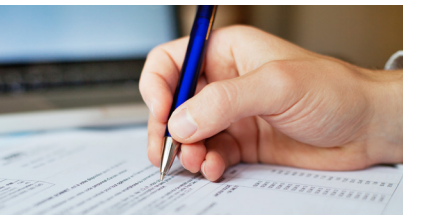
– J. FLYNN –
INSURANCE AGENCY, LLC

A Guide To Disability and Death Benefits

Contact Us With Any Questions

Jennifer Flynn
J. Flynn Insurance Agency, LLC.
631.910.4256
jennifer@jflynninsurance.com

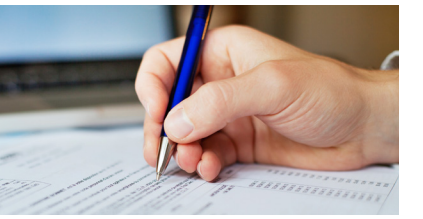
Introduction

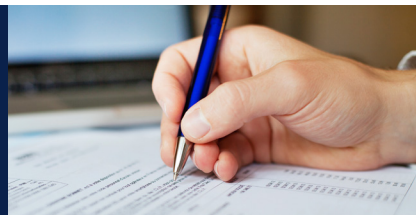


Disability benefits are payments that guarantee income when an employee cannot work because of sickness (physical or mental) or accident. The length and cause of the disability are two key factors in determining the form of disability benefit that may apply. Disability periods may be temporary or permanent and may result from an on-the-job accident (typically paid from a workers' compensation plan) or illness or may be completely unrelated to work.

Legal Disclaimer: Information in this document is general in nature and not intended to replace legal advice in any particular manner.

Contents





Types of Disability

Short-Term Disability

A short-term disability is usually defined as an employee's inability to perform the duties of the employee's current position. Paid sick leave and short-term disability plans protect employees against loss of income during temporary absences from work due to illness or accident. Sick leave is provided to most full-time employees, and sickness and accident insurance to a significant but smaller number of full-time employees. Some employees have both sick leave and short-term disability plans, with the two benefits coordinated. The duration of short-term disability benefits typically ranges from 13 to 52 weeks, although most employees are covered for up to 26 weeks. Short-term disability plans usually specify when successive periods of disability are considered to be separate disabilities and when they are considered to be a continuous disability.

Often, paid sick leave is available to the employee without any waiting period, and it may be used during the interim before sickness and accident insurance payments begin. Under most sickness and accident insurance plans, the disability must exist for at least one week before an employee becomes eligible for benefits. This waiting period is intended to control plan costs and simplify plan administration.

Sick leave usually provides 100 percent of an employee's normal earnings, and the plan frequently specifies a maximum number of covered days each year that are permitted for paid sick leave (for example 13 days). Since 2011, the state of Connecticut requires paid sick leave to accrue at one hour per 40 hours worked, if an employer employs more than 49 people in Connecticut. Effective July 1, 2015 the state of California requires certain employers with at least one employee to provide paid sick leave. Additionally, effective July 1, 2015, the state of Massachusetts requires up to 40 hours of paid sick leave per individual annually if there are more than 10 employees. Other plans provide sick leave benefits (for example 30 days) per illness instead of per year. When used in conjunction with sick leave plans, sickness and accident plans provide benefits after sick leave benefits are exhausted.

The level of sickness and accident benefits for short-term disability may be expressed as a dollar amount or as a percentage of employee earnings. The level and duration of benefits may increase with service. Generally, benefits replace between one-half and two-thirds of a person's predisability gross weekly income. It is often thought that a higher replacement rate would create a disincentive for employees to return to work.

Employers generally pay for short-term disability plans. These plans may be financed under the following:

- A group insurance contract with a private insurance carrier
- An employer self-insurance arrangement.
- An employer-established employee benefit trust fund.
- General corporate assets (such as for a sick leave plan).

Long-Term Disability

In most long-term plans, disability for the first two years is defined somewhat differently from disability under short-term plans (for example, an employee's inability to perform the duties of the employee's occupation vs. the duties of the current position). If the disability continues for more than two years, the definition of disability usually changes to the inability to perform any occupation that the person is reasonably suited to do by training, education, and experience.

Private sources of long-term disability benefits include the following:

- Disability provisions under long-term disability plans
- Group life insurance.
- Employment-based pension plans.
- Other insurance arrangements (such as individual insurance protection).

Like short-term benefits, long-term disability benefits are integrated with benefits from other sources to produce reasonable replacement rates and to control costs.

Long-term benefits generally begin after short-term disability benefits (such as sick leave, and illness or accident insurance) expire. Most plans provide benefits for the length of a disability up to a specified age (for example age 65, when Social Security and employment-based retirement benefits usually begin).

