

June 10, 2016

CN/WC Union Group Insurance Plan (Engineers, Trainmen and Conductors)
Open Enrollment Ends: July 29th, 2016
New Coverage Effective: August 1st, 2016

Dear Member,

We are pleased to inform you that Open-Enrollment for the CN/WC union group insurance plan has begun. All CN/WC Engineers, Trainmen and Conductors are eligible to enroll. All of the available coverages are offered **separately** and your participation in one or all of those coverages, and the level to which you elect to participate, is **voluntary** and strictly your individual choice. The purpose of this group insurance plan is to give you options to supplement your income in the event that you cannot work as a result of an injury or illness. The group plan offers Short Term Disability, Long Term Disability, Life Insurance and Accidental Death & Dismemberment coverages.

It is important to note: During the open enrollment period, **which ends July 29th, 2016**, you are **pre-approved and cannot be declined**. In order to take advantage of the coverages being offered, you simply need to complete the enclosed enrollment forms or call our office at (847) 387-3555 to enroll **no later than July 29th, 2016**. In addition to the highlights of this insurance plan listed below, also enclosed is more specific information for your review.

Short Term Disability (Option A = \$400 per week, Option B = 60% of Income):

- This benefit begins on the 15th day of injury and illness with a maximum benefit duration of 50 weeks
- No offset until 80% of pre-disability earnings are attained
- **Option A**
 - \$400 per week stackable to 80% of pre-disability earnings
- **Option B**
 - 60% of weekly income stackable to 80% of pre-disability earnings

Long Term Disability (Option A = \$2,000, Option B & C = 60% of monthly income):

- **Option A**
 - \$2,000 per month stackable to 70% of pre-disability earnings
 - Benefit Duration is 5 years
 - 360 day waiting period (STD covers entire first year)
- **Option B**
 - 60% of monthly income offset by RRB and other contract benefits
 - Benefit Duration is 2 years
 - 360 day waiting period (STD covers entire first year)
- **Option C**
 - 60% of monthly income offset by RRB and other contract benefits
 - Benefit Duration is 5 years
 - 360 day waiting period (STD covers entire first year)

Voluntary Group Life Insurance and AD&D offers:

- **Flexibility:** You may elect term life insurance and AD&D coverage for yourself to a maximum of \$200,000 **without taking a paramedical exam.**
- **Dependent Coverage:** Your spouse and dependent children (birth to 19 years old, or 25 if a full time student) can be insured on this plan as well. Your spouse can elect either **\$50,000 guaranteed** (not to exceed 50% of whatever you elect). Children are covered at an elected amount of **\$15,000** of Life insurance and AD&D.
- **No Pre-Existing Condition Limitations:** All pre-existing conditions are covered!

Your income and health are two of the most important assets you have. This plan gives you the ability to protect your income if you cannot work as a result of most health-related issues. Until now, this type of insurance has not been available to you. While your Union Officers have reviewed the policies offered and believe them to be the best coverages available in the industry, the decision to elect coverage and take advantage of any/all of these coverages is the individual responsibility of each member based on what they determine to be best for them and their family. We encourage you to study the enclosed information carefully and choose the plan that best accommodates the insurance needs of your family.

Call the Cornerstone office at (847) 387-3555 to enroll over the phone or complete and return the enclosed enrollment forms by **July 29th, 2016** to qualify for the open enrollment for this insurance. **If you meet the above deadline, your coverage will begin on August 1st, 2016** when the policy goes effective.

If you have any questions, please feel free to contact any member of the Cornerstone Assurance Group.

Best Regards,

Cornerstone Assurance Group

Cornerstone Office (847) 387-3555

Summary of Benefits & Rates



CN/WC

22333 Classic Court • Lake Barrington, IL 60010
(847) 387-3555 • www.railroaddisability.com

SHORT TERM DISABILITY (STD) - 24 hour coverage / on and off the job

- Pays on the 15th day of injury and illness
- Pre-existing conditions are covered after 12 months
- Benefits are stackable to 80% of pre-disability pre-tax earnings

Option A

- Pays a flat \$400 per week for a maximum of 50 weeks

Option B

- Pays 60% of income per week
- Pays for 50 weeks

Income	OPTION A		OPTION B		
	Weekly Max Benefit Amount	Monthly Premium	Income	Weekly Max Benefit Amount	Monthly Premium 50 Week Benefit
Any Income	\$400.00	\$87.20	\$70,000	\$807.69	\$161.54
			\$75,000	\$865.38	\$173.08
			\$80,000	\$923.08	\$184.62
			\$85,000	\$980.77	\$196.15
			\$90,000	\$1,038.46	\$207.69
			\$95,000	\$1,096.15	\$219.23
			\$100,000	\$1,153.85	\$230.77

