ARCHDIOCESE OF INDIANAPOLIS
The Church in Central and Southern Indiana

***Office of* Human Resources**
1400 N. Meridian Street, Indianapolis, IN 46202-2367
P.O. Box 1410, Indianapolis IN 46206-1401

Voluntary Insurance – Open Enrollment

- Short-Term Disability
- Supplemental Life Insurance

Our disability and life insurance carrier, OneAmerica, has agreed to extend a "limited guarantee issue" Open Enrollment opportunity, for full-time employees to enroll in either or both **Short-Term Disability** and **Supplemental Life Insurance**.

Your election in these coverages is guaranteed, as long as you were not previously declined for either coverage. **Your elected coverage will go into effect on January 1, 2020**.

Please note, the Short-Term Disability plan includes a 12-month limitation on pre-existing conditions. You are not prohibited from enrolling in coverage due to a pre-existing condition but Short-Term Disability benefits will not be payable during the first 12 months of coverage, for a pre-existing condition that would cause a disability.

HOW TO ENROLL

Step 1: Review coverage outlines and premium rates (based on Age for Life Insurance and both Age and Annual Earnings for Short-Term Disability)

Step 2: Complete **Enrollment Form** & **Banking Authorization Form**

Step 3: Send completed **Enrollment Form**, **Banking Authorization Form** & **Voided Check** to one of the following persons:

Darrel Fitch	WalkerHughes Insurance	Email: d.fitch@walkerhughes.com Fax: (317) 672-4061
Craig Chapman	Dunn & Associates	Email: cchapman@dunnbenefit.com Fax: (317) 672-4061

WalkerHughes Insurance is our Agent for these coverages, Dunn & Associates manages the enrollment and premium deductions. The monthly premiums will be deducted from your personal bank account.

Your enrollment forms must be submitted by December 1st!

Roman Catholic Archdiocese of Indianapolis

Products and financial services provided by
American United Life Insurance Company®
a ONEAMERICA® company
One American Square, P.O. Box 6033
Indianapolis, IN 46206-6033

ONEAMERICA®

AUL's Group Voluntary Term Life Insurance Coverage for Eligible Employees

Guaranteed Issue Amount: $200,000	If you are eligible and you enroll timely, you will be able to apply for coverage up to the guaranteed issue amount without providing Evidence of Insurability. Any amount of coverage requested as a late enrollee or in excess of the guaranteed issue amount will first require medical underwriting and written approval by AUL. If approved, coverage will become effective on the date identified by AUL.
Flexible Choices	You may apply for a benefit amount of group life insurance coverage in increments of $1,000, in a minimum amount of $10,000, and up to a maximum amount of: 1) $500,000 or 2) 5 times annual base salary rounded to the next $1,000, whichever is less. Annual Base Salary is based on the amount shown in Box 1 of the Employee's last IRS Form W-2 form.
Waiver of Premium Benefit	If eligible under the insurance contract and approved for this benefit, AUL will waive premium payments for your coverage while you remain totally disabled.
Accelerated Life Benefit	If eligible for this benefit, you or your spouse may apply for payment of 25%, 50%, or 75% of the amount of life insurance coverage.
Portability	You may be eligible to apply for continuation of coverage should your coverage terminate. Approval for this benefit will extend your coverage for an additional period of time.
Continuation of Insurance	You may be eligible to request continuance of insurance should you take a temporary leave of absence or if you are on temporary layoff.
Eligible Employees	An eligible employee is a full-time employee legally authorized to work and reside in the US. You must work 30 or more hours per week and cannot be considered a part-time, temporary or seasonal employee. If you are not actively at work on the contract effective date, group insurance coverage will not exist until you return to full-time active work.
Evidence of Insurability	If you do not enroll timely, or if amounts of coverage greater than the guaranteed issue amount are requested, you will be required to provide a statement or proof of medical history. AUL will then review that information to determine if coverage can be approved.
Suicide Limitation	The insurance contract contains a Two Year Suicide Limitation.
Reduction Schedule	Coverage will reduce upon reaching certain ages as follows:

Employee's Age When Reduction Occurs	70	75	80	85	90
Percent of Life Amount Remaining	45%	30%	20%	15%	10%

Notes:
This invitation to inquire allows interested eligible employees an opportunity to inquire further about group insurance coverage and is limited in its description of the losses for which benefits may be payable. The contract has exclusions, limitations, reduction of benefits, and terms under which the contract may be continued in force or discontinued. The contract may contain a waiting or elimination period between the effective date of the contract and the effective date of coverage, and a time period between the date a loss occurs and the date benefits begin to be payable for the loss. Any payable benefit is based on a percentage of an employee's covered earnings subject to AUL's approval, contract maximums, contract reductions, and according to contract terms and conditions.

