CORNERSTONE
ASSURANCE GROUP

22333 Classic Court • Lake Barrington, IL 60010
(847) 387-3555 • www.railroaddisability.com

June 10, 2016

CN/WC Union Group Insurance Plan (Engineers, Trainmen and Conductors)
Open Enrollment Ends: July 29th, 2016
New Coverage Effective: August 1st, 2016

Dear Member,

This letter serves to inform you of significant and important changes coming to your union group insurance policy. As you are aware, your policy is with Lincoln Financial Group (LFG) who currently underwrites your union's group insurance plan.

Over the past year many members of the union have benefited from having this coverage. Specifically, **$4,258,415.00** has been paid and reserved to and for members who have needed to file Short Term Disability, Long Term Disability and Life Insurance claims. During that same time all participating members have collectively paid a total of **$417,215.00** in premium to LFG.

While many members have benefited significantly from having this policy in place, changes are required for the overall health of the plan. The policy is renewing on August 1, 2016, and due to the overall claims volume versus the overall premium paid, the insurance company is requiring rates and plan design (coverages) changes to all coverage currently in force. I should mention that after August 1, 2016 there will no longer be different pay classes of insureds as all members will be eligible for the same benefits and rates.

We have explored all insurance avenues and without question the enclosed plan is the best option for coverage moving forward. Many top insurance companies were given the opportunity to compete for your group insurance plan. The new plan design and rates were the best offered to the group. That being said, most members will see benefits decrease and rates increase.

Enclosed you will find specific details about the benefit changes. While there are rate changes the new benefit structure should give you the ability to retain coverage at an affordable premium rate. The following serves to highlight some key changes to the plan designs:

Short Term Disability (**Option A** = $400 per week, **Option B** = 60% of Income):

- This benefit begins on the 15th day of injury and illness with a maximum benefit duration of 50 weeks
- No offset until 80% of pre-disability earnings are attained
- **Option A**
  - $400 per week stackable to 80% of pre-disability earnings
- **Option B**
  - 60% of weekly income stackable to 80% of pre-disability earnings

Note: *The STD renewal plan changes are a significantly better benefit as they allow members to receive up to 80% of their earnings on a tax free basis for up to one year. The expiring policy allowed for up to 100% of earnings for 90 days then the transition to LTD allowed for a max of 60% of earning thereafter.*

Long Term Disability (**Option A** = $2,000, **Option B & C** = 60% of monthly income):

- **Option A**
  - $2,000 per month stackable to 70% of pre-disability earnings
  - Benefit Duration remains the same at 5 years
  - 360 day waiting period (STD now covers entire first year)
- **Option B**
  - 60% of monthly income offset by RRB
  - Benefit Duration is 2 years
  - 360 day waiting period (STD now covers entire first year)

- **Option C**
    - 60% of monthly income offset by RRB
    - Benefit Duration is 5 years
    - 360 day waiting period (STD now covers entire first year)

Life Insurance and AD&D:

- Change from age-banded rates to composite rates
- All members electing life coverage will now pay $0.36 per $1,000 of benefit

While some members may find a need to reduce coverage or pay higher premiums for the same coverage, others will find that their premiums are lower for the same coverage. This is a result of the elimination of age banded life premiums in favor of a flat premium.

As many of you already know, the voluntary insurance options provided by this plan are designed to supplement RRB and your contract benefits. In addition to providing income for injured or sick employees, disability insurance also provides members with the leverage they need when they find themselves being charged for sustaining an injury on the job. Because all of the benefit options provided by this plan are voluntary, members may tailor a plan to their individual needs and independent of other benefits.

Enclosed is your enrollment packet. Please review the packet thoroughly so you are aware of all change as well as benefit options being made available for you and your family. If you have any specific questions, please direct them to me or my office.