Typically, long-term disability plans pay benefits amounting to approximately 60 percent of a person's predisability monthly pay. However, some plans provide as much as 70 percent of predisability pay. Additionally, some plans contain a provision stating that private-sector long-term disability benefits plus Social Security disability benefits cannot exceed a stated amount (for example 75 percent of predisability salary). Most plans set a limit on monthly payments. The cost of long-term disability benefits may be financed by the following:

- Employer contributions.
- Employee contributions
- Employer/employee cost sharing.

Similar to short-term disability plans, long-term plans usually specify when successive periods of disability are considered to be separate disabilities and when they are considered to be a continuous disability. In addition, some long-term plans provide for continued payment of at least some disability benefits when long-term disabled persons engage in rehabilitative employment.

Disability Benefit Options

The following choices are available to employers that decide to offer disability benefits:

- Paid sick leave benefits.
- Short-term disability insurance.
- Long-term disability insurance

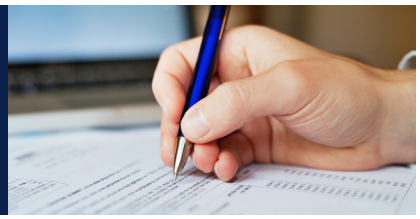
There are other state- or federally-mandated programs for employees who become disabled. They are not benefit programs in that employers are not required to purchase them as they would a conventional benefit plan; however, employers may be required to pay for them, administer them in part, and provide employees with information about them. These benefits include the following:

- Workers' compensation.
- State-run temporary disability programs.
- Federal Social Security disability benefits.

Paid Sick Leave Benefits

Paid sick leave benefits are discussed in more detail in other PGP materials and communications.

Disability Insurance



More employers are beginning to recognize the value of disability insurance as a benefit. These products offer peace of mind, because if an employee suffers a disabling illness or accident, the employee can focus on recovery knowing their financial stability is protected. By providing competitive benefits to employees, employers can attract and keep employees while increasing productivity, as well as the overall health and well-being of the workforce.

Since disability protection is something employees need and want, it is sensible for employers to provide the coverage. Beyond the needs of employees, these benefits offer important advantages to employers. The hidden or indirect costs of disability — such as salaries for replacement employees or the value of lost productivity — are an expensive problem for businesses.

Disability insurance coverage can be paid for in the following ways:

- Fully paid by the employer.
- Cost-shared with employees.
- Offered as an employee-paid, voluntary benefit.

In many cases, employers fund a basic plan to protect employees, and employees may then add supplemental coverage to better address their individual financial circumstances.

Types of Disability Policies

Short-Term Disability Policies

Short-term disability policies are private policies that employers may purchase for employees. Short-term disability insurance is designed to provide income to employees who become disabled due to sickness or an accident and are unable to work after an initial waiting period (generally one to seven days). Short-term benefits are usually expressed in terms of the maximum number of weeks that the plan will pay (the industry standard is 26 weeks). Government statistics show that these benefits typically replace about 50 percent to 67 percent of an employee's income.

Benefits Period

Benefits payment is usually expressed in terms of a maximum number of weeks (13, 26, or 52) of benefits for a single period of disability. While statistics show that most short-term disabilities last far less than 13 weeks, 26 weeks is the most common limitation on disability policies.

Waiting Period

Generally, an employee will be required to satisfy a waiting period before disability benefit payments will begin. During the waiting period, employees are likely to use sick leave, vacation, or personal leave, if those benefits are offered. If an employee is collecting disability benefits and the duration of the disability exceeded the limits of the short-term policy, either of the following would happen:

- The employee might begin collecting under a long-term disability plan (if one is offered by the employer).
- Benefits would terminate.

Long-Term Disability Policies

Long-term disability policies take up where short-term policies leave off, covering employees who become disabled and unable to work for longer periods of time (generally six months or longer).

Benefits Period

Long-term disability insurance typically provides 50 to 60 percent of pay to disabled employees, which continues to retirement age or for a specified number of months, depending on the employee's age at the time of disability. In most plans, benefits are paid for the duration of the disability up to the age of 65. Benefits are usually computed as a percentage of the employee's basic compensation prior to the disability. There is usually a maximum dollar amount per week or month.

What Counts as Disabled

Long-term disability insurance plans generally define disability in one of the following two ways

- The inability to perform the tasks of one's own occupation.
- The inability to perform the tasks of any occupation at all.

A plan may use both definitions of disability for separate periods of time. For example, for the first 24 months of a disability, disability may be defined as an inability to perform the employee's regular job. However, after that it may mean an inability to perform any job that the employee is qualified to perform.

An employee does not have to be permanently disabled to receive benefits; however, most plans require that the employee must have been a regular, full-time employee for at least a year to be eligible.