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Voluntary Term Life Coverage Monthly Premium Illustration

EMPLOYEE OPTIONS

EMPLOYEE COVERAGE AMOUNT

Employee Age	29 and under	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70+
$10,000	$0.60	$0.60	$0.80	$1.15	$1.75	$2.80	$4.50	$5.75	$10.00	$26.55
$20,000	$1.20	$1.20	$1.60	$2.30	$3.50	$5.60	$9.00	$11.50	$20.00	$53.10
$30,000	$1.80	$1.80	$2.40	$3.45	$5.25	$8.40	$13.50	$17.25	$30.00	$79.65
$40,000	$2.40	$2.40	$3.20	$4.60	$7.00	$11.20	$18.00	$23.00	$40.00	$106.20
$50,000	$3.00	$3.00	$4.00	$5.75	$8.75	$14.00	$22.50	$28.75	$50.00	$132.75
$60,000	$3.60	$3.60	$4.80	$6.90	$10.50	$16.80	$27.00	$34.50	$60.00	$159.30
$70,000	$4.20	$4.20	$5.60	$8.05	$12.25	$19.60	$31.50	$40.25	$70.00	$185.85
$80,000	$4.80	$4.80	$6.40	$9.20	$14.00	$22.40	$36.00	$46.00	$80.00	$212.40
$90,000	$5.40	$5.40	$7.20	$10.35	$15.75	$25.20	$40.50	$51.75	$90.00	$238.95
$100,000	$6.00	$6.00	$8.00	$11.50	$17.50	$28.00	$45.00	$57.50	$100.00	$265.50
$110,000	$6.60	$6.60	$8.80	$12.65	$19.25	$30.80	$49.50	$63.25	$110.00	$292.05
$120,000	$7.20	$7.20	$9.60	$13.80	$21.00	$33.60	$54.00	$69.00	$120.00	$318.60
$130,000	$7.80	$7.80	$10.40	$14.95	$22.75	$36.40	$58.50	$74.75	$130.00	$345.15
$140,000	$8.40	$8.40	$11.20	$16.10	$24.50	$39.20	$63.00	$80.50	$140.00	$371.70
$150,000	$9.00	$9.00	$12.00	$17.25	$26.25	$42.00	$67.50	$86.25	$150.00	$398.25
$160,000	$9.60	$9.60	$12.80	$18.40	$28.00	$44.80	$72.00	$92.00	$160.00	$424.80
$170,000	$10.20	$10.20	$13.60	$19.55	$29.75	$47.60	$76.50	$97.75	$170.00	$451.35
$180,000	$10.80	$10.80	$14.40	$20.70	$31.50	$50.40	$81.00	$103.50	$180.00	$477.90
$190,000	$11.40	$11.40	$15.20	$21.85	$33.25	$53.20	$85.50	$109.25	$190.00	$504.45
$200,000	$12.00	$12.00	$16.00	$23.00	$35.00	$56.00	$90.00	$115.00	$200.00	$531.00

MINIMUM COVERAGE AMOUNT **$10,000**
MAXIMUM COVERAGE AMOUNT **$500,000** NOT TO EXCEED **5** TIMES EMPLOYEE'S ANNUAL SALARY

SPOUSE OPTIONS

SPOUSE COVERAGE AMOUNT

Employee Age	29 and under	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69
$5,000	$0.30	$0.30	$0.40	$0.58	$0.88	$1.40	$2.25	$2.88	$5.00
$10,000	$0.60	$0.60	$0.80	$1.15	$1.75	$2.80	$4.50	$5.75	$10.00
$15,000	$0.90	$0.90	$1.20	$1.73	$2.63	$4.20	$6.75	$8.63	$15.00
$20,000	$1.20	$1.20	$1.60	$2.30	$3.50	$5.60	$9.00	$11.50	$20.00
$25,000	$1.50	$1.50	$2.00	$2.88	$4.38	$7.00	$11.25	$14.38	$25.00
$30,000	$1.80	$1.80	$2.40	$3.45	$5.25	$8.40	$13.50	$17.25	$30.00
$35,000	$2.10	$2.10	$2.80	$4.03	$6.13	$9.80	$15.75	$20.13	$35.00
$40,000	$2.40	$2.40	$3.20	$4.60	$7.00	$11.20	$18.00	$23.00	$40.00
$45,000	$2.70	$2.70	$3.60	$5.18	$7.88	$12.60	$20.25	$25.88	$45.00
$50,000	$3.00	$3.00	$4.00	$5.75	$8.75	$14.00	$22.50	$28.75	$50.00