Best Regards,

Andrew Haley – President
Cornerstone Assurance Group
(847) 387-3555 Office

Summary of Benefits & Rates

CN/WC

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SHORT TERM DISABILITY (STD) - 24 hour coverage / on and off the job

- Pays on the 15th day of injury and illness
- Pre-existing conditions are covered after 12 months
- Benefits are stackable to 80% of pre-disability pre-tax earnings

Option A

- Pays a flat $400 per week for a maximum of 50 weeks

Option B

- Pays 60% of income per week
- Pays for 50 weeks

OPTION A			OPTION B		
Income	Weekly Max Benefit Amount	Monthly Premium	Income	Weekly Max Benefit Amount	Monthly Premium 50 Week Benefit
Any Income	$400.00	$87.20	$70,000	$807.69	$161.54
			$75,000	$865.38	$173.08
			$80,000	$923.08	$184.62
			$85,000	$980.77	$196.15
			$90,000	$1,038.46	$207.69
			$95,000	$1,096.15	$219.23
			$100,000	$1,153.85	$230.77

LONG TERM DISABILITY (LTD) - 24 hour coverage / on and off the job

- Pays after 12 month waiting period
- Pre-existing conditions are covered after 24 months or 12 months treatment free

Option A

- Pays $2,000 per month for a maximum of 5 years
- Stackable to 70% of pre-disability pre-tax earnings

Option B

- Pays 60% of income per month to a maximum of $5,200
- Pays for 2 years OR
- Pays for 5 years

OPTION A			OPTION B			
Income	Monthly Max Benefit Amount	Monthly Premium	Income	Monthly Max Benefit Amount	Monthly Premium 2 Year Benefit	Monthly Premium 5 Year Benefit
Any Income	$2,000.00	$46.00	$70,000	$3,500.00	$29.05	$40.25
			$75,000	$3,750.00	$31.13	$43.13
			$80,000	$4,000.00	$33.20	$46.00
			$85,000	$4,250.00	$35.28	$48.88
			$90,000	$4,500.00	$37.35	$51.75
			$95,000	$4,750.00	$39.43	$54.63
			$100,000	$5,000.00	$41.50	$57.50

Please See Reverse Side for Life/AD&D Benefits

Summary of Benefits & Rates

CN/WC

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LIFE AND AD&D

- Elect life insurance up to the guaranteed issue amount of $200,000
- Elect spouse coverage up to the guaranteed issue amount of $50,000
- Elect $15,000 of dependent coverage

MEMBER LIFE INSURANCE AND AD&D	
Insurance Amount	Monthly Premium
$10,000	$3.60
$20,000	$7.20
$30,000	$10.80
$40,000	$14.40
$50,000	$18.00
$60,000	$21.60
$70,000	$25.20
$80,000	$28.80
$90,000	$32.40
$100,000	$36.00
$110,000	$39.60
$120,000	$43.20
$130,000	$46.80
$140,000	$50.40
$150,000	$54.00
$160,000	$57.60
$170,000	$61.20
$180,000	$64.80
$190,000	$68.40
$200,000	$72.00

SPOUSE LIFE INSURANCE AND AD&D	
Insurance Amount	Monthly Premium
$5,000	$1.80
$10,000	$3.60
$15,000	$5.40
$20,000	$7.20
$25,000	$9.00
$30,000	$10.80
$35,000	$12.60
$40,000	$14.40
$45,000	$16.20
$50,000	$18.00

DEPENDENT LIFE INSURANCE AND AD&D	
Insurance Amount	Monthly Premium
$15,000	$3.00

Benefits Estimator (based on an income of $100k)

Important: This is for estimating purposes only. This benefits estimator assumes you qualify for benefits and that all of the general information provided applies. **Note:** This is not a guarantee of benefits. Benefits are paid by the provisions of the group policy. Please review the policy as some changes may not be reflected in this estimator.

General Information

Railroad: CN
Union: Other

Contract Benefit Carrier: MetLife
Contract Benefit Amount: $546
Contract Benefit Duration: 52 Weeks

RRB Qualify: Yes
RRB Amount: $300

Short Term Disability

Income: **$100,000**
Offset A&B: **80%**

Max weekly combined benefit A&B: **$1,538**

Weekly Amount: **$546** | **MetLife**

RRB weekly amount: **$300**

This total is the maximum amount of money you are entitled to receive on a weekly basis. If the combined total of all your eligible benefits (Union STD Benefit + Contract Benefit + RRB Benefit) exceeds **80%** of your pre-tax pre-disability income your benefit will be offset. Amounts do not reflect elimination (waiting) periods.

