



# AMERICAN SENTINEL INSURANCE COMPANY

HARRISBURG, PA

## TOTAL DISABILITY INCOME INSURANCE

### OUTLINE OF COVERAGE

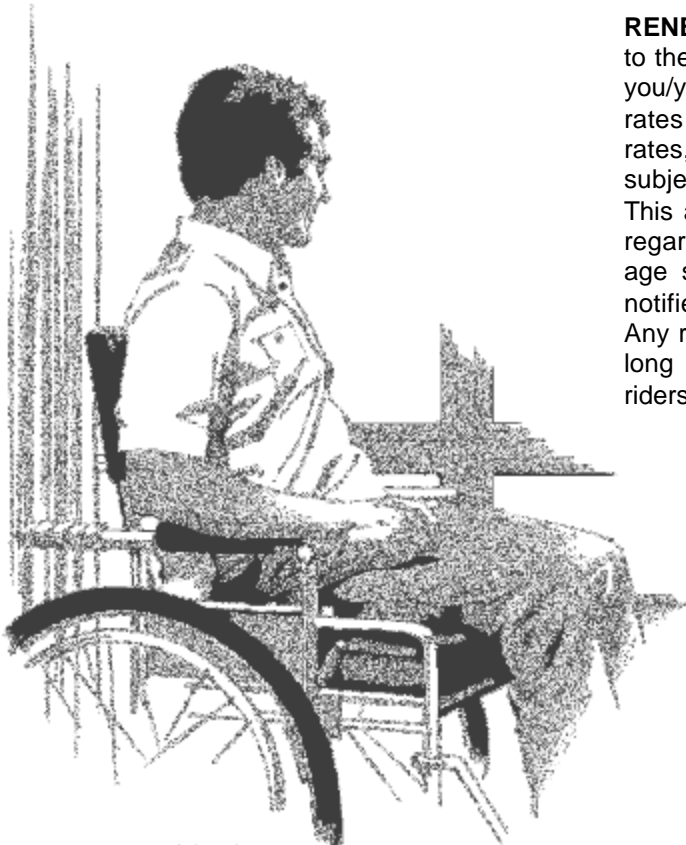
**DISCLOSURE STATEMENT.** This policy provides disability income insurance. It does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York Insurance Department. This Outline of Coverage provides a very brief summary of your policy. This policy:

**Total Disability Income Protection Coverage.** This category of coverage is designed to provide, to persons insured, benefits for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy.

**BENEFITS OF THE POLICY** The policy will pay the monthly income benefit selected below when you are Totally Disabled. Totally Disabled (or Total Disability) means a condition caused by accident or sickness which affects you: (1) if employed, to the following extent: (a) you are unable to perform each and every duty of your regular occupation (2) if non-employed, to the extent that you are continuously unable to perform the normal activities of a person the same age and sex.

The policy pays a monthly income of \$ \_\_\_\_\_ for a covered Accident beginning on the \_\_\_\_\_ day of Total Disability, or, for a covered Sickness beginning on the \_\_\_\_\_ day of Total Disability. The benefit per Accident or Sickness is payable for as long as the elected Maximum Benefit Period.

**EXCLUSIONS:** The policy does not cover loss caused by: (1) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the Armed Forces or units auxiliary thereto; (2) suicide; attempted suicide or intentionally self-inflicted injuries; (3) pregnancy except that complications of pregnancy are covered as any other Sickness or Accident; or, (4) operating, learning to operate, or serving as a member of a crew of an aircraft.



**RENEWABILITY OF THIS POLICY** The policy is guaranteed renewable to the premium due date on or next following the Insured's (herein called you/your) 65<sup>th</sup> birthday. We reserve the right to modify our premium rates applicable to policies of the same class. Any change in premium rates, shall be made only on a class basis. Premium rate changes are subject to prior approval of the New York State Insurance Department. This applies to all policies delivered or issued for delivery in New York regardless of a later change in your residence. Your original insuring age shall be used to determine the new premium rate. You will be notified at least 31 Days before an increase would become effective. Any rate change shall be implemented on a policy anniversary date. As long as the policy continues in force, we cannot place any restrictive riders thereon with respect to coverage already in force.

**Premium:** Annual \$ \_\_\_\_\_  
Semi-Annual \$ \_\_\_\_\_  
Quarterly \$ \_\_\_\_\_  
Monthly \$ \_\_\_\_\_

The policy itself sets forth the rights and obligations of both you and American Sentinel Insurance Company. It is therefore, important that you **READ YOUR POLICY CAREFULLY.**

**EXPECTED BENEFIT RATIO** for this policy is 61%. This ratio is the portion of future premiums which American Sentinel Insurance Company expects to return as benefits, when averaged over all people with this policy.



**ACCIDENT AND SICKNESS** (Annual Premium Rates – Disability Income Per \$100 Monthly Benefit)

**6 Month Accident / 6 Month Sickness**

<u>Issue Age</u>	<u>Elimination Period</u>	<u>Class 1</u>	<u>Class 2</u>	<u>Class 3</u>	<u>Class 4</u>
18-25	0-15	\$25.49	\$33.14	\$40.78	\$50.98
	30-30	19.49	25.34	31.18	38.98
	60-60	16.49	21.44	26.38	32.98
26-35	0-15	32.75	42.58	52.40	65.50
	30-30	25.75	33.48	41.20	51.50
	60-60	22.75	29.58	36.40	45.50
36-45	0-15	42.03	54.64	67.25	84.06
	30-30	34.03	44.24	54.45	68.06
	60-60	30.03	39.04	48.05	60.06
46-55	0-15	50.27	65.35	80.43	100.54
	30-30	40.27	52.35	64.43	80.54
	60-60	35.27	45.85	56.43	70.54
56-60	0-15	53.56	69.63	85.70	107.12
	30-30	41.56	54.03	66.50	83.12
	60-60	35.56	46.23	56.90	71.12

**Plan features of American Sentinel's Individual Disability Policy**

- Fully portable (policy is individually owned)
- 24 hour coverage – worldwide (occupational and non-occupational)
- Guaranteed renewable policy (cannot be cancelled due to health problems)
- Accident and Sickness coverage
- Benefits not offset by Workers' Compensation and Social Security
- Covers most *blue* and white collar occupations
- Uni-sex rates

**Simplified Underwriting**

- No physical examinations, blood, urine, attending physician's statements, or investigative reports required
- No income documentation
- Will consider *all* earned income ranges
- Will not deny coverage on employed persons with unearned income

**Design Your Plan from These Options**

- 6 month or 1 year Benefit Period
- 0 day accident – 15 day sickness Elimination Period
- 30 day accident – 30 day sickness Elimination Period
- 60 day accident – 60 day sickness Elimination Period



**AMERICAN SENTINEL INSURANCE COMPANY** Agency \_\_\_\_\_

P.O. Box 61140, Harrisburg, PA 17106-1140  
717-540-0600 • 800-692-7338 • FAX 717-657-9499

**Application for Total Disability Insurance**

Agent's Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Occupational Classification \_\_\_\_\_

Amount Applied For: \$ \_\_\_\_\_ per month

Elimination Period Desired: **Accident** **Sickness**  
 0 day                      15 day  
 30 day                      30 day  
 60 day                      60 day

PREMIUM \_\_\_\_\_

If semi-annual, add \$5.00 and divide by 2;

If quarterly, add \$10.00 and divide by 4;

If monthly, add \$20.00 and divide by 12.

Maximum Benefit Period Desired:  6 Months  12 Months

Proposed Insured \_\_\_\_\_  Male  Female

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

1. \_\_\_\_\_ ( ) \_\_\_\_\_  
Resident Address Street City State Zip Home Phone

2. \_\_\_\_\_  
Occupation (Position or Title) Duties Performed Marital Status

3. \_\_\_\_\_  
Employer Business Address

4. ( ) \_\_\_\_\_  
Business Phone Type of Business How long with present employer?

5. If with present employer less than one year, who was your previous employer?  
Business Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_ How long? \_\_\_\_\_

6. Average monthly earned income \$ \_\_\_\_\_

7. If you become disabled, will your salary be continued?  Yes  No

8. Do you understand and agree that, under the terms of this insurance a) no benefits are payable for the first \_\_\_\_\_ days of disability due to accident; and b) no benefits are payable for the first \_\_\_\_\_ days of disability due to sickness?  Yes  No

9. What other disability coverage is in force or applied for in all companies?

Company Monthly Benefit Benefit Period

10. Will this insurance replace any disability coverage currently in force?  Yes  No

11. Have you within the past 5 years had medical or surgical advice or treatment or been hospital confined?  Yes  No

12. Have you ever received medical care, advice or been diagnosed from a licensed health care provider for:

- |                         |                              |                             |                               |                              |                             |
|-------------------------|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|
| Abnormal Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ulcers                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Arthritis                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatism                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mental or Nervous Disorder    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Venereal Disease        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma or Emphysema           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hernia                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | AIDS or ARC                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pregnancy (Are you pregnant?) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Back Problems           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                               |                              |                             |

Please give details of "YES" answers for Questions 11 & 12 \_\_\_\_\_

"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."

I have read the answers and statements made in this application and declare that they are true and complete to the best of my knowledge and belief. I understand that any policy issued and delivered to me will be in effect on the date approved by the Home Office or if advanced payment is accepted according to the terms of a conditional receipt.

Signature of Proposed Insured \_\_\_\_\_ Application Date \_\_\_\_\_

**AUTHORIZATION** I authorize American Sentinel Insurance Company to acquire from and authorize any hospital, physician, medical practitioner, clinic, medically related facility, Insurance company or the Bureau of Motor Vehicles to release to American Sentinel Insurance Company information regarding me for the purpose of evaluating this application for insurance. I also authorize American Sentinel Insurance Company to disclose all such information to any physician or any other insurance company in order to evaluate a claim or an application for insurance. This authorization shall remain valid for a period of two years from the issue date of this policy. A photocopy if this authorization will be as valid as the original. A copy of the authorization is available upon request to the Company.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Signed by Proposed Insured \_\_\_\_\_

**FORM DIA (NY)**