applying for coverage Signature of Child over Age 21 if applying for coverage

A-00684A (01/23) Policy Form No. ML-00031-1

TO: LOS ANGELES CITY BOARD OF EDUCATION

I hereby authorize the Payroll Department to deduct from my salary such amount for insurance premiums as may now or hereafter 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 authorization 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.

_____
EMPLOYEE SIGNATURE

APPROVED BY UTLA

Employee No. _____ Date _____ Effective Date _____

Rev. 01/23

This salary deduction authorization must be received by the Deduction Control Unit of the Payroll Branch by the first Thursday after your regular payday (not ESA payday) in order to be effective for your next regular payday.