Option	Benefit Type	Offsets	Benefit Max	Benefit if receiving RRB & Contract	Benefit if only receiving contract benefit	Benefit if only receiving RRB	Max Benefit duration
A	Flat Rate	Offsets occur at 80% of Income	**$400**	$400	$400	$400	50 weeks
B	60% of Income	Offsets occur at 80% of Income	**$1,154**	$692	$992	$1,154	50 Weeks

Long Term Disability

Income: **$100,000**
Offset A: **70%**
Offset B: **60%**

Max monthly combined benefit A: **$5,833**
Max monthly combined benefit B: **$5,000**

Monthly Amount: **$0** | **MetLife**

RRB monthly amount*: **$3,080**

***Average disability annuity in 2013**

This total is the maximum amount of money you are entitled to receive on a monthly basis. If the combined total of all your eligible benefits (Union STD Benefit + Contract Benefit + RRB Benefit) exceeds 7**0% or 60%** of your pre-tax pre-disability income your benefit will be offset. Amounts do not reflect elimination (waiting) periods.

Option	Benefit Type	Offsets	Benefit Max	Benefit if receiving RRB	Benefit if NOT receiving RRB	Max Benefit duration
A	Flat Rate	Offsets occur at 70% of Income	**$2,000**	$2,000	$2,000	5 years
B	60% of Income	Offsets occur at 60% of Income	**$5,000**	$1,920	$5,000	2 years
C	60% of Income	Offsets occur at 60% of Income	**$5,000**	$1,920	$5,000	5 years

Member Voluntary Benefits Enrollment Form

Please sign, date and return this form to: **22333 Classic Court • Lake Barrington, IL 60010 Fax: 815-425-5349**

Please print clearly and mark carefully.

EMPLOYER NAME: CN/WC		Benefits Effective: 8/1/16
PLEASE CHECK THE APPROPRIATE BOX ☐ Initial Enrollment ☐ Re-Enrollment ☐ Add Member/Dependents ☐ Information Change ☐ Increase Amount ☐ Family Status Change ☐ Drop/Refuse Coverage		Group Plan Number:
Class: All Eligible Members	Division:	

ABOUT YOU

First Name, MI, Last Name:		
Home Address:		
City, State:		Zip Code:
Gender: ☐ Male ☐ Female	Date of Birth (mm-dd-yy):	Social Security Number:
Are you married or do you have a spouse? ☐ Yes ☐ No	Home Phone:	Mobile Phone:
Date of marriage/union:	Email Address:	

ABOUT YOUR JOB

Job Title:		Hours worked per week:
Date of full-time hire (mm-dd-yy):	Work Status: ☐ Active ☐ Retired ☐ On Disability	Annual Salary:

ABOUT YOUR FAMILY

Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exception. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (First, MI, Last Name)		Gender: ☐ M ☐ F	Date of birth (mm-dd-yy):	Status (check all that apply): ☐ Student (post high school) ☐ Disabled ☐ Non-standard dependent
Child/Dependent 1:	☐ Add ☐ Drop	Gender: ☐ M ☐ F	Date of birth (mm-dd-yy):	Status (check all that apply): ☐ Student (post high school) ☐ Disabled ☐ Non-standard dependent
Child/Dependent 2:	☐ Add ☐ Drop	Gender: ☐ M ☐ F	Date of birth (mm-dd-yy):	Status (check all that apply): ☐ Student (post high school) ☐ Disabled ☐ Non-standard dependent
Child/Dependent 3:	☐ Add ☐ Drop	Gender: ☐ M ☐ F	Date of birth (mm-dd-yy):	Status (check all that apply): ☐ Student (post high school) ☐ Disabled ☐ Non-standard dependent
Child/Dependent 4:	☐ Add ☐ Drop	Gender: ☐ M ☐ F	Date of birth (mm-dd-yy):	Status (check all that apply): ☐ Student (post high school) ☐ Disabled ☐ Non-standard dependent

If you have questions, please call the Enrollment Office at (847) 387-3555

Make Your Insurance Elections – If you have questions, please call the Enrollment Office at (847) 387-3555

SHORT TERM DISABILITY (STD) OPTIONS - All benefits are non-taxable (covers on and off the job)

Voluntary Short Term Disability (STD) Coverage:

- This benefit begins on the 15th day of injury and illness with a maximum benefit duration of 50 weeks.
- Pre-existing conditions are covered for the full benefit duration after 12 months of continuous coverage.
- This benefit will offset once 80% of your pre-disability earnings are attained.