LONG TERM DISABILITY (LTD) - 24 hour coverage / on and off the job

- Pays after 12 month waiting period
- Pre-existing conditions are covered after 24 months or 12 months treatment free

Option A

- Pays \$2,000 per month for a maximum of 5 years
- Stackable to 70% of pre-disability pre-tax earnings

Option B

- Pays 60% of income per month to a maximum of \$5,200
- Pays for 2 years OR
- Pays for 5 years

Income	OPTION A		OPTION B			
	Monthly Max Benefit Amount	Monthly Premium	Income	Monthly Max Benefit Amount	Monthly Premium 2 Year Benefit	Monthly Premium 5 Year Benefit
Any Income	\$2,000.00	\$46.00	\$70,000	\$3,500.00	\$29.05	\$40.25
			\$75,000	\$3,750.00	\$31.13	\$43.13
			\$80,000	\$4,000.00	\$33.20	\$46.00
			\$85,000	\$4,250.00	\$35.28	\$48.88
			\$90,000	\$4,500.00	\$37.35	\$51.75
			\$95,000	\$4,750.00	\$39.43	\$54.63
			\$100,000	\$5,000.00	\$41.50	\$57.50

Please See Reverse Side for Life/AD&D Benefits

Summary of Benefits & Rates



CN/WC

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LIFE AND AD&D

- Elect life insurance up to the guaranteed issue amount of \$200,000
- Elect spouse coverage up to the guaranteed issue amount of \$50,000
- Elect \$15,000 of dependent coverage

MEMBER LIFE INSURANCE AND AD&D	
Insurance Amount	Monthly Premium
\$10,000	\$3.60
\$20,000	\$7.20
\$30,000	\$10.80
\$40,000	\$14.40
\$50,000	\$18.00
\$60,000	\$21.60
\$70,000	\$25.20
\$80,000	\$28.80
\$90,000	\$32.40
\$100,000	\$36.00
\$110,000	\$39.60
\$120,000	\$43.20
\$130,000	\$46.80
\$140,000	\$50.40
\$150,000	\$54.00
\$160,000	\$57.60
\$170,000	\$61.20
\$180,000	\$64.80
\$190,000	\$68.40
\$200,000	\$72.00

SPOUSE LIFE INSURANCE AND AD&D	
Insurance Amount	Monthly Premium
\$5,000	\$1.80
\$10,000	\$3.60
\$15,000	\$5.40
\$20,000	\$7.20
\$25,000	\$9.00
\$30,000	\$10.80
\$35,000	\$12.60
\$40,000	\$14.40
\$45,000	\$16.20
\$50,000	\$18.00

DEPENDENT LIFE INSURANCE AND AD&D	
Insurance Amount	Monthly Premium
\$15,000	\$3.00

Benefits Estimator (based on an income of \$100k)

Important: This is for estimating purposes only. This benefits estimator assumes you qualify for benefits and that all of the general information provided applies. **Note:** This is not a guarantee of benefits. Benefits are paid by the provisions of the group policy. Please review the policy as some changes may not be reflected in this estimator.

General Information

Railroad:	<input type="text" value="CN"/>	Contract Benefit Carrier:	<input type="text" value="MetLife"/>	RRB Qualify:	<input type="text" value="Yes"/>
Union:	<input type="text" value="Other"/>	Contract Benefit Amount:	<input type="text" value="\$546"/>	RRB Amount:	<input type="text" value="\$300"/>
		Contract Benefit Duration:	<input type="text" value="52 Weeks"/>		

Short Term Disability

Income:	<input type="text" value="\$100,000"/>	Weekly Amount:	<input type="text" value="\$546"/>	<input type="text" value="MetLife"/>	RRB weekly amount:	<input type="text" value="\$300"/>
Offset A&B:	<input type="text" value="80%"/>	Max weekly combined benefit A&B:	<input type="text" value="\$1,538"/>			

This total is the maximum amount of money you are entitled to receive on a weekly basis. If the combined total of all your eligible benefits (Union STD Benefit + Contract Benefit + RRB Benefit) exceeds **80%** of your pre-tax pre-disability income your benefit will be offset. Amounts do not reflect elimination (waiting) periods.

Option	Benefit Type	Offsets	Benefit Max	Benefit if receiving RRB & Contract	Benefit if only receiving contract benefit	Benefit if only receiving RRB	Max Benefit duration
A	Flat Rate	Offsets occur at 80% of Income	\$400	\$400	\$400	\$400	50 weeks
B	60% of Income	Offsets occur at 80% of Income	\$1,154	\$692	\$992	\$1,154	50 Weeks

Long Term Disability

Income:	<input type="text" value="\$100,000"/>	Monthly Amount:	<input type="text" value="\$0"/>	<input type="text" value="MetLife"/>	RRB monthly amount*:	<input type="text" value="\$3,080"/>
Offset A:	<input type="text" value="70%"/>	Max monthly combined benefit A:	<input type="text" value="\$5,833"/>			
Offset B:	<input type="text" value="60%"/>	Max monthly combined benefit B:	<input type="text" value="\$5,000"/>			

This total is the maximum amount of money you are entitled to receive on a monthly basis. If the combined total of all your eligible benefits (Union STD Benefit + Contract Benefit + RRB Benefit) exceeds **70% or 60%** of your pre-tax pre-disability income your benefit will be offset. Amounts do not reflect elimination (waiting) periods.