MINIMUM COVERAGE AMOUNT **$5,000**
MAXIMUM COVERAGE AMOUNT **$250,000** NOT TO EXCEED **50%** OF EMPLOYEE'S AMOUNT

CHILD(REN) OPTIONS

CHILD(REN) COVERAGE AMOUNT

	1	2	3	4
Child(ren) 6 months to under age 26	$2,500	$5,000	$10,000	$15,000
Child(ren) live birth to 6 months	$1,000	$1,000	$1,000	$1,000
Monthly Premium	**$0.54**	**$1.08**	**$2.16**	**$3.24**

Rates shown include all eligible children

YOU MUST ELECT EMPLOYEE COVERAGE IN ORDER TO ELECT ANY DEPENDENT COVERAGE

Spouse coverage terminates when the spouse turns age 70.
Rates above may vary slightly due to rounding. Actual premium will be calculated by AUL,
and will increase upon reaching certain age brackets, according to contract terms, and are subject to change.

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ONEAMERICA®

AUL's Group Voluntary Disability Insurance Coverage for Eligible Employees

Guaranteed Issue	If you enroll timely, you will be able to apply for coverage without providing Evidence of Insurability.
Benefit Amount	Any payable benefit is based on a percentage of an employee's covered earnings subject to AUL's approval, contract maximums, reduction by other income benefits and according to contract terms and conditions.
Evidence of Insurability	If you do not enroll timely, you will be required to provide a statement or proof of medical history. AUL will then review that information to determine if coverage can be approved.
Partial Disability Benefit	Because of injury or sickness, you, while unable to perform every material and substantial duty of your regular occupation on a full-time basis, are performing at least one of the material and substantial duties of your regular occupation, or another occupation, on a full or part-time basis, and are earning less than 80% of your indexed pre-disability earnings due to the same injury or sickness.
Elimination Period	This is a period of consecutive days of disability before benefits may become payable under the contract.
Residual Benefit	The elimination period may be met with the period of time you are totally disabled, partially disabled, or a combination of both.
Portability Privilege	You may be eligible to apply for extend your coverage for an additional period of time should your coverage terminate.
Pre-existing Condition Limitations[1]	Certain disabilities are not covered if the cause of the disability is traceable to a condition existing prior to your effective date of coverage. A pre-existing condition is any condition for which you have received medical treatment or consultation, taken or were prescribed drugs or medicine, or received care or services, including diagnostic measures, within a time-frame specified in the contract. You must also be treatment free for a time-frame specified in some contracts following your individual effective date of coverage.
Continuation of Insurance under FMLA	If eligible under the insurance contract and approved for the FMLA (Family Medical Leave Act) benefit, your coverage may be continued for a period for time outlined in the contract while on an employer approved leave of absence under the FMLA.
Eligible Employees	An eligible employee is a full-time employee legally authorized to work and reside in the US. You must work 30 or more hours per week and cannot be considered a part-time, temporary or seasonal employee. If you are not actively at work on the contract effective date, group insurance coverage will not exist until you return to full-time active work.

Note:
This invitation to inquire allows eligible employees an opportunity to inquire further about group insurance coverage and is limited in its description of the losses for which benefits may be payable. The contract has exclusions, limitations, reduction of benefits, and terms under which the contract may be continued in force or discontinued. The contract may contain a waiting or elimination period between the effective date of the contract and the effective date of coverage, and between the date a loss occurs and the date benefits begin to be payable for the loss.

Roman Catholic Archdiocese of Indianapolis
Voluntary Group Short Term Disability Income Insurance
Benefit Outline

Monthly Benefit: 60% of an Employee's covered monthly earnings to a maximum of $6,000, and then reduced by Other Income Benefits as outlined in the contract.

Elimination Period (EP): The EP is the period of time a disabled Employee must wait before monthly disability benefits begin.
Plan 1: The greater of 15 days or the period of sick leave and or salary continuance, if longer.
Plan 2: The greater of 30 days or the period of sick leave and or salary continuance, if longer.