Select a weekly Short Term Disability (STD) benefit:

Option A ☐ I elect Option A. **Pays a flat $400 per week.** **Monthly premium: $87.20**

Option B ☐ I elect Option B. **Pays 60% of weekly income per week for 50 weeks.** **Monthly premium:** ____________

Decline ☐ I decline to purchase Short Term Disability (STD).

LONG TERM DISABILITY (LTD) OPTIONS - All benefits are non-taxable (covers on and off the job)

Voluntary Long Term Disability (LTD) Coverage:

- This benefit starts paying after an elimination period of 360 days.
- Pre-existing conditions are covered after 24 months of continuous coverage or 12 months treatment free.
- Long Term Disability (LTD) Option B and C are offset (reduced) by Railroad Retirement Board benefits and contract benefits.

Select a monthly Long Term Disability (LTD) benefit:

Please refer to the enclosed Rate Sheet for Monthly Premium Cost.

Option A ☐ I elect Option A. **Pays a flat $2,000 per month for 5 years - stackable to 70% of your pre-disability earnings**. **Monthly premium: $46.00**

Option B ☐ I elect Option B. **Pays 60% of monthly income per month for 2 years to a maximum of $5,200 per month - offset by RRB.** **Monthly premium:** ____________

Option C ☐ I elect Option C. **Pays 60% of monthly income per month for 5 years to a maximum of $5,200 per month - offset by RRB.** **Monthly premium:** ____________

Decline ☐ I decline to purchase Long Term Disability (LTD).

LIFE INSURANCE AND AD&D OPTIONS - All benefits are non-taxable (covers on and off the job)

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D):

Please refer to the enclosed Rate Sheet for Monthly Premium Cost.

Select your Life and AD&D coverage:

Member

- Guarantee Issue amount is **$200,000**.

☐ I elect $______________________ of Voluntary Life and AD&D coverage at a monthly cost of $_________________.

☐ I decline this coverage.

Spouse

- Spouse Guarantee Issue amount is **$50,000**.
- The amount may not be more than 50% of the Member amount for Voluntary Life.

☐ I elect $______________________ of Spousal Voluntary Life and AD&D coverage at a monthly cost of $_________________.

☐ I decline this coverage.

Dependent/Child(ren)

- **$15,000** is guaranteed issue and covers all children.

☐ I elect **$15,000** of Child Life coverage at a monthly cost of **$3.00**. (all children covered for **$3.00**)

☐ I decline this coverage.

Important Notes:
Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Voluntary Life.

If you have questions, please call the Enrollment Services at (847) 387-3555

LIFE INSURANCE BENEFICIARY DESIGNATION

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by these plans.

PRIMARY BENEFICIARY

Primary Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Primary Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Primary Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Primary Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:

CONTINGENT BENEFICIARY

In the event the designated beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains the beneficiary information.

Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:

- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I understand that my dependent(s) cannot be enrolled for a coverage, if I am not enrolled for that coverage.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of insurability. The carrier has the right to reject your request.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- Plan design limitations and exclusions may apply. Coverage changes may take effect after enrollment. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- Your coverage will not be effective until approved by the insurance company or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I acknowledge and consent to receiving electronic copies of coverage related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I certify that I, as the Applicant, have read the completed application and understand that any false statement or misrepresentation in this application may result in the loss of coverage under this policy.
- I attest that the information provided above is true and correct to the best of my knowledge.
- **I understand that rates and benefits may change at or before renewal.**

Any person who with intent to defraud or knowing that he/she 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.
The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page. The laws of New York require the following statement appear:

