- 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

## GROUP TERM LIFE INSURANCE PLAN

Policyholder:
United Associations of America
Group Insurance Trust

Underwritten by:
**Fidelity Security Life Insurance Company**
Kansas City, MO 64111

This brochure explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this brochure and the policy, the terms of the policy apply. All benefits are subject to the terms and conditions of the policy. Policies underwritten by Fidelity Security Life Insurance Company detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in full or discontinued. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy issued to the policyholder. Not available in all states. Some benefits, exclusions or limitations may vary by state.

**Policy No. TL-141; Policy Form No. M-1006**

Administered by:

Pacific Educators is the Plan Administrator and Insurance broker that administers the insurance plan on behalf of Fidelity Security Life Insurance Company. Pacific Educators is compensated for the placement of insurance and for the services it provides to customers on behalf of the insurance company, in addition to other compensation it may receive.

2808 E. Katella Ave., Suite 101 • Orange, CA 92867

**(800) 722-3365 • (714) 639-0962**

www.PEinsurance.com Lic.#0429928

PE-Group-1 (10/15)

# GROUP TERM LIFE INSURANCE PLAN

**FAMILY PROTECTION**

**AVAILABLE ONLY TO SCHOOL PERSONNEL AND THEIR FAMILIES**

- With Premiums starting at **$4.50 Per Month**
- **NEW PLAN** With Coverage up to **$402,000.00**

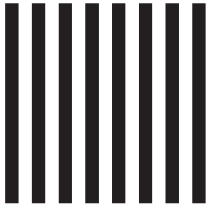
**BUSINESS REPLY MAIL**

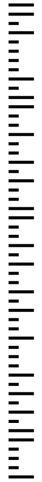
FIRST CLASS MAIL PERMIT NO. 335 ORANGE, CA

POSTAGE WILL BE PAID BY ADDRESSEE

**PACIFIC EDUCATORS INC**
POST OFFICE BOX 1526
ORANGE CA 92856-9975

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES





# PROTECTION

## Help to Ensure Your Family's Future

### If something happened to you, would your family be financially secure?

### Term Life insurance can help give your family the protection they need … and deserve.

But how much life insurance is enough? To find out, begin by estimating your monthly expenses. Include mortgage or rent payments, car loan, medical expenses, utility bills, charge account bills and grocery bills — and don't forget the amount you save regularly for vacations and the children's college education. Then divide the amount of your present life insurance by your monthly expenditure. Please consult a professional financial advisor, as individual needs may vary.

You may find that your present life insurance would not cover all of these expenses. Three in ten American households (35 million) are uninsured and half say they need more life insurance.*

Now, there's an insurance plan that helps give you the protection you may need at a price that's more affordable: the Life/ Accidental Death and Dismemberment insurance plan. It's an economical combination of coverage that helps give you extra protection. Best of all, its reasonable rates can work for most budgets!

This plan lets you buy what you may need. Term life insurance with accidental death and dismemberment coverage built in to help strengthen your overall insurance protection. And with six coverage amounts to choose from,there's sure to be one that helps fit your needs — and your pocket book!

### Eligibility

All active employees/members who are Actively-at-Work Members of California School Districts Teachers, School Staff, District Staff; and their legal spouse and dependent children are eligible to apply. **Your spouse may be insured for the same plan as you.** For an additional cost, you can provide additional spouse and children coverage by selecting the dependent plan: $5,000 for your spouse under age 70 and each of your dependent, unmarried children age 6 months to 23 years ($500 for those age 15 days to 6 months).

### Eligibility Restrictions:

When a husband and wife are both insured:

a) coverage may not be duplicated by applying as dependents of each other; and
b) coverage for Dependent Child may be requested by either the wife or the husband, but not both.

No Dependent Child will be covered unless either the Insured or Spouse is covered.

# FEATURES

## Of Our Life Insurance Program

### Six plans to choose from

The plan amounts you may select are determined by your age. Select your own plan of coverage beginning at $402,000, $281,400, $201,000, $120,600, $80,400 or $40,200 under age 25, and decreasing as you get older, according to the Benefit Schedule.

### Accidental Death and Dismemberment coverage

The program provides an additional amount of insurance for accidental losses listed in the policy. The amount of Accidental Death and Dismemberment coverage you may receive is based on your age, the plan you select, and the type and/or severity or your loss. Check the benefit schedule for exact amounts. Accidental losses must occur within 365 days of the covered accident to be eligible for benefits. Accidental Death and Dismemberment Benefits are not payable for dependents of active members or retired member's coverage.