Tax Treatment of Disability Benefits

Amounts received by an employee through accident or health insurance for personal injuries or sickness are included in the employee's gross income to the degree they are the following:

- Attributable to employer's contributions that were not includible in the gross income of the employee
- Paid by the employer

An employee's gross income does not include amounts received through accident or health insurance for personal injuries or sickness to the extent that the payments received adhere to the following:

- Constitute payment for the permanent loss or loss of use of a body member (such as arm, leg, hand, or eye or function of the body or the permanent disfigurement of the employee or the employee's dependent.
- Are computed with reference to the nature of the injury, not the period the employee is absent from work.

Insurance Plan Terms

This section explains some of the terms that employers need to be aware of when making plan choices.

Own Occupation or Any Occupation

Long-term disability plans provide income when an employee is unable to work in the employee's **own occupation** or to work in **any occupation** for which the person is suited by education, training, and experience. Some plans have the more restrictive own occupation standard for an initial period — usually two years. During this time, the plan pays benefits if the person cannot perform the essential work functions of the job in which the person was employed when becoming disabled. That two-year period is customarily followed by the broader any occupation standard. Under this standard, a plan would continue to pay benefits only if the person were unable to perform any job functions for which the individual might be qualified based on education, experience, and training.

Income Replacement

Plans typically replace 50 to 60 percent of income known as **income replacement**. Plans are structured to balance financial assistance in a time of great need with incentives to return to work.

Waiting or Elimination Period

With a **waiting** or **elimination period**, benefits in a long-term disability plan usually start 30 to 180 days after the disability occurs. Employers should coordinate coverage so that once any sick pay and short-term disability benefits have been exhausted, long-term disability benefits begin immediately.

Residual or Partial Disability

Residual or **partial disability** benefits assist when an employee experiences a disability and then returns to work part time. The partial payments offset earnings lost while the employee makes a transition back to a full-time schedule.

Rehabilitation

Employers should be familiar with the rehabilitation and disability case management capabilities the insurance carrier offers. **Rehabilitation** management considers how successful the carrier has been in assisting employees as they return to productive work. In addition, employers should look into how well these rehabilitation and management resources coordinate with services the company provides on its own or through other benefits service providers. Easy integration for seamless administration is key to program success.

Ease of Use

It is beneficial when employers and employees have plenty of **ease of use** (easy, timely ways to get information).

Large employers often value online access or other simple methods to obtain facts about their short-and long-term disability experience, such as knowing how many employees are out, how long employees are out on average, and at which locations.

Employers of any size often find value in receiving help with the Family and Medical Leave Act (FMLA), Americans with Disabilities Act (ADA), and other regulations. Disability insurance plans are a potential tool for making FMLA notification in a timely, accurate way.

From the employee perspective, plans often work best when there are multiple ways to get information — mail, fax, phone, or online. The easier it is for employees to access information they need — such as status of a benefit check — the easier it will be for the employer's human resource or benefits area.

Customization

It is essential for short- and long-term disability insurance providers to offer **customization** (customize a plan towards a company's existing benefits and information systems). This is particularly true for large organizations of 2,000 or more employees that may already have some form of disability insurance and are making a change or addition to the current program. Consider how well the plan will work with and transfer information from prior plans. Employers should also check if the plan offers provisions that solve problems specific to the employer's organization.

Coordination and Integration

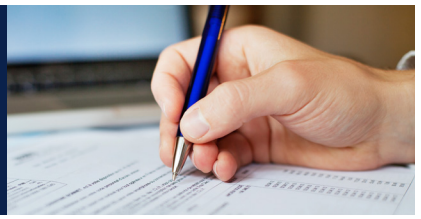
The best plans offer **coordination and integration** (coordinate the short- and long-term benefit processes, and also coordinate with other health and welfare benefits the employee may need to access, for example workers' compensation). How tightly the different benefits need to coordinate or integrate depends on the size and nature of the organization. Larger companies likely will have more benefit programs to coordinate and greater potential gains from active management of those programs because they will have more claim situations. Smaller companies, especially those with little or no human resource staffing, primarily need a quality plan that works well at all junctures in the process — communicating the benefit to the employee, serving the employee as a customer, and integrating easily with other benefits.

Another alternative in coordinating benefits is for an employer to supplement group disability insurance with individual disability income insurance. Group disability insurance is a very valuable benefit, but may leave a gap in coverage for some individuals (such as those who are highly compensated). Supplemental individual disability income insurance can be customized to help fill any gaps in coverage. The employer chooses if the individual policies are employer-or employee-paid. (Contact the insurance representative or financial professional for more information.)

Workers' Compensation Programs

Workers' compensation is an essential employer-financed, no-fault insurance benefit program that compensates employees who have been disabled because of a work-related injury, illness, or disease. In addition to federal regulations, each state has enacted some form of workers' compensation law to protect employees against loss of employment income and substantial medical fees resulting from a work-related disability.