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF MEMBER X ______________________________ **DATE** ______________

Additional Information (if applicable)

SPECIAL REQUEST

ADDITIONAL DEPENDENTS

Child/Dependent	Add/Drop	Gender	Date of birth (mm-dd-yy)	Status (check all that apply)
Child/Dependent 1:	☐ Add ☐ Drop	Gender: ☐ M ☐ F	Date of birth (mm-dd-yy):	Status (check all that apply): ☐ Student (post high school) ☐ Disabled ☐ Non-standard dependent
Child/Dependent 2:	☐ Add ☐ Drop	Gender: ☐ M ☐ F	Date of birth (mm-dd-yy):	Status (check all that apply): ☐ Student (post high school) ☐ Disabled ☐ Non-standard dependent
Child/Dependent 3:	☐ Add ☐ Drop	Gender: ☐ M ☐ F	Date of birth (mm-dd-yy):	Status (check all that apply): ☐ Student (post high school) ☐ Disabled ☐ Non-standard dependent
Child/Dependent 4:	☐ Add ☐ Drop	Gender: ☐ M ☐ F	Date of birth (mm-dd-yy):	Status (check all that apply): ☐ Student (post high school) ☐ Disabled ☐ Non-standard dependent

ADDITIONAL LIFE INSURANCE BENEFICIARY DESIGNATION

Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:

COMMUNICATION

Please deliver all policy information and correspondence by:

☐ Email

☐ U.S. Postal Service Mail

Enrollment Office
22333 Classic Court
Lake Barrington, IL 60010
PHONE (847) 387-3555
FAX (815) 425-5349
www.railroaddisability.com

PAYMENT AUTHORIZATION FORM

ES23069 - CN/WC

CUSTOMER # (FOR OFFICE USE ONLY)	DATE:

Effective Date of Authorization: ______ / ______ / ______

Type of Authorization Form:
- ☐ New authorization
- ☐ Change banking information
- ☐ Change payment date
- ☐ Change payment amount
- ☐ Discontinue electronic payment

COMPLETE BELOW

First Name, MI, Last Name:

Address:

City, State:	Zip Code:

Email Address:

MONTHLY PAYMENT

☐ I elect to split my premium into 2 equal payments per month.

Payment Day 1: _________ Payment Day 2: _________ Date of 1st Payment: 8 / ____ / 16

Payment dates will be the 10th & 20th if no payment days are selected.

☐ I elect to pay my premium once per month.

Payment Day: _________ Date of 1st Payment: 8 / ____ / 16

Payment day will be the 15th if no payment day is selected.

STD Premium	$
LTD Premium	$
Life and AD&D Premium	$
Service Fee	$1.00
Total Monthly Payment	$

CHECKING/SAVINGS

Please debit payments from my (check one):

☐ **Checking Account** (attach a voided check below)

☐ **Savings Account** (contact your financial institution for Routing #)

Routing Number: ______________________________

Account Number: ______________________________

⑆123456789⑆ 123 123456⑈ 0001

Routing Number / Account Number / Check Number

Valid Routing # must start with 0, 1, 2, or 3

I authorize the above organization to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.

Signature:______________________________ **Date:**____________________

If using a checking account, please attach a voided check below.

Please attach voided check here.

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Important Notice for Currently Participating Members

If you are currently participating in the group insurance plan, then you will automatically be enrolled in the benefit options that most closely mirror your current elections. Your previously completed enrollment forms will be accepted by the current insurer and your monthly premium will be adjusted accordingly.

New coverage to include premium changes will be effective starting 08/01/2016.

You may also complete new enrollment forms whereby you can add, change or delete coverage during this open-enrollment period which ends on **07/29/2016**.

You may also terminate all your coverages by returning this form. Simply initial and sign below and return in the enclosed postage paid envelope.

OPT OUT FORM

Initial

[ ]

I wish to terminate all coverage.

I understand that after **08/01/2016** any and all coverage will cease, to include my monthly premium payments.

____ **XXX-XX-** ____________________

First Name **Last Name** **Last Four Digits of Social Security #**

(Please note this is required for verification.)

______________________________ ____________________

Signature **Date**