



574 Boston Road
P.O. Box 5059
Billerica, MA 01822-5059
Telephone (978) 663-3232
(800) 464-0039
Fax (978) 663-5431

GUARANTEED ACCEPTANCE

DISABILITY INCOME PLAN

Northeast Business Trust is pleased to make available to its members and employees a unique disability income plan which can provide an easy solution **to protect your most valuable asset.....your ability to earn a living!**

Do you have a need for disability insurance? If you can't afford to be disabled and without income for one, two, three or even up to twelve months, the answer may be YES.

Look at these Highlights

- **Guaranteed acceptance** - no health statements to complete*
- Benefits will begin on the **15th day** of disability due to a non-occupational accident or sickness
- Choice of benefit duration (**26 or 52 weeks**)
- Choice of **weekly benefit** amounts (up to **\$750 per week**)
- **Voluntary enrollment**, no participation requirements (employees decide if they want to participate and can pay for their own coverage)
- Available to all employees who work at least 20 hours/week
- Low premiums - due to NBT's group buying power

For monthly rates and requirements, see the Rate Sheet

*Acceptance is guaranteed, however, pre-existing conditions do apply. Benefits will not be paid during the first 12 months on the plan for any conditions for which treatment was received in the 12 months prior to your effective date.

HERE'S HOW TO ENROLL

1. Select weekly benefits and plan duration (ALL EE's must select the same benefit duration)
2. **Employer** (owner or sole proprietor) completes **NBT Membership Application** and **Employer Application**
3. **Each employee** enrolling completes **Employee Application**
4. Enclose first monthly premium (**payable to NBT Inc.**)
5. Enclose annual membership dues of \$25 (**payable to NBT Inc.**)

Forward all enrollment materials to:

Northeast Business Trust, Inc 574 Boston Rd, PO Box 5059 Billerica, MA 01821

If you have any questions, please call one of our specialists at 1-800-464-0039.

Northeast Business Trust

(Short Term Disability Income Plans)

Benefits begin: 15th day for accident or sickness and continue for either **26 or 52 weeks***

Monthly Premium Based on Age

FOLLOW THE COLUMNS IN DESCENDING ORDER

STEP 1

FIND YOUR ANNUAL SALARY

If it is at least:

\$22,285	\$29,715	\$33,430	\$37,143	\$44,571	\$55,714
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STEP 2

YOUR ANNUAL SALARY QUALIFIES YOU FOR A BENEFIT OF:

\$300/week	\$400/week	\$450/week	\$500/week	\$600/week	\$750/week
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STEP 3

CHOOSE YOUR BENEFIT PLAN

Monthly Premium

Age	26 Week Benefit Plan					
18-39	\$22.77	\$30.36	\$34.16	\$37.95	\$45.54	\$56.93
40-44	\$21.45	\$28.60	\$32.18	\$35.75	\$42.90	\$53.63
45-49	\$24.75	\$33.00	\$37.13	\$41.25	\$49.50	\$61.88
50-54	\$29.70	\$39.60	\$44.55	\$49.50	\$59.40	\$74.25
55-59	\$35.97	\$47.96	\$53.96	\$59.95	\$71.94	\$89.93
60-64	\$41.91	\$55.84	\$62.87	\$69.85	\$83.82	\$104.78

Monthly Premium

Age	52 Week Benefit Plan					
18-39	\$26.40	\$35.20	\$39.60	\$44.00	\$52.80	\$66.00
40-44	\$26.14	\$34.85	\$39.20	\$43.56	\$52.27	\$65.34
45-49	\$30.16	\$40.22	\$45.24	\$50.27	\$60.32	\$75.41
50-54	\$36.17	\$48.22	\$54.25	\$60.28	\$72.34	\$90.42
55-59	\$43.82	\$58.43	\$65.74	\$73.04	\$87.65	\$109.56
60-64	\$51.05	\$68.07	\$76.58	\$85.09	\$102.10	\$127.63