Option	Benefit Type	Offsets	Benefit Max	Benefit if receiving RRB	Benefit if NOT receiving RRB	Max Benefit duration
A	Flat Rate	Offsets occur at 70% of Income	\$2,000	\$2,000	\$2,000	5 years
B	60% of Income	Offsets occur at 60% of Income	\$5,000	\$1,920	\$5,000	2 years
C	60% of Income	Offsets occur at 60% of Income	\$5,000	\$1,920	\$5,000	5 years

Member Voluntary Benefits Enrollment Form

Please sign, date and return this form to: **22333 Classic Court • Lake Barrington, IL 60010 Fax: 815-425-5349**

Please print clearly and mark carefully.

EMPLOYER NAME: CN/WC				Benefits Effective: 8/1/16	
PLEASE CHECK THE APPROPRIATE BOX					Group Plan Number:
<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> Re-Enrollment	<input type="checkbox"/> Add Member/Dependents	<input type="checkbox"/> Information Change		
<input type="checkbox"/> Increase Amount	<input type="checkbox"/> Family Status Change	<input type="checkbox"/> Drop/Refuse Coverage			
Class: All Eligible Members			Division:		

ABOUT YOU		
First Name, MI, Last Name:		
Home Address:		
City, State:		Zip Code:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm-dd-yy):	Social Security Number:
Are you married or do you have a spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Phone:	Mobile Phone:
Date of marriage/union:	Email Address:	

ABOUT YOUR JOB		
Job Title:		Hours worked per week:
Date of full-time hire (mm-dd-yy):	Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> On Disability	Annual Salary:

ABOUT YOUR FAMILY			
Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exception. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.			
Spouse (First, MI, Last Name)	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm-dd-yy):	Status (check all that apply): <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non-standard dependent
Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm-dd-yy):	Status (check all that apply): <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non-standard dependent
Child/Dependent 2:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm-dd-yy):	Status (check all that apply): <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non-standard dependent
Child/Dependent 3:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm-dd-yy):	Status (check all that apply): <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non-standard dependent
Child/Dependent 4:	<input type="checkbox"/> Add <input type="checkbox"/> Drop Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm-dd-yy):	Status (check all that apply): <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non-standard dependent

SHORT TERM DISABILITY (STD) OPTIONS - All benefits are non-taxable (covers on and off the job)

Voluntary Short Term Disability (STD) Coverage:

- This benefit begins on the 15th day of injury and illness with a maximum benefit duration of 50 weeks.
- Pre-existing conditions are covered for the full benefit duration after 12 months of continuous coverage.
- This benefit will offset once 80% of your pre-disability earnings are attained.

Select a weekly Short Term Disability (STD) benefit:

- Option A** I elect Option A. **Pays a flat \$400 per week.** **Monthly premium: \$87.20**
- Option B** I elect Option B. **Pays 60% of weekly income per week for 50 weeks.** **Monthly premium: _____**
- Decline** I decline to purchase Short Term Disability (STD).

LONG TERM DISABILITY (LTD) OPTIONS - All benefits are non-taxable (covers on and off the job)

Voluntary Long Term Disability (LTD) Coverage:

- This benefit starts paying after an elimination period of 360 days.
- Pre-existing conditions are covered after 24 months of continuous coverage or 12 months treatment free.
- Long Term Disability (LTD) Option B and C are offset (reduced) by Railroad Retirement Board benefits and contract benefits.

Select a monthly Long Term Disability (LTD) benefit:

Please refer to the enclosed Rate Sheet for Monthly Premium Cost.

- Option A** I elect Option A. **Pays a flat \$2,000 per month for 5 years - stackable to 70% of your pre-disability earnings.** **Monthly premium: \$46.00**
- Option B** I elect Option B. **Pays 60% of monthly income per month for 2 years to a maximum of \$5,200 per month - offset by RRB.** **Monthly premium: _____**
- Option C** I elect Option C. **Pays 60% of monthly income per month for 5 years to a maximum of \$5,200 per month - offset by RRB.** **Monthly premium: _____**
- Decline** I decline to purchase Long Term Disability (LTD).

