

# ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) PLAN



*Available to Members of FALSS*

This is worldwide, 24-hour protection that pays benefits in the event that you suffer an accidental death or dismemberment. This coverage pays in addition to any other insurance. Administrative costs for group coverage are low, so you can save in premium costs and enjoy the benefits of the plan.

## ELIGIBILITY

Members of FALSS, actively at work, and under age 70, are eligible for guaranteed acceptance into the Accidental Death & Dismemberment Insurance (AD&D) plan.

## MONTHLY GROUP RATES

Principal Benefit Amount	Enrollee Only	Enrollee & Family+
\$100,000 (available for limited time)	\$3.90	\$6.50
\$250,000	\$9.75	\$16.25
\$275,000	\$10.72	\$17.88
\$300,000	\$11.70	\$19.50
\$325,000	\$12.68	\$21.13
\$350,000	\$13.65	\$22.75
\$375,000	\$14.63	\$24.38
\$400,000	\$15.60	\$26.00
\$425,000	\$16.58	\$27.63
\$450,000	\$17.55	\$29.25
\$475,000	\$18.53	\$30.88
\$500,000	\$19.50	\$32.50

Rates do not increase with age. Rates shown are guaranteed for initial year of coverage only. The rates in this brochure will not be changed unless they are changed for all insureds in your classification.

+Dependents Coverage - If you choose Enrollee & Family coverage, your dependents coverage is as follows: (I) Spouse Only - Insured at 50% of Enrollee Amount; (II) Children Only - Each child Insured at 15% of Enrollee Amount, not to exceed \$25,000; (III) Spouse & Children - Spouse insured at 40% of Enrollee Amount. Each child insured at 10% of Enrollee Amount, not to exceed \$25,000. Dependent children are eligible to age 19, or to age 25 if a full-time student.

## BENEFITS FOR ACCIDENTS

The FALSS endorsed Group AD&D Plan pays benefits for the following occurrences:

For the loss of:	The benefit will be:
Loss of Life	Full Amount
Loss of both hands, both feet or sight of both eyes	Full Amount
Loss of one hand and one foot	Full Amount
Loss of speech and hearing in both ears	Full Amount
Loss of one hand or one foot and sight of one eye	Full Amount
Loss of one hand or one foot or sight of one eye	50% of Full Amount
Loss of Speech	25% of Full Amount
Loss of hearing in both ears	25% of Full Amount
Loss of thumb and index finger of same hand	25% of Full Amount
Paralysis of one limb	25% of Full Amount
Paralysis of three limbs	75% of Full Amount
Quadriplegia	Full Amount
Paraplegia	50% of Full Amount
Hemiplegia	50% of Full Amount

## EMERGENCY TRAVEL ASSISTANCE BENEFIT

When traveling more than 100 miles from home, ING Travel Assistance offers you and your dependents four types of services: Pre-Trip Information, Emergency Personal Services, Medical Assistance Services, and Emergency Transportation Services. See *Travel Assistance brochure for more details.*

## ADDITIONAL BENEFITS AS PART OF YOUR PROTECTION

### Safe Driver Benefit

Your beneficiary will receive an additional 10% of benefit amount (up to \$25,000) if you have a fatal accident and are wearing a seatbelt at the time.

### Education Benefit

Your children can receive an additional 5% of benefit amount (up to \$5,000) per year for up to four years to continue their education.

### Child Care Benefit

If you have children under 13, they are eligible to receive an additional 3% of benefit (up to \$2,500) annually for up to six years if you die in a covered accident.

### Common Carrier Benefit

An additional 50% of benefit amount (up to \$50,000) additional benefits if loss occurs while traveling as a fare-paying passenger of boarding or debarking a licensed common carrier.

### Training Benefit

Your spouse or domestic partner can receive an additional 5% of benefit amount (up to \$5,000) to attend a professional or trade training program.

