

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

SECTION TO BE COMPLETED BY EMPLOYER

Name of Employer: _____		Billing Contact Name: _____	
Address Street _____	City _____	State _____	Zip Code _____
			Billing Phone No: _____

SECTION TO BE COMPLETED BY EMPLOYEE

Name (print) First Middle Last	Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address Street	City, State, Zip Code	<input type="checkbox"/> Single <input type="checkbox"/> 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	Hours worked per week	
Reason for Enrollment: <input type="checkbox"/> New Coverage <input type="checkbox"/> Change in Coverage Amount Requested <input type="checkbox"/> Change in Enrollment Other Than Coverage Amount		

PLAN DESIGN

Benefit can pay 60% 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 ADEA schedule, provided you remain disabled. Benefits are received tax-free. Work-life balance employee assistance program (EAP) and worldwide emergency travel

PAYROLL DEDUCTION CALCULATION: (ENTER FIGURES FROM RATE SHEET)

1. Indicate Your Annual Earnings \$ _____

2. Multiply Your Annual Earnings by the rate of \$.0053 to obtain your total LTD annual cost. \$ _____

3. Divide the answer in Step 2 by your pay mode frequency to obtain your LTD cost per pay period. \$ _____

ELECT COVERAGE OR WAIVE COVERAGE

Yes, I would like to participate. I authorize my employer to deduct from my salary or wages the necessary premium for this coverage. 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. I have also read and understand the information in the Plan Highlights and enrollment materials, including all statements regarding exclusions.

No, I do not wish to participate. I understand that evidence of insurability will be required, at my own expense, if I decide to elect this coverage in the future.

Employee Signature: _____ Date: _____

Please complete, sign and return 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-RBI Office use only

Org ID: _____	Participant ID: _____	Reviewed By: _____
1 st Deduction Date: _____	Coverage Effective Date: _____	Revised 2009-03-25

PCA Retirement & Benefits, Inc.
Employee Paid Voluntary Long Term Disability
 Underwritten by UNUM

RATE SHEET

Rates Effective: March 1, 2009

Weekly Cost per Monthly Benefit Amount

Annual Income	Monthly Benefit	Weekly Cost	Annual Income	Monthly Benefit	Weekly Cost	Annual Income	Monthly Benefit	Weekly Cost
\$20,000	\$1,000	\$2.04	\$55,000	\$2,750	\$5.61	\$90,000	\$4,500	\$9.17
\$25,000	\$1,250	\$2.55	\$60,000	\$3,000	\$6.12	\$95,000	\$4,750	\$9.68
\$30,000	\$1,500	\$3.06	\$65,000	\$3,250	\$6.63	\$100,000	\$5,000	\$10.19
\$35,000	\$1,750	\$3.57	\$70,000	\$3,500	\$7.13	\$105,000	\$5,250	\$10.70
\$40,000	\$2,000	\$4.08	\$75,000	\$3,750	\$7.64	\$110,000	\$5,500	\$11.21
\$45,000	\$2,250	\$4.59	\$80,000	\$4,000	\$8.15	\$115,000	\$5,750	\$11.72
\$50,000	\$2,500	\$5.10	\$85,000	\$4,250	\$8.66	\$120,000	\$6,000	\$12.23

* The plan maximum monthly benefit amount is \$6,000. If your salary is not noted in the above chart, please refer to the following worksheet to calculate your cost of insurance.

1. Indicate your annual earnings (the maximum covered annual earnings is \$120,000 – if greater than \$120,000 – use \$120,000)	= \$
2. Multiply the amount in Step 1 by the rate of \$0.0053 to obtain your total LTD annual cost.	= \$
3. Divide the amount in Step 2 by 52 to obtain your Total LTD Weekly Cost	= \$

Cost of insurance for all coverages, which are deducted from your paycheck, may increase or decrease in the future based upon the claims experience of participants. All provisions that apply to this coverage are governed by the Certificate. Rates may be subject to change.

PCA Retirement & Benefits, Inc.
Employee Paid Voluntary Long Term Disability
 Underwritten by UNUM

RATE SHEET

Rates Effective: March 1, 2009

Bi-Weekly Cost per Monthly Benefit Amount

Annual Income	Monthly Benefit	Bi-Weekly Cost	Annual Income	Monthly Benefit	Bi-Weekly Cost	Annual Income	Monthly Benefit	Bi-Weekly Cost
\$20,000	\$1,000	\$4.08	\$55,000	\$2,750	\$11.21	\$90,000	\$4,500	\$18.35
\$25,000	\$1,250	\$5.10	\$60,000	\$3,000	\$12.23	\$95,000	\$4,750	\$19.37
\$30,000	\$1,500	\$6.12	\$65,000	\$3,250	\$13.25	\$100,000	\$5,000	\$20.38
\$35,000	\$1,750	\$7.13	\$70,000	\$3,500	\$14.27	\$105,000	\$5,250	\$21.40
\$40,000	\$2,000	\$8.15	\$75,000	\$3,750	\$15.29	\$110,000	\$5,500	\$22.42
\$45,000	\$2,250	\$9.17	\$80,000	\$4,000	\$16.31	\$115,000	\$5,750	\$23.44
\$50,000	\$2,500	\$10.19	\$85,000	\$4,250	\$17.33	\$120,000	\$6,000	\$24.46

* The plan maximum monthly benefit amount is \$6,000. If your salary is not noted in the above chart, please refer to the following worksheet to calculate your cost of insurance.