*Subject to 12/12 pre-existing condition exclusion



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NBT Membership Application

2006 V1

<u>Employer (Correct Legal Name)</u>		<u>Date Business Established (Mo./Yr.)</u>		
<u>Employer's Business Address (street, city, state, zip)</u>		<u>Telephone</u> ()		
<u>Name of Owner/Principal Contact</u>	<u>Title</u>	<u>Fax</u> ()		
<u>Billing Address (street, city, zip) If different than the business address</u>				
<u>Type of Business</u> <u>Corporation</u> <u>Partnership</u> <u>Proprietorship</u> <u>Other (explain below)</u>				
<u>Nature of Business</u>	SIC code (4 digits) [] or NAICS code (6 digits) []	<u># Full-time Employees</u> (30 hours or more)	<u># Part-time Employees</u>	<u>Employer's Tax ID #</u>
Primary Business Activity				
Finance	Retail	Real Estate		
Insurance				
Construction	Manufacturing	Wholesale		
Professional	Service	Transportation	Other _____	
Areas of Interest				
Group HMO Plans		Retirement Planning	Discounted Telephone Service	
Low Cost Term Life		Group Dental & Vision	Discounted Car Rental	
Group Salary Continuation		Discounted Computers	Discounted Shipping	
I certify that the information on this form is true and complete.				
<u>Signature (Authorized Employer Representative)</u>		<u>Title</u>	<u>Date</u>	

Broker Name (If Applicable)	<u>Street, City, State, Zip</u>		Telephone _____
			E-Mail _____
			Fax _____

For NBT Use Only	<u>Account No.</u>	<u>Effective Date</u>	<u>Approved By</u>	<u>Date</u>	<u>Account Rep</u>
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EMPLOYER APPLICATION

EMPLOYER INFORMATION			
Employer (Correct Legal Name) <input type="checkbox"/> <u>Sole Proprietor</u> <input type="checkbox"/> <u>Corporation</u> <input type="checkbox"/> <u>Partnership</u> <input type="checkbox"/> <u>Other</u> _____			
Mailing Address <u>Street</u> _____		City _____	
<small>(DO NOT USE P.O. BOX)</small>		State _____	
Telephone Number _____		Nature of Business _____	
		Waiting period (Future employees) <i>Select one</i> _____ 30 Days _____ 60 Days	
Requested Effective Date <small>(must be 1st of the month)</small>		Benefits Payable (15th day accident, 15th day sickness) Benefit Duration (Select one) <input type="checkbox"/> 26 Weeks <input type="checkbox"/> 52 Weeks	
		No. of Eligible Employees	No. enrolled

Application for membership in the Financial Services Trust

The undersigned employer applies for membership in the Financial Services Trust (the "Trust"). Application for membership includes group insurance provided under the master group policy(ies) issued by Medical Life Insurance Company (the "Company") to the Trust.

- 1) Each participating employer shall subscribe to and adopt the terms and provisions of the Trust agreement.
- 2) Each participating employer shall be bound by the provisions, conditions and limitations of the Master Group Policy, the General Conditions in the Application for Voluntary Benefits, and any applicable administrative provisions.
- 3) Insurance issued hereunder is in consideration of the Application of the Participating Employer and the payment of premiums when due.

Any Employer shall cease to be a participating employer under the Trust on the earliest of the following dates:

- 1) the date the employer no longer meets one or more of the requirements set forth in this application for membership;
- 2) the date he discontinues or suspends active business operations or is placed in bankruptcy or receivership;
- 3) the date his business loses its entity by means of dissolution, merger or otherwise; or
- 4) the date the Master Group Policy is terminated.

It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does he have any obligation under any policy of insurance. All claims for and benefits provided by the insurance applied for shall be made to and payable by the Company in accordance with the provisions of such policy(ies). The Trust Agreement and Master Group Policy(ies) held by the Trustee are available for inspection during regular business hours at the office of the Company.

GENERAL CONDITIONS

1. All active employees who work at least 20 hours a week are eligible to enroll.
2. Each employee must make written application to Medical Life and must be Actively at Work on his effective date for coverage to become effective. If not Actively at work (as defined in the policy) on the day coverage would otherwise become effective, an employee's coverage will begin on the date of his return to Active Work.
3. Premiums are due and payable monthly on the first day of each month.
4. No insurance under this Application will become effective until this Application is accepted and approved by Medical Life Insurance Company.
5. Benefit amounts are subject to a 12/12 pre-existing condition exclusion.
6. I have read and understand all the sections of this application.

