CHURCH PENSION GROUP
Passionate About Our Purpose

Enrollment or Termination Form
Employee-Paid Short-Term and Long-Term Disability Coverage

Section 1—Employee Information

Legal Name
First MI
Last

Mailing Address
Street
City
State Zip Code
Country

Home Phone
Mobile Phone
Personal Email
Social Security # / TIN
Date of Birth
Gender Male Female
Is employee actively at work? Yes No
Does employee work in the US? Yes No
Work Location
Work Phone
Scheduled number of work hours per week

Section 2—Employer Information

Employer Name
Client Number

Mailing/Billing Address
Street
City
State Zip Code
Country

Phone
Diocese
List Bill

Aflac®

Section 3— Enrollment, Coverage Change or Termination

Transaction Type

☐ New Hire
☐ Late Enrollee
☐ Newly Eligible
☐ Employee Termination of Coverage* (proceed to Section 4B)
☐ Annual Enrollment

Effective Date of Change _____

Short-Term Disability Coverage

Policy Selected**

☐ STD 26 Weeks 60%
☐ STD 26 Weeks 66.67%
☐ STD 13 Weeks 60%
☐ STD 13 Weeks 66.67%

Long-Term Disability Coverage

Policy Selected**

☐ LTD 180 Days 50%
☐ LTD 90 Days 50%

Enrollment deadline:

Enrollments in a Short-Term and/or Long-Term Disability plan must be made within 31 days of the employee's hire date. The plans do not allow for waiting periods.

** Terminated employees who have been enrolled in either of the Employee-Paid (Voluntary) Long- Term Disability Plans for 12 or more consecutive months can convert their LTD coverage if they apply directly through Zurich American Life Insurance Company of New York within 31 days of their termination date. Forms are available at cpg.org.*

*** Coverage subject to elimination period and maximum amount.*

Section 4A—Acknowledgment, Signatures, and Notices (Do not complete if selected Employee Termination of Coverage)

Employee Signature

The employee and employer organization must sign this form. By signing below, I certify that:

- I accept the insurance coverage(s) chosen above.
- I authorize my employer to deduct the required contribution in advance from wages due me.
- I understand that my insurance will not go into effect unless I am actively at work on the effective date.
- I understand the conditions for the requested insurance to be effective are described in the Benefit Summary and the Certificate of Coverage. Approval of this request by Zurich American Life Insurance Company of New York is one of those conditions.
- I hereby certify that to the best of my knowledge and belief, all written statements I have given are true and complete.

Employee Signature _____ Date _____

Employer Signature

By signing below, the employer certifies the employee is eligible for all coverages applied for, that the employer agrees to deduct and timely remit the required contribution from the employee's wages and, to the best of the employer's knowledge, all information provided above is correct.

Employer Signature _____ Date _____

Section 4B—Acknowledgment, Signatures, and Notices for Termination

Employee Signature	By signing below, I certify my desire to terminate and end my Disability Coverage enrollment. Employee Signature_____ Date _____
Employer Signature	By signing below, the employer certifies and agrees not to deduct and remit the required contribution from the employee's wages and, to the best of the employer's knowledge, all information provided above is correct. Employer Signature_____ Date _____

Please note that this material is provided for informational purposes only and should not be viewed as investment, tax, or other advice. It does not constitute a contract or an offer for any products or services. In the event of a conflict between this material and the official plan documents or insurance policies, the official plan documents or insurance policies will govern.

In New York, the terms and conditions for the Group Short Term Disability Income Insurance Policy are set forth in policy form number 1000-ZAGP-DS-NY-01. The policies are issued by Zurich American Life Insurance Company of New York, a New York domestic life insurance company, located at its registered home address of Four World Trade Center, 150 Greenwich Street, New York, NY 10007.

In all states other than New York, the terms and conditions for the Group Short Term Insurance are set forth in policy form number 1000-ZAGP-01-01 or applicable state variation. The policies are issued by Zurich American Life Insurance Company, an Illinois domestic life insurance company, located at its registered home address of 1299 Zurich Way, Schaumburg, IL 60196.

In New York, the terms and conditions for the Group Long Term Disability Income Insurance Policy are set forth in policy form number 1000-ZAGP-DS-NY-01. The policies are issued by Zurich American Life Insurance Company of New York, a New York domestic life insurance company, located at its registered home address of 150 Greenwich Street, Four World Trade Center, 54th Floor, New York, NY 10007-2366.

In all states other than New York, the terms and conditions for the Group Long Term Disability Insurance Policy are set forth in policy form number 1000-ZAGP-01-01 or applicable state variation. The policies are issued by Zurich American Life Insurance Company, an Illinois domestic life insurance company, located at its registered home address of 1299 Zurich Way, Schaumburg, IL 60196.

The policies are subject to the laws of the state where they are issued. This material is a summary of the product features only. Please read the policy carefully for details. Certain coverages may not be available in all states and policy provisions may vary by state.

On March 19, 2020, Aflac, Inc. announced the agreement to acquire Zurich North America's U.S. group benefits business (ZEB), which consists of group life, group disability, and absence management products. Aflac Columbus and Aflac NY (Aflac) will reinsure, on an indemnity basis, Zurich's U.S. in-force group life and disability policies. As of November 2, 2020, and subject to customary closing conditions, Aflac will assume the administration of the aforementioned re-insured Zurich Employee Benefits policies and services. Aflac herein means American Family Life Assurance Company of Columbus WWHQ | 1932 Wynnton Road | Columbus, GA 31999.

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2020–2022 Disability Insurance Rates

All Rates Are Per $100 of Covered Monthly Payroll

MLPS Coverage Code	Plan Name	Age Bracket	Monthly Rate to be Paid by Employee
GSEE3	STD 26 weeks 60% EE Paid (Maximum covered compensation is $130,000)	<30	$ 0.779
		31-40	$ 0.625
		41-50	$ 0.458
		51>	$ 0.696
GSEE4	STD 26 weeks 66.67% EE Paid (Maximum covered compensation is $117,000)	<30	$ 0.894
		31-40	$ 0.738
		41-50	$ 0.553
		51>	$ 0.812
GSEE1	STD 13 weeks 60% EE Paid (Maximum covered compensation is $130,000)	<30	$ 0.215
		31-40	$ 0.175
		41-50	$ 0.124
		51>	$ 0.186
GSEE2	STD 13 weeks 66.67% EE Paid (Maximum covered compensation is $117,000)	<30	$ 0.301
		31-40	$ 0.259
		41-50	$ 0.166
		51>	$ 0.240

MLPS Coverage Code	Plan Name	Age Bracket	Monthly Rate to be Paid by Employees
GLEE2	LTD 180 days 50% EE Paid (Maximum covered compensation is $120,000)	<30	$ 0.233
		31-40	$ 0.466
		41-50	$ 0.837
		51>	$ 1.696
GLEE1	LTD 90 days 50% EE Paid (Maximum covered compensation is $120,000)	<30	$ 0.413
		31-40	$ 0.806
		41-50	$ 1.081
		51>	$ 2.131

Sample Calculation

A	Annual Covered Compensation*	$42,000
B	Divide by 12	12
C	Monthly Compensation	(A/B) $3,500
D	STD Coverage Rate (STD 26 weeks 66.67% age 31-40)	$0.738
E	Multiply Monthly Compensation and Rate	(C*D) $2,583
F	Divide by 100	100
G	Monthly Premium	(E/F) $25.83

** Compensation should be capped at the maximum covered compensation (e.g., $117,000)*