Maximum Benefit Duration: This is the length of time that an insured Employee may be entitled to benefits if continuously disabled as outlined in the contract.
Plan 1: 11 weeks
Plan 2: 9 weeks

Maternity Coverage: Benefits will be paid the same as any other qualifying disability, subject to any applicable pre-existing condition exclusion.

Total Disability: This means an insured Employee that cannot perform the material and substantial duties of his or her regular occupation because of injury or sickness.

Partial Disability Benefit: A partial disability benefit may be paid, if because of injury or sickness an Employee, while unable to perform every material and substantial duty of his or her regular occupation on a full-time basis, is performing at least one of the material and substantial duties of his or her regular occupation, or another occupation, on a full or part-time basis, and is earning less than 80% of his or her indexed pre-disability earnings due to the same injury or sickness.

Pre-Existing Condition Exclusion: Benefits will not be paid if the Employee's disability begins in the first 12 months following the effective date of the Employee's coverage; and the Employee's disability is caused by, contributed to by, or the result of a condition, whether or not that condition is diagnosed at all or is misdiagnosed, for which:

1) the Employee received medical treatment, consultation, care or services, including diagnostic measures, or was prescribed drugs or medicines in the 3 months just prior to the Employee's individual effective date of insurance; or
2) the Employee was not treatment free for 3 consecutive months after the Employee's individual effective date of insurance.

Portability Benefit: If insured for 12 months just prior to termination of coverage, an Employee may apply for Portability. This will extend the Employee's current coverage for an additional 12 months. Application for Portability must be made within 31 days of your termination date.

Recurrent Disability Benefit: A recurrent disability is the direct result of the injury or sickness that caused a prior disability. This benefit allows claim payments to continue without satisfying a new elimination period if an Employee returns to active full-time work and has a recurrent disability within 30 days.

Note: This invitation to inquire allows interested employees an opportunity to inquire further about group insurance coverage and is limited in its description of the losses for which benefits may be payable. The contract has exclusions, limitations, reduction of benefits and terms under which the contract may be continued in force or discontinued. The contract may contain a waiting or elimination period between its effective date and the effective date of coverage, and a time period between the date a loss occurs and the date benefits begin to be payable for the loss.

If a choice of the amount of benefits is offered, the amount of benefits provided depends upon the coverage selected and premiums can vary with the amount of benefits selected. If a range of benefit levels is present, the insured is only entitled to the benefit level shown in the contract.

Any payable benefit is based on a percentage of annual base salary subject to AUL's approval, contract maximums, contract reductions and according to contract terms and conditions.

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Indianapolis, IN 46206-6033

ONEAMERICA®

AUL's Group Voluntary Disability Insurance Coverage for Eligible Employees

Voluntary Short Term Disability	Monthly Premium Rate Per $100 of Covered Monthly Earnings		Benefit Percentage	Maximum Monthly Benefit	Elimination Period	Maximum Benefit Duration	Pre-Existing Limitation Benefit
Option 1	**Age Band**	**Rate**	60%	$6,000	15 days	11 weeks	3/3/12
	39 and under	$0.19					
	40-44	$0.32					
	45-49	$0.44					
	50-54	$0.65					
	55-59	$0.85					
	60+	$1.00					
Option 2	**Age Band**	**Rate**	60%	$6,000	30 days	9 weeks	3/3/12
	39 and under	$0.17					
	40-44	$0.24					
	45-49	$0.41					
	50-54	$0.47					
	55-59	$0.63					
	60+	$0.74					

To Estimate Monthly Premium, do the following:

1. To determine the Employee's Monthly Salary, divide the amount shown in Box 1 of the Employee's last IRS Form W-2 form by 12. = _____
2. Enter the lesser of Employee's Monthly Salary or $10,000 = _____
3. Divide Step 2 by 100. = _____
4. Enter appropriate rate from "Age Band" chart above. = _____
5. Multiply Step 3 times Step 4. = _____

Note:
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Group Enrollment Form

DUNN & Associates
BENEFIT ▪ ADMINISTRATORS ▪ INC.

Dunn & Associates Benefit Administrators, Inc.
Attention: Eligibility Department
4550 Middle Road, Suite A
Columbus, IN 47203
Fax: 317-672-4061
Customer Service: 1-800-880-9960

ONEAMERICA®

Applicant's Full Legal Name:		Employment Status: Active Retired
Applicant's Social Security Number:		Gender: Male Female
Date of Birth	Marital Status: Single Married	**Employer:** **Roman Catholic Archdiocese of Indianapolis**
Home Street Address:	City: State Zip:	
Are you authorized to work and reside in the US? Yes No	Employed Full-Time: Yes No	Hours worked per week: **40**

Name of Primary Beneficiary	Relationship	DOB
Name of Contingent Beneficiary	Relationship	DOB

COVERAGE BEING APPLIED FOR: Apply for or decline each coverage listed below. Not checking either box will be considered a declination of that coverage.

