



TO: All Benefit Eligible Employees

FROM: Joan Courtney Murray

DATE: April 7, 2021

RE: Long Term Disability Program – Special Open Enrollment

The Town of Westwood is pleased to announce a *special one-time open enrollment period* for our group Long Term Disability program with Lincoln Financial Group for any benefit eligible employees who are not enrolled in the program. This open enrollment will run from **April 7th through Wednesday, May 5th**, with an effective date of the coverage of July 1st. Our Long Term Disability program is designed to pay monetary benefits (60% of your salary tax free) for extended periods of time (to age 65 or beyond) when an injury or illness prevents you from earning an income. In essence, it is income replacement insurance.

Employees that sign up for the program during this open enrollment period may do so on a guaranteed issue basis. This open enrollment period is very important as employees can enroll in the program *without* having to complete a medical evidence of insurability questionnaire. If you decide against electing coverage in this one time offering and wish to sign up later, you are not guaranteed coverage in the plan. All employees that enroll will be subject to our plan's pre-existing condition clause highlighted in the enclosed informational handout. We encourage all employees not currently enrolled in the program to consider taking advantage of this benefit.

Please note that any Town or School employee currently enrolled in the LTD program does not have to complete new paperwork and does not have to take any action at all.

If you have any questions about our LTD plan, please feel free to contact our consultant at Mosse & Mosse, Brian Fitzgerald, at 781-224-1709 x139 or brf@mosseservices.com. He will be happy to go over the program with you in more detail and answer any questions you may have.

Forms should be returned to Kristina LaFrance in Human Resources by Wednesday, May 5th at the latest. Forms may be mailed, emailed to benefits@townhall.westwood.ma.us and klafrance@townhall.westwood.ma.us or faxed to 781-320-1067.

Westwood Public Schools / Town of Westwood
Long Term Disability Program Outline – SPECIAL OPEN ENROLLMENT

- **Guaranteed Issue.** The benefit is a guaranteed issue product, meaning if you sign up during this one time open enrollment, you cannot be denied access to the plan for any reason. However, if you do not elect the coverage during this open enrollment and then wish to join the plan at a later date, you have to prove evidence of insurability and you may be denied access to the plan. All new enrollees must be actively at work on their effective date and are subject to our plan's pre-existing condition clause outlined below.
- **Benefit: 60% of gross pay to a maximum of \$8,500 per month.** All benefits will be paid income tax free, both federal and state, because the employees are paying the premium with post tax payroll deductions.
- **Elimination Period: 90 Calendar days.** This is the length of time that one has to be out of work due to a disability prior to benefits being eligible.
- **Benefit Duration:** benefits payable for disability to age 65/SSNRA/ADEA (schedules attached).
- **Exclusions:**
 - Intentional self-inflicted injury
 - War, declared or undeclared, or any act of war
 - Committing or attempting to commit an assault, felony or other illegal act
- **Two year limitation** on benefits for:
 - Outpatient drug and alcohol abuse
 - Outpatient mental and nervous disorder
- **Residual/Partial Benefit:** During elimination and benefit period, an employee showing a 20% or greater earnings loss due to disability is benefit eligible. In the elimination period, the days worked on partial basis count towards fulfillment of period. After the elimination period, employee will receive partial benefits not to exceed 100% of pre-disability earnings.
- **Integration/Minimum benefit:** plan offsets with other forms of income including: workers' compensation, social security and retirement awards. Minimum benefit is greater of 10% or \$100 per month.
- **Extended Own Occupation Protection** for all School Employees and Non Fire, Police, DPW, Custodian and Drivers Town Employees; **Two Year Own Occupation** for Fire, Police, DPW, Custodian and Drivers on the Town Side. This is the definition of disability and states when an individual is considered disabled. This definition states that an individual is disabled if he or she is unable to perform one material and substantial duty of his or her own occupation. Two year own occupation protects an employee's own occupation for the first two years of disability.
- **3/12 pre-existing condition clause.** Benefits will not be paid for any disability which begins in the first 12 months of being insured which is due to, or results from, a pre-existing condition. A pre-existing condition is any sickness or injury for which the employee has received treatment, took prescribed drugs or medicines, or consulted a physician during the 3 months prior to the employee's effective date of coverage.