### Total and Permanent Disability Benefit

Your FULL BENEFIT amount is payable if you are totally and permanently disabled, as defined in the certificate, as part of a covered accident.

### Exclusions

Reliastar Life does not pay benefits for loss directly or indirectly caused by any of the following: (a) An accident occurring before the Effective Date of the Group Policy; (b) Suicide or intentionally self-inflicted injury, while sane or insane; (c) Physical or mental illness; (d) Bacterial infection or bacterial poisoning. Exception: Infection from a cut or wound caused by an accident; (e) Any armed conflict, whether declared as war or not, involving any country or government; (f) An accident which occurs when the insured person commits or attempts to commit a crime; (g) Use of any drug, narcotic or hallucinogenic agent, unless prescribed by a doctor or taken as directed by a doctor or the manufacturer; (h) The Insured person's intoxication. Intoxication means the individual's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

### Termination

You may maintain your Group Accidental Death and Dismemberment Insurance coverage until age 85, as long as the Master Policy remains in force, you remain a member of FALSS, an employee of an attorney or law firm in Florida, and pay your premium on time. Coverage for your dependents terminates when your coverage ends, you stop paying premiums, or they are no longer eligible due to change in age, dependency or marital status.

### Programs Administrator

For all inquiries, contact the FALSS Member Benefits Insurance & Retirement Programs administrator: BPC Financial, 7645 Gate Parkway, Suite 101, Jacksonville, FL 32256. 1-800-282-8626. [www.MemberBenefits.com/falss](http://www.MemberBenefits.com/falss)

### The Organization Behind The Coverage

Your insurance is provided by ReliaStar Life Insurance Company, rated "A+" (Superior) by A.M. Best, an independent insurance rating agency. This is the second of 15 rating categories ranging from A++ to F for operating performance and financial strength. ReliaStar Life Insurance Company, Minneapolis, MN has Minnesota roots tracing back to 1885. ReliaStar Life is a member of the ING family of companies and is a wholly owned indirect subsidiary of ING Groep N.V., an Amsterdam-based global leader in integrated financial services, providing banking, insurance and asset management businesses in over 50 countries worldwide.



*This document is for summary purposes only. For a complete description of benefits and limitations, please read your Certificate of Insurance. Policy form HP10GPIL. Florida Licensed Agent: Earl C. Trefry, Jr. CLU*

# ENROLLMENT INSTRUCTIONS

## AD&D INSURANCE FOR MEMBERS OF FALSS



### 1. COMPLETE ENROLLMENT FORM

Make sure to complete to complete the form in its entirety. Monthly rates for available options are included in kit. Omissions and illegible print may delay issuance of coverage.

Your coverage will become effective on the 1st of the month following receipt of your Enrollment Form and your initial payment. When you receive your Certificate of Coverage, review it carefully. Be sure you understand all of your rights and benefits under the plan. If you are not completely satisfied, for any reason, you may notify us within 30 days to receive a full refund of any premiums you've paid.

### 2. PAYMENT OPTIONS

#### Payment Option 1 - Monthly Auto Pay

If you elect to pay by Monthly Bank Draft (ACH), you do not need to send any premium. Upon approval of your enrollment form, we will automatically draft your account on a monthly basis. Make sure to complete the Authorization section and include a VOIDED check.

#### Payment Option 2 - Direct Annual Billing

If you elect this method, **please make check or money order written out to BPC Financial**, for the pro-rata premium required to pay your coverage through the end of the plan year (December 31st) plus the one-time \$20.00 non-refundable processing fee\*.

**For example**, if you are applying for a 7/1 desired effective date, you need to submit 6 months premium. You will be invoiced on an annual basis (due Jan. 1st each year) thereafter.

\*The \$20.00 processing fee is required for each primary enrollee that selects the Direct Billing payment method. The processing fee is waived when enrolling with a firm of 5 or more primary enrollees or when selecting Monthly Auto Pay. Contact administrator for Firm list billing options.