The above information is accurate to the best of my knowledge. I understand that the information on this Application and any other information I provide shall serve as the basis for the insurance to be issued, and that I have a duty to notify the Company of any changes. I have relied upon no oral or written representations that contradict item (2) above.

Date Signed _____ **Authorized Signature/Employer** _____

PREMIUM CALCULATION

Employee Name	Age	Weekly Benefit	Benefit Plan 26 or 52 week	Monthly Premium \$
TOTAL MONTHLY PREMIUM				

Group No./Div. _____

EMPLOYEE APPLICATION To be completed by each applicant

EMPLOYEE INFORMATION					
<u>NAME OF EMPLOYEE</u>			<u>FIRST</u>	<u>MIDDLE</u>	<u>LAST</u>
			<u>DATE OF HIRE (FULL TIME) MO / DAY / YEAR</u>		<u>HRS WORKED / WEEK</u>
<u>SOCIAL SECURITY NO.</u>		<u>SEX</u>		<u>DATE OF BIRTH</u> MO / DAY / YEAR	<u>ANNUAL SALARY</u>
		<input type="checkbox"/> M <input type="checkbox"/> F			\$
					<u>JOB TITLE</u>
<u>EMPLOYER</u>			<u>STREET</u>		<u>CITY</u>
					<u>ZIP CODE</u>

BENEFIT SELECTION

Benefit : Eligible employees select weekly benefit, subject to 70% of basic weekly income

Initial Enrollment Decline Coverage Open Enrollment: Change (Benefit Amount: _____)

Indicate choice of plan:

Select Plan:	Providing a Weekly Benefit of:	Your Annual Salary Must be at Least:	Select Plan:	Providing a Weekly Benefit of:	Your Annual Salary Must be at Least:
<input type="checkbox"/>	\$300	\$22,285	<input type="checkbox"/>	\$500	\$37,143
<input type="checkbox"/>	\$400	\$29,715	<input type="checkbox"/>	\$600	\$44,571
<input type="checkbox"/>	\$450	\$33,430	<input type="checkbox"/>	\$750	\$55,714

Benefits Payable: (15th Day Accident; 15th Day Sickness)

- New STD plans and subsequent increases in the weekly benefit amount are subject to a 12/12 pre-existing condition exclusion.
- Benefits are payable for non-occupational disabilities only.
- This coverage does not replace or change any requirement for coverage under any Worker's Compensation or similar law.

GENERAL CONDITIONS

1. All active employees who work at least 20 hours a week are eligible to enroll.
2. Each employee must make written application to Medical Life and must be Actively at Work on his effective date for coverage to become effective. If not Actively at work (as defined in the policy) on the day coverage would otherwise become effective, an employee's coverage will begin on the date of his return to Active Work.
3. I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits.
4. If I have declined coverage, I understand that if I choose to enroll at a later date, my cost may be higher.

Date Signed _____ Employee Signature _____



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PRE-AUTHORIZED CHECKING APPLICATION

**Authorization Agreement To Honor Pre-Authorized Payments
Drawn By And Payable To Northeast Business Trust.**

Company Name (As appears on your NBT bill): _____

Company Account Number (As appears on your NBT bill): _____

I (We) hereby request and authorize Northeast Business trust ("NBT") to initiate withdrawals from my (our) checking account indicated below at the depository named below. Said withdrawals to be made up to 5 days prior to the first of each month and to be used as payment for full monthly balance due on the above named account and company. This authorization is to remain in full force and effect until NBT has received written notification from me (us) revoking the authorization agreement in such time as to afford NBT a reasonable opportunity to act on it.

Depositor Name (as appears on account): _____

Depository (Bank) Name: _____ Branch: _____

City: _____ State: _____ Zip: _____

Account Number: _____ Checking Savings

Routing Number (9 Digits): _ _ _ _ _

Name (please print): _____

Signature: X _____

Date: _____

ATTACH VOIDED CHECK HERE