Who should sign up for the long term disability coverage?

All employees not yet at 80% retirement should consider signing up for the coverage. If you are at 80% retirement, or have enough accrued sick leave to get you to 80% retirement if you were to be disabled tomorrow, there is no need for you to sign up for the coverage. All other employees are encouraged to consider the program.

How much does the plan cost?

The single composite rate for our plan is the most competitive in the marketplace for the benefits in our contract. The rate is \$0.47 per \$100 of income and each employee will have the same rate regardless of age or salary. Below are several examples of the costs associated with our plan but the actual cost will be tailored specifically to each employee's individual annual salary.

Annual Salary	Annual Cost	Cost Per Pay Period (based on 26 pays)	Cost Per Pay Period (based on 21 pays)	Annual Salary / 100 x \$0.47 = Annual Premium
\$20,000	\$94.00	\$3.62	\$4.48	
\$30,000	\$141.00	\$5.42	\$6.71	Annual Premium / Pay Periods =
\$40,000	\$188.00	\$7.23	\$8.95	Cost per pay period
\$50,000	\$235.00	\$9.04	\$11.19	
\$60,000	\$282.00	\$10.85	\$13.43	
\$70,000	\$329.00	\$12.65	\$15.67	
\$80,000	\$376.00	\$14.46	\$17.90	
\$90,000	\$423.00	\$16.27	\$20.14	

How do I sign up?

If you wish to take advantage of this coverage, please complete the enrollment form by filling out your name, date of birth, check "yes" under acceptance and sign the bottom of the form. If you do not choose to enter the program, simply check "no" under refusal and sign the bottom of the form. All employees need to complete a form, even if they don't wish to participate in the program.

If you have any questions about our LTD plan, please feel free to contact our consultant, Brian Fitzgerald, directly at **781-224-1709 x139** or email him at brf@mosseservices.com. He will be happy to go over the program with you in more detail and answer any questions you may have.

Forms should be returned to the Kristina LeFrance in the Human Resources Office in Town Hall.
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Maximum Benefit Duration Schedule

Duration of Benefit Schedule - SSNRA

<u>Year of Birth</u>	<u>Normal Retirement Age</u>
Before 1938	Age 65
1938	Age 65 and 2 months
1939	Age 65 and 4 months
1940	Age 65 and 6 months
1941	Age 65 and 8 months
1942	Age 65 and 10 months
1943 through 1954	Age 66
1955	Age 66 and 2 months
1956	Age 66 and 4 months
1957	Age 66 and 6 months
1958	Age 66 and 8 months
1959	Age 66 and 10 months
After 1959	Age 67

Duration of Benefit Schedule – ADEA

<u>Age at Disablement</u>	<u>Duration of Benefit</u>
Age 65 but before 68	24 months of disability
Age 68 but before 70	18 months of disability
Age 70 but before 72	15 months of disability
Age 72 or more	12 months of disability

*Maximum Benefit Period is SSNRA or ADEA whichever is greater



The Lincoln National Life Insurance Company
 P.O. Box 2616, Omaha, NE 68103-2616
 Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: WSTWOOD	GROUP POLICY #: 000010243824	Billing Division or Location:
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A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) Town of Westwood and Westwood Public Schools			County	Employer ZIP	State MA
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		Home Phone ()		Work Phone ()

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly \$ _____	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Class	Effective Date	Type of Coverage	Amount of Coverage	Total Premium
		Voluntary Long Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$	Employee Paid

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

C. Request for Coverages

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company. I hereby enroll for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.

NOT ENROLL myself in the Program. I understand that if I enroll for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOT ENROLL my dependents in the Program. I understand that if I enroll for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTE: A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name: _____ Employee Signature: _____ Date: _____