### 3. FAX OR MAIL FORMS TO:

You may use this form as a FAX COVER

Fax to: (904) 396-2091

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Attn: Enrollment/Processing

Or Mail to:

Program Administrator

BPC Financial

7645 Gate Parkway, Suite 101

Jacksonville, FL 32256

**ANY QUESTIONS? CALL TOLL-FREE: 1-800-282-8626**

#### **MONEY-BACK GUARANTEE. YOU RISK NOTHING BY APPLYING NOW.**

If you are not completely satisfied when you receive your Certificate of Insurance, just notify us within 30 days and we'll refund any premium you've paid. No insurance will be in force, and you will be under no further obligation.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE  
FOR MEMBERS OF FALSS ENROLLMENT FORM

Mail or Fax to Administrator: BPC Financial  
7645 Gate Parkway, Suite 101, Jacksonville, FL 32256  
Toll Free (800) 282-8626 Fax (904) 396-2091

**1. INDICATE COVERAGE DESIRED**

Desired AD&D Face Amount (\$100,000 - 500,000): \_\_\_\_\_  
Desired Effective Date: \_\_\_\_\_ 0 1 \_\_\_\_\_  
(Month) (Day) (Year)

Plan Type (check one):  Enrollee Only  
 Enrollee & Family

**2. PRIMARY ENROLLEE INFORMATION**

VERY IMPORTANT - PLEASE PRINT LEGIBLY (Please leave one blank box between each word)

Name: \_\_\_\_\_  
(Last, First, Middle)  
Mailing Address: \_\_\_\_\_  
(Street Address)  
\_\_\_\_\_  
(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)  
Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Month) (Day) (Year)  
Email Address: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
FALSS Member #: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Male  
 Female

**3. AUTOMATIC BENEFICIARY DESIGNATION**

Your beneficiary will be your legal spouse or domestic partner, if living. If you have no spouse or domestic partner, your beneficiary will be your children, or your estate, in that order. (You are the beneficiary for insurance on your spouse, domestic partner, and children.) If you wish to make other beneficiary arrangements, please complete below. If space below is not sufficient, please attach separate page.

Enrollee's Beneficiary: \_\_\_\_\_ Relationship to Enrollee: \_\_\_\_\_  
(Last, First, Middle)  
Beneficiary's Address: \_\_\_\_\_

**4. PLEASE INDICATE YOUR PAYMENT METHOD**

**Monthly Auto-Pay.** Include a VOID check and complete the Authorization below.

I hereby authorize BPC Financial to initiate debit entries and to initiate, if necessary, credit entries as adjustments for any debit entries in error to my Checking account and the Financial Institution named below to debit and/or credit the same account. BPC Financial will not be held responsible for a policy lapse or cancellation due to nonpayment if withdrawal is prepared and not honored for any reason and amount due is not paid. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

This authority is to remain in full force and effective until BPC Financial and the Financial Institution have received written notice from me of its termination in such time and manner as to afford BPC Financial and the Financial Institution a reasonable opportunity to act on it.

**X** \_\_\_\_\_  
Accountholder's Signature: Date Signed: Name of Financial Institution:

**Annual Direct Bill.** (If you select this method, you will receive an initial invoice along with your certificate of insurance. After you pay your initial invoice, you will be billed on a calendar quarterly basis)

**5. READ CAREFULLY, THEN SIGN AND DATE**

I wish to enroll in the Member Group AD&D Insurance Plan underwritten by ReliaStar Life Insurance Company. I have read and understand the conditions and exclusions as described in the enclosed brochure. I understand that coverage is effective on the first day of the month after I receive my Certificate of Insurance indicating the effective date of coverage, provided my first premium is paid during the lifetime of the insured. To the best of my knowledge and belief, the information I've provided is complete and correct. I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life and the first premium is paid in my lifetime. I understand my coverage begins on the "effective date" assigned by ReliaStar Life.

**X** \_\_\_\_\_  
Primary Enrollee's Signature: Date Signed: