PCA RETIREMENT & BENEFITS, INC.

PCA GROUP LONG TERM DISABILITY (LTD) (unum Group Policy 575359; PCA Retirement & Benefits, Inc.)

TO BE COMPLETED BY EMPLOYER

Name of Employer: ______________________________ Billing Contact Name: ____________________

______________________________ Billing Phone No: ____________________

Address Street City State Zip Code

Is your organization currently participating in the PCA/RBI LTD Plan? ☐ Yes ☐ No Organization Group # __________

BENEFIT PLAN ELECTIONS TO BE COMPLETED BY EMPLOYER

Coverage Options*: Flexibility to choose the plans that are right for your employees. Choose, one, two or all three options.

☐ **Employer Paid Enhanced (must be 100% class participation) (enter class description below)**

☐ **Employer Paid Basic (must be 100% class participation) (enter class description below)**

☐ **Employee Paid Voluntary (must be at least 25% class participation) (enter class description below)**

***Classification of employees is necessary and names of employees in each class must be provided to determine eligibility. Please provide a description of each classification and a listing of employees in the respective class. (Excel spreadsheet is preferred. See sample census on page 3)**

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PREMIUM CALCULATION RECAP – SHOW TOTALS FOR ALL ENROLLED PER CENSUS

Premium calculation for enrolled coverage. Calculate separately for Employer Paid Enhanced and Employer Paid Basic, using the applicable rate:

Employer Paid Enhanced

Annual Compensation: Salary $__________ + Housing Allowance (Ordained only) $__________ = Total: $__________

Annual Compensation Total $__________ x Rate* .0051 = Annual Premium/12 = $__________ Monthly Premium

Employer Paid Basic

Annual Compensation: Salary $__________ + Housing Allowance (Ordained only) $__________ = Total: $__________

Annual Compensation Total $__________ x Rate* .0038 = Annual Premium/12 = $__________ Monthly Premium

Example: Annual Compensation Total for all employees in the class = $150,000

For *Employer Paid Enhanced*: $150,000 x .0051 = $765/Annual Premium / 12 = $63.75 Monthly Premium

*Rates:

Employer Paid Enhanced ($0.51/$100 of covered pay) (Maximum covered pay is $200,000)

Employer Paid Basic ($0.38/$100 of covered pay) (Maximum covered pay is $120,000)

Employee Paid Voluntary

If you offered Voluntary coverage, please submit a Voluntary LTD enrollment /waiver form for each eligible employee.

Employee Paid Voluntary ($0.53/$100 of covered pay) (Maximum covered pay is $120,000)

PCA-RBI Office use only

Org ID: Participant ID: Reviewed By:

PCA RETIREMENT & BENEFITS, INC.

SECTION TO BE COMPLETED BY EMPLOYEE

Name (print) First Middle Last	Social Security No.	☐ Male ☐ Female
Address Street	City, State, Zip Code	☐ Single ☐ Married
Daytime Phone	Home Phone	Date of Birth (M/D/Y)
PCA Ordination Date (if applicable)	Start Date (at current employer)	Occupation or job title
E-mail Address	Annual Salary	Hours worked per week

Reason for Enrollment:
☐ New Coverage ☐ Change in Coverage Amount Requested ☐ Change in Enrollment Other Than Coverage Amount

PLAN DESIGN HIGHLIGHTS

Employer Paid Enhanced: Benefit will pay 66.67% of pre-disability income up to $10,000 per month. Benefits begin to accrue after 90 days of disability. Benefits can continue until age 65 or in accordance with the Age Discrimination in Employment Act schedule, provided you remain disabled. Benefits also include a 9% Retirement Income Protection contribution to your PCA Retirement account. Work Incentive Benefit applies. Benefits have a 3% annual Cost Of Living Adjustment. Worldwide emergency travel assistance with Assist America is included. Eligibility requires 100% of class participation.

Employer Paid Basic: Benefits will pay 66.67% of pre-disability income up to $6,000 per month. Benefits begin to accrue after 90 days of disability. Benefits can continue until age 65 or in accordance with the Age Discrimination in Employment Act schedule, provided you remain disabled. Worldwide emergency travel assistance with Assist America is included. Eligibility requires 100% of class participation.

EMPLOYEE SIGNATURE

My signature verifies the accuracy of the information contained on this form. I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective.

Employee Signature: ________________________________ Date: ________________

Please complete pages 1 (Employer) and Page 2 (Employee), returning both pages to:

PCA Group Insurance
PCA Retirement & Benefits, Inc.
1700 North Brown Road, Suite 106
Lawrenceville, GA 30043

You may scan and email to: rbi@pcanet.org

Or, you may fax to: (678) 825 - 1261

PCA Retirement & Benefits, Inc.

unum

Name of Employer: ______________________________

Address: ______________________________

City, ST, Zip: ______________________________

☐ Exisiting Employer Group

☐ New Employer Group

Employee List as of: ______________

Classification of employees is necessary and names of employees in each class must be provided to determine eligibility. Please provide a description of each classification and a listing of employees in the respective class.

☐ Employer Paid Enhanced - Class Description: ______________________________

✠✠ Employer Paid Basic - Class Description: ______________________________

* Maximum Annual Salary to report for Employer Paid Enhanced is $200,000
* Maximum Annual Salary to report for Employer Paid Basic is $120,000

Electronic census is preferred.

Employee Last Name	Employee First Name	Social Security Number	Gender	D.O.B	D.O.H.	Basic Monthly Earnings*	Monthly Housing Allowance (if applicable)	Title or Occupation	Home Address	Home City	Home ST	Home ZIP	Hrs worked per week	Employee Class
Example	***Mary***	999-99-9999	F	1/1/1960	1/1/1990	$4,167	$2,000	Sales	123 Sample Street	Sample	WI	53122	40	Enhanced