*Facts from LIMRA, Facts Of Life 2012

### Terminations

Your coverage remains in effect as long as you pay the required premiums, and the group master policy remains in force. Spouse and family coverage ends when yours does, unless your spouse is no longer married to you and your dependent children no longer meet the eligibility requirements, or the date the Insured Person's plan of benefits or class is terminated, or the death of the Insured.

### Premiums

Premiums are subject to change on a class wide basis.

### Reductions

Benefits reduce as you enter new age category.

### Affordable Group Rates

Premiums for this important program are economical because of the mass purchasing power of your group and the savings of standardized administration.

### Definitions

**Loss means:** for a hand or foot, total, complete and permanent severance of all four fingers or entire hand above the wrist joint or the entire foot at or above the ankle joint; for thumb and index finger through or above the metacarpophalangeal joints; for loss of use, movement or total feeling in the arm including the hand, or in the leg, including the foot, and the loss is determined by a physician to be total and irrecoverable; for an eye, total and irrecoverable loss of sight; for speech and/or hearing total and irrecoverable loss of speech and/or hearing; for death, the direct result of a covered accidental bodily injury.

**Injury** means bodily Injury caused by an accident. The accident must happen while the Insured Person is covered by the Policy and must be the direct cause of loss, independent of sickness or other causes. All injuries to an Insured Person in a single accident are treated as one Injury.

### Suicide Limitation

Death by suicide, while sane or insane is not covered for 24 months from the Insured's effective date. In such event the Company will only refund the premiums paid.

This provision will also apply if the Insured Person commits suicide during the two years immediately following an increase in coverage under the Policy. In that event, the amount of insurance payable will equal the amount of insurance inforce prior to the increase, plus an amount equal to the premium paid for the increase to the date of death.

### Exclusions

Accidental Death and Dismemberment benefits are not payable for any loss caused directly by: intentional self-inflicted Injury or suicide while sane or insane; sickness including any medical or surgical treatment of sickness; infections, except pyogenic infection resulting from an accidental bodily Injury or from accidental ingestion of a contaminated substance; participation in a riot or insurrection; active duty as a member of any military, naval or air force; war or any act of war, declared or not; commission or attempted commission of a felony, assault or illegal action; voluntary use of any alcohol, drug or narcotic unless prescribed by a Physician and taken as prescribed; voluntary inhalation of any kind of gas including carbon monoxide; travel or flight in any aircraft except as a fare paying passenger of a commercial airline flying on regularly scheduled routes between definitely established airports; driving a vehicle while legally intoxicated according to the laws of the area where the accident occurred; an on-the-job Injury covered by Workers Compensation.

### Prompt Claim Processing

Benefits are processed promptly upon proof of death, in a lump sum amount.

More details

# BENEFIT SCHEDULE

## Premiums Below Apply to You or Your Spouse

| Premiums Monthly Tenthly | Plan 6 $39.75 each 47.70 each | Plan 5 $27.74 each 33.30 each | Plan 4 $19.49 each 23.40 each | Plan 3 $12.00 each 14.40 each | Plan 2 $8.25 each 9.90 each | Plan 1 $4.50 each 5.40 each | Plus All Plans Included |
|---|---|---|---|---|---|---|---|
| **Your Age[1]** | **Life** | **Life** | **Life** | **Life** | **Life** | **Life** | **AD&D** |
| Under 25 | $402,000.00 | $281,400.00 | $201,000.00 | $120,600.00 | $80,400.00 | $40,200.00 | $40,200.00 |
| 25-29 | 360,000.00 | 252,000.00 | 180,000.00 | 108,000.00 | 72,000.00 | 36,000.00 | 36,000.00 |
| 30-34 | 321,000.00 | 224,700.00 | 160,500.00 | 96,300.00 | 64,200.00 | 32,100.00 | 32,100.00 |
| 35-39 | 279,000.00 | 195,300.00 | 139,500.00 | 83,700.00 | 55,800.00 | 27,900.00 | 27,900.00 |
| 40-44 | 222,000.00 | 155,400.00 | 111,000.00 | 66,600.00 | 44,400.00 | 22,200.00 | 22,200.00 |
| 45-49 | 144,000.00 | 100,800.00 | 72,000.00 | 43,200.00 | 28,800.00 | 14,400.00 | 14,400.00 |
| 50-54 | 129,600.00 | 90,720.00 | 64,800.00 | 38,880.00 | 25,920.00 | 12,960.00 | 12,960.00 |
| 55-59 | 118,800.00 | 83,160.00 | 59,400.00 | 35,640.00 | 23,760.00 | 11,880.00 | 11,880.00 |
| 60-64 | 97,200.00 | 68,040.00 | 48,600.00 | 29,160.00 | 19,440.00 | 9,720.00 | 9,720.00 |
| 65-69 | 63,180.00 | 44,230.00 | 31,590.00 | 18,950.00 | 12,640.00 | 6,320.00 | 6,320.00 |
| 70 & over | 31,590.00 | 22,115.00 | 15,795.00 | 9,475.00 | 6,320.00 | 3,160.00 | 3,160.00 |

Upon retirement, you may continue your coverage under the retired schedule of benefits.

## Optional Family Life Insurance Coverage

Monthly Premium (covers all eligible family members)
**$1.00 monthly** ($1.20 paid tenthly through payroll deductions)

| | Life Insurance Amount |
|---|---|
| Spouse | **$5,000** |
| Dependent Children: | |
| Age 6 months to 23 years | **5,000** |
| Age 15 days to 6 months | **500** |

Family premium covers all eligible dependent children. There is no AD&D benefit for dependent coverage.

## Guarantee Issue Benefit for New Employees

**How to Apply**

If you are a NEW employee, for 120 days following initial date employed, you are guaranteed acceptance under Plan 1 or Plan 2 and optional family coverage for your eligible dependents without evidence of insurability. That means you do not have to answer questions 1, 2 & 3. However, you must be actively employed on the effective date of your coverage. If you are enrolling for more than Plan 1 or Plan 2, or have been employed for more than 120 days, please complete the entire application. Your answers to the general health questions will help determine your insurability, so be sure your answers are correct and complete.

## Retirement Coverage Provision

You must notify the Plan Administrator when you retire. You may continue your coverage under the retirement plan with no evidence of insurability. Your benefits under the retirement plan are based on your attained age and will reduce as you enter a new age category. Accidental Death and Dismemberment benefits are not payable under the retirement plan or for dependents of active members. Please contact your Plan Administrator at 1-800-722-3365 for more information.

Be sure to sign and date the application form, and if you are insuring your spouse, have him or her do the same. Detach, staple, and mail to the administrator. No postage needed. Send no money; premiums will be handled through payroll deductions, if available, or you will be billed later.

You have 30 days to review your coverage after receiving your certificate. Please read it carefully. Make sure it's everything you expected. If you are dissatisfied for any reason, you have a right to send your certificate back to the insurance company, or to Pacific Educators, within 30 days of its receipt and your coverage will be cancelled with no questions asked.

Acceptance into this plan is subject to medical evidence of insurability as determined by Fidelity Security Life Insurance Company. Depending on your age, the amount of coverage you request, and your answers on the application, a medical examination, medical test(s), or other evidence of good health may be required. Any exams/tests requested by the company will be conducted at your convenience and at no expense to you.

### Effective Date

Coverage will become effective the first of the month following approval of your application by the underwriting company and receipt of your first premium payment.

### Personal History Interview

To provide you, our client, with the best possible service, we may also conduct what we call a personal history interview. This is a phone call placed from our underwriting office. Its purpose is to make sure that the application information is complete. Our interviewers are trained to conduct their calls in a friendly, professional manner. The nature of the information discussed is always treated as personal and confidential and will only be used to assess your eligibility for insurance.

### 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, Inc., 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.

FSL 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.

**QUESTIONS? Call 1-800-722-3365**

To Apply, Any Time of Year: Complete Application & Mail
Postage is Paid

**GROUP TERM LIFE INSURANCE APPLICATION FIDELITY SECURITY LIFE INSURANCE COMPANY, KANSAS CITY, MO 64111 (the "Company")** **Policy No. TL-141**

**Proposed Insured Name** ________________________________ ☐Male ☐Female ____/____/____
(First, Middle, Last) Date of Birth

Address ________________________________ Height ______ Weight ______
Street City State Zip Ft. In. lb.

Place of Birth ______________ Occupation ______________
State/Country

**Your Beneficiary**

Name ______________ Relationship ______________ ☐Male ☐Female ____/____/____ Phone # ______________
Date of Birth

Address ________________________________ Social Security Number ______________
Street City State Zip

**Spouse's Name** ________________________________ ☐Male ☐Female ____/____/____
(if applying) (First, Middle, Last) Date of Birth

Place of Birth ______________ Occupation ______________ Height ______ Weight ______
State/Country Ft. In. lb.

| **Please Select Plan:** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Proposed Insured | ☐ Plan 6 | ☐ Plan 5 | ☐ Plan 4 | ☐ Plan 3 | ☐ Plan 2 | ☐ Plan 1 | **SPOUSE & CHILDREN** ☐ $5,000 Dependent Plan |
| | Proposed Spouse | ☐ Plan 6 | ☐ Plan 5 | ☐ Plan 4 | ☐ Plan 3 | ☐ Plan 2 | ☐ Plan 1 | |

**Dependent Coverage.** If applying for Dependent coverage, please complete the following: (Attach sheet of paper if additional space is needed)

| Dependent Full Name | Relationship | Date of Birth |
|---|---|---|
| | | / / |
| | | / / |
| | | / / |

*The Proposed Insured will be the beneficiary for the Dependents.*

**Please answer the following questions for you and your spouse, if applying:**

| Question | Answer |
|---|---|
| 1. In the last 2 years, have you or your Spouse been unable to perform the full-time duties of your occupation for 10 consecutive days? If not employed, have you or your Spouse been unable to carry out the normal and customary duties of a person of like age and sex in good health during the 90-day period immediately preceding the date of this application for 10 consecutive days? | ☐Yes ☐No |
| 2. In the past 10 years, has anyone proposed for coverage been diagnosed or treated by a member of the medical profession for: A. A heart murmur, high blood pressure, stroke, or any disease or disorder of the heart, blood or circulatory systems? | ☐Yes ☐No |
| B. Asthma, shortness of breath, tuberculosis or any disease or disorder of the lungs or respiratory system? | ☐Yes ☐No |
| C. Colitis, ulcer, kidney disease or liver disease or disorder, or any disease of the digestive, urinary or reproductive systems? | ☐Yes ☐No |
| D. Alcoholism, drug abuse, severe headaches, epilepsy, dizziness or any disease or disorder of the brain or nervous system including mental or emotional disorders? | ☐Yes ☐No |
| E. Cancer, tumor, diabetes, blood or sugar in urine, or any disease or disorder of the glands or thyroid? | ☐Yes ☐No |
| F. Arthritis, impaired sight or hearing, or any disease of the skin, bones or joints, including neck or back disorders? | ☐Yes ☐No |
| G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder, excluding HIV tests? | ☐Yes ☐No |
| 3. During the past 5 years has anyone proposed for coverage consulted any physician, surgeon, psychologist, psychiatrist or other practitioner for any reason not previously noted on this application; or have you been confined or treated in any hospital, mental health facility or similar institution? | ☐Yes ☐No |

**If any of the above questions were answered "Yes", please explain and provide the following details** (required for processing): (Attach sheet of paper if additional space is needed)

| Question Number and Condition | Name of Family Member | Dates | Physician's Name, Full Address and Phone Number |
|---|---|---|---|
| | | | |
| | | | |

**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

## AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE INFORMATION

I understand and acknowledge that by applying for this group insurance, I am becoming a member of the United Associations of America Group Insurance Trust. I understand the insurance applied for will 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 are made to obtain the insurance applied for. I understand that any false statement or material misrepresentations in the application may result in claim denial or rescission of coverage, and that if coverage is rescinded, the Company's only obligation will be to refund all premiums paid for that person. 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, other medical or medically-related facility, insurance company, its authorized representatives, Pharmacy Benefit Manager, MIB, Inc. (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 non medical 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 two years 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, 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 signed copy of this authorization.

**The falsity of any statement in this Application will not bar the right to recovery under the Policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the Company.**

Signature ______________ Date ______ Signature ______________ Date ______
(Proposed Insured Sign Name in full) (If applying) (Spouse's Sign Name in full)

A-01192CA M-1006

I hereby authorize my employer to deduct from my salary such amounts as may now or hereafter be payable by me and to pay this amount to The Hartford or its authorized administrator for me. The authorization will continue in effect until my employment is terminated or until I submit timely written notice of cancellation to the Payroll Department.

Date ______ Signature ______________ Social Security Number ______________

Original Date Employed ______ Home Phone ( ) ______ Home Email Address ______________

I am now a regular active employee of the ______________ district Business Phone ( ) ______