LIFE INSURANCE AND AD&D OPTIONS - All benefits are non-taxable (covers on and off the job)

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D):

Please refer to the enclosed Rate Sheet for Monthly Premium Cost.

Select your Life and AD&D coverage:

Member

- Guarantee Issue amount is **\$200,000**.

I elect \$ _____ of Voluntary Life and AD&D coverage at a monthly cost of \$ _____.

I decline this coverage.

Spouse

- Spouse Guarantee Issue amount is **\$50,000**.
- The amount may not be more than 50% of the Member amount for Voluntary Life.

I elect \$ _____ of Spousal Voluntary Life and AD&D coverage at a monthly cost of \$ _____.

I decline this coverage.

Dependent/Child(ren)

- **\$15,000** is guaranteed issue and covers all children.

I elect **\$15,000** of Child Life coverage at a monthly cost of **\$3.00**. (all children covered for **\$3.00**)

I decline this coverage.

Important Notes:

Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Voluntary Life.

LIFE INSURANCE BENEFICIARY DESIGNATION

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by these plans.

PRIMARY BENEFICIARY

Primary Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Primary Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Primary Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Primary Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:

CONTINGENT BENEFICIARY

In the event the designated beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains the beneficiary information.

Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:

- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I understand that my dependent(s) cannot be enrolled for a coverage, if I am not enrolled for that coverage.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of insurability. The carrier has the right to reject your request.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- Plan design limitations and exclusions may apply. Coverage changes may take effect after enrollment. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- Your coverage will not be effective until approved by the insurance company or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I acknowledge and consent to receiving electronic copies of coverage related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I certify that I, as the Applicant, have read the completed application and understand that any false statement or misrepresentation in this application may result in the loss of coverage under this policy.
- I attest that the information provided above is true and correct to the best of my knowledge.
- **I understand that rates and benefits may change at or before renewal.**

Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page. The laws of New York require the following statement appear:

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. (Does not apply to Life Insurance.)

SIGNATURE OF MEMBER X _____ **DATE** _____

Additional Information (if applicable)

SPECIAL REQUEST

ADDITIONAL DEPENDENTS

Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm-dd-yy):	Status (check all that apply): <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non-standard dependent
Child/Dependent 2:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm-dd-yy):	Status (check all that apply): <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non-standard dependent
Child/Dependent 3:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm-dd-yy):	Status (check all that apply): <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non-standard dependent
Child/Dependent 4:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm-dd-yy):	Status (check all that apply): <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non-standard dependent

ADDITIONAL LIFE INSURANCE BENEFICIARY DESIGNATION

Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:
Contingent Beneficiary Name:	Date of birth (mm-dd-yy):	Relationship:	Percentage:

COMMUNICATION

Please deliver all policy information and correspondence by:

- Email
 U.S. Postal Service Mail

Enrollment Office

22333 Classic Court
 Lake Barrington, IL 60010
 PHONE (847) 387-3555
 FAX (815) 425-5349
www.railroaddisability.com

PAYMENT AUTHORIZATION FORM

ES23069 - CN/WC

CUSTOMER # (FOR OFFICE USE ONLY)	DATE:
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Effective Date of Authorization: ____ / ____ / ____

Type of Authorization Form:

<input type="checkbox"/> New authorization	<input type="checkbox"/> Change banking information	<input type="checkbox"/> Change payment date
<input type="checkbox"/> Change payment amount	<input type="checkbox"/> Discontinue electronic payment	

COMPLETE BELOW

First Name, MI, Last Name: _____

Address: _____

City, State: _____	Zip Code: _____
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Email Address: _____

MONTHLY PAYMENT

I elect to split my premium into 2 equal payments per month.

Payment Day 1: _____ Payment Day 2: _____ Date of 1st Payment: 8 / ____ / 16
Payment dates will be the 10th & 20th if no payment days are selected.

I elect to pay my premium once per month.

Payment Day: _____ Date of 1st Payment: 8 / ____ / 16
Payment day will be the 15th if no payment day is selected.

STD Premium	\$ _____
LTD Premium	\$ _____
Life and AD&D Premium	\$ _____
Service Fee	\$1.00
Total Monthly Payment	\$ _____

CHECKING/SAVINGS

Please debit payments from my (check one): <input type="checkbox"/> Checking Account (attach a voided check below) <input type="checkbox"/> Savings Account (contact your financial institution for Routing #)	Routing Number: _____ Account Number: _____ <div style="font-size: small; margin-top: 5px;"> ⑆ 1 2 3 4 5 6 7 8 9 ⑆ 1 2 3 ⑆ 1 2 3 4 5 6 ⑆ 0 0 0 ⑆ Routing Number Account Number Check Number Valid Routing # must start with 0, 1, 2, or 3 </div>
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I authorize the above organization to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.

Signature: _____ Date: _____

If using a checking account, please attach a voided check below.

Please attach voided check here.