Request	Decline		
☐	☐	Employee Voluntary Term Life Coverage $ _____	
☐	☐	Dependent* Spouse** Voluntary Term Life Coverage $ _____	
☐	☐	Dependent Child(ren)*** Voluntary Term Life Coverage:	**$2,500 $5,000 $10,000 $15,000**
☐	☐	Voluntary Short Term Disability	**Plan 1 – 15 day Elimination Period** **Plan 2 – 30 day Elimination Period**

*Dependent Coverage is only available with Employee Coverage

**If spouse is included in dependent coverage: Spouse Name _____ Date of birth _____.

***If children are included in dependent coverage: Child #1 Name _____ Date of birth _____.

Child #2 Name _____ Date of birth _____.

Child #3 Name _____ Date of birth _____.

Child #4 Name _____ Date of birth _____.

- I hereby apply for the group insurance coverage for which I and my dependents, if any, are eligible and available under AUL's policy. I understand receipt of any coverage greater than the guaranteed issue amount or application for coverage after the approved enrollment period first requires medical underwriting and written approval by AUL
- I authorize my employer to deduct from my wages the amount of premium required for the amount of coverage approved by AUL, including any premium increases due to age bracket or salary changes when applicable. Premium payments greater than the amount of premium owed will not result in additional coverage under AUL's policy.
- The undersigned represents any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief. **The undersigned understands and agrees 1. any insurance coverage or benefits are contingent upon any statements made to AUL as being complete and correct and 2. benefits under any policy will be paid only if AUL decides in its discretion the applicant is entitled to them. The undersigned have read, understand, and retained the notices, limitations, and exclusions for his/her records.**
- **Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.**

Signature of Applicant: _____ **Date:** _____

TO BE COMPLETED BY THE EMPLOYER

Group Policy#: **G 600555**	Date Hired Full Time:	Salary: **$**

DUNN & Associates
BENEFIT ▪ ADMINISTRATORS ▪ INC.

4550 Middle Road
Suite A, PO Box 2369
Columbus, Indiana 47203
Fax: 317-672-4061

AUTHORIZATION AGREEMENT FOR ACH DEBIT PAYMENTS

This is a: ☐ New/First Time Enrollment ☐ Change to Previous Authorization ☐ Cancellation

Name: _____
(First, Middle, Last) (Please Print) (Date of Birth)

Name (Co-Applicant – If applicable): _____
(First, Middle, Last) (Please Print)

Address: _____

City: _____ State: _____ Zip: _____

Social Security #_____Home or Cell Phone: _____Work Phone: _____

E-Mail (Work): _____ E-Mail (Personal): _____

I (we) hereby authorize Dunn & Associates Benefit Administrators, Inc., hereinafter called Dunn, to withdraw funds from my/our ☐ checking or ☐ savings account (select only one) for the AUL premium amounts for my voluntary life and/or short- term disability from the financial institution named below. AUL premiums for voluntary life and/or short- term disability is due monthly. Withdraws for these premiums will be deducted on or before the 14th day of each month from my/our checking or savings account for coverage in the same month. If my payment is returned unpaid, in addition to the monthly premiums, the account will be subject to the prevailing non-sufficient fund charge as well as a handling fee of $12.

Bank/Financial Institution Name: _____

Branch: _____

City: _____ State: _____ Zip: _____

ROUTING NUMBER: _____

ACCOUNT NUMBER: _____

- Coverage and participation in the voluntary insurance program(s) could lapse or terminate if premiums are not funded through the account within 60 days. A penalty fee equal to the current prevailing non-sufficient charge plus a handling fee of $12 will be applied. Debits will show as **"AUL PREM"**
- This authorization is to remain in full force and effect until Dunn has received written notification from me (or either of us) of termination at least 10 business days prior to the next monthly scheduled deduction. Incomplete applications will not be accepted. Debits will show as **"AUL PREM"**

_____
Signature Date

_____
Signature of Co-Applicant (if applicable) Date

Important Note: Please attach a voided check from your checking account or a deposit slip from your savings account to this authorization form.