1. Indicate your annual earnings (the maximum covered annual earnings is \$120,000 – if greater than \$120,000 – use \$120,000)	= \$
2. Multiply the amount in Step 1 by the rate of \$0.0053 to obtain your total LTD annual cost.	= \$
3. Divide the amount in Step 2 by 26 to obtain your Total LTD Bi-Weekly Cost	= \$

Cost of insurance for all coverages, which are deducted from your paycheck, may increase or decrease in the future based upon the claims experience of participants. All provisions that apply to this coverage are governed by the Certificate. Rates may be subject to change.

PCA Retirement & Benefits, Inc.
Employee Paid Voluntary Long Term Disability
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RATE SHEET

Rates Effective: March 1, 2009

Semi-Monthly Cost per Monthly Benefit Amount

Annual Income	Monthly Benefit	Semi - Monthly Cost	Annual Income	Monthly Benefit	Semi - Monthly Cost	Annual Income	Monthly Benefit	Semi - Monthly Cost
\$20,000	\$1,000	\$4.42	\$55,000	\$2,750	\$12.15	\$90,000	\$4,500	\$19.88
\$25,000	\$1,250	\$5.52	\$60,000	\$3,000	\$13.25	\$95,000	\$4,750	\$20.98
\$30,000	\$1,500	\$6.63	\$65,000	\$3,250	\$14.35	\$100,000	\$5,000	\$22.08
\$35,000	\$1,750	\$7.73	\$70,000	\$3,500	\$15.46	\$105,000	\$5,250	\$23.19
\$40,000	\$2,000	\$8.83	\$75,000	\$3,750	\$16.56	\$110,000	\$5,500	\$24.29
\$45,000	\$2,250	\$9.94	\$80,000	\$4,000	\$17.67	\$115,000	\$5,750	\$25.40
\$50,000	\$2,500	\$11.04	\$85,000	\$4,250	\$18.77	\$120,000	\$6,000	\$26.50

* The plan maximum monthly benefit amount is \$6,000. If your salary is not noted in the above chart, please refer to the following worksheet to calculate your cost of insurance.

1. Indicate your annual earnings (the maximum covered annual earnings is \$120,000 – if greater than \$120,000 – use \$120,000)	= \$
2. Multiply the amount in Step 1 by the rate of \$0.0053 to obtain your total LTD annual cost.	= \$
3. Divide the amount in Step 2 by 24 to obtain your Total LTD Semi-Monthly Cost	= \$

Cost of insurance for all coverages, which are deducted from your paycheck, may increase or decrease in the future based upon the claims experience of participants. All provisions that apply to this coverage are governed by the Certificate. Rates may be subject to change.

PCA Retirement & Benefits, Inc.
Employee Paid Voluntary Long Term Disability
 Underwritten by UNUM

RATE SHEET

Rates Effective: March 1, 2009

Monthly Cost per Monthly Benefit Amount

Annual Income	Monthly Benefit	Monthly Cost	Annual Income	Monthly Benefit	Monthly Cost	Annual Income	Monthly Benefit	Monthly Cost
\$20,000	\$1,000	\$8.83	\$55,000	\$2,750	\$24.29	\$90,000	\$4,500	\$39.75
\$25,000	\$1,250	\$11.04	\$60,000	\$3,000	\$26.50	\$95,000	\$4,750	\$41.96
\$30,000	\$1,500	\$13.25	\$65,000	\$3,250	\$28.71	\$100,000	\$5,000	\$44.17
\$35,000	\$1,750	\$15.46	\$70,000	\$3,500	\$30.92	\$105,000	\$5,250	\$46.38
\$40,000	\$2,000	\$17.67	\$75,000	\$3,750	\$33.13	\$110,000	\$5,500	\$48.58
\$45,000	\$2,250	\$19.88	\$80,000	\$4,000	\$35.33	\$115,000	\$5,750	\$50.79
\$50,000	\$2,500	\$22.08	\$85,000	\$4,250	\$37.54	\$120,000	\$6,000	\$53.00

* The plan maximum monthly benefit amount is \$6,000. If your salary is not noted in the above chart, please refer to the following worksheet to calculate your cost of insurance.

1. Indicate your annual earnings (the maximum covered annual earnings is \$120,000 – if greater than \$120,000 – use \$120,000)	= \$
2. Multiply the amount in Step 1 by the rate of \$0.0053 to obtain your total LTD annual cost.	= \$
3. Divide the amount in Step 2 by 12 to obtain your Total LTD Monthly Cost	= \$

Cost of insurance for all coverages, which are deducted from your paycheck, may increase or decrease in the future based upon the claims experience of participants. All provisions that apply to this coverage are governed by the Certificate. Rates may be subject to change.