For more information, see Workers' Compensation.



State Temporary Disability Insurance

Temporary disability insurance, sometimes referred to as cash sickness benefits, provides employees with partial compensation for loss of wages caused by temporary nonoccupational disability. Only the states of California, Hawaii, New Jersey, New York, Rhode Island, the territory of Puerto Rico, and the railroad industry currently have temporary disability insurance laws.

The temporary disability insurance laws, like the unemployment insurance programs, cover most commercial and industrial wage and salary employees in private employment. Principal occupational groups excluded are the following:

- Domestic workers.
- Family workers
- Government employees.
- The self-employed (although California law permits elective coverage for self-employed persons).

State and local government employees are included in Hawaii, and the other state laws permit some or all public employees to elect coverage. Agricultural workers are not covered in most jurisdictions, but California, Hawaii, New Jersey, and Puerto Rico do grant coverage in varying degrees.

In Rhode Island, all benefits are provided from publicly operated disability insurance funds. In California, New Jersey, and Puerto Rico, employers may "contract out" of the public plan by providing an approved private plan, usually one insured by a commercial company or financed on a self-insured basis. The laws in Hawaii and New York require employers to provide sickness protection of a specified value for employees by establishing a privately insured or self-insured plan, or in the case of New York, by insuring with a state fund that has many characteristics of a private carrier. In jurisdictions that allow private plans, union or union-management plans may provide the sickness benefits required by law.

Qualification

To qualify for state managed benefits, a claimant must have a specified amount of past employment or earnings and be disabled. The laws generally define **disability** as the inability to perform regular or customary work because of a physical or mental condition.

In most jurisdictions with private plans, employees become immediately insured upon their employment or, in some cases, some probationary period of employment is required, usually from one to three months. Upon cessation of employment after a specified period, employees generally lose their private plan coverage and must rely on the state fund for such protection.

Benefits Payment

All the state laws restrict payment of benefits when a claimant is also receiving workers' compensation. However, the specific statutes usually contain some exceptions to this rule — for example, if the workers' compensation is for partial disability or for previously incurred work disabilities. California will pay the difference if the temporary disability payment is larger than the workers' compensation benefit.

State laws differ with respect to the treatment of sick leave payments. Rhode Island pays temporary disability benefits in full even though the claimant draws wage-continuation payments. New York deducts from the benefits any payment from the employer or from a fund contributed to by the employer, except for benefits paid pursuant to a collective-bargaining agreement. In California, New Jersey, and Puerto Rico, benefits plus paid sick leave for any week during disability may not exceed the individual's weekly earnings before the disablement.

All the state laws provide that a claimant cannot receive disability benefits for any week for which the individual receives unemployment benefits. Additionally, the New Jersey law deducts from disability payments the amount of any pension received if the pension was contributed to by the claimant's most recent employer. Puerto Rico disallows benefits if a pension is being received without the claimant having had insured work for at least 15 weeks immediately preceding the disability claim.

In all six temporary disability insurance systems, as with unemployment insurance in the United States, weekly benefit amounts are related to the claimant's previous earnings in covered employment. In general, the benefit amount for a week is intended to replace at least one-half of the weekly wage loss for a limited time. All the laws, however, specify minimum and maximum amounts payable for a week. In three states (Hawaii, New Jersey, and Rhode Island), the maximum amount is recomputed annually so that it will equal a specified percentage of the state's average weekly wage in covered employments. Rhode Island also pays benefits to dependents.

Duration

The maximum duration of benefits varies between 26 and 52 weeks. The length of time that benefits are payable depends on the total amount of base period earnings and the length of employment.

Waiting Periods

A noncompensable waiting period of a week or seven consecutive days of disability (four days for railroad employees) is generally required before the payment of benefits for subsequent weeks. The waiting period, however, applies only to the first sickness in a benefit year in Rhode Island, and is waived in California and Puerto Rico from the date of confinement in a hospital. In New Jersey, the waiting period is compensable after benefits have been paid for three consecutive weeks. In each of the temporary disability insurance programs, an employee may be paid benefits on a prorated basis for partial weeks of sickness after the waiting period has been satisfied.

Private Plans

The statutory provisions described previously govern the benefits payable to employees covered by the state-operated plans. In those states where private plans are permitted to participate, the public plans represent standards against which the private plan can be measured (in accordance with provisions in the state law). Thus, although identical statutory provisions apply to all covered employees under the public system in Rhode Island, for example, a different situation prevails in the other states where private plans may deviate sharply from statutory specifications.

Additionally, in California, before a private insurance plan can be substituted for the state plan, it must afford benefit rights greater than those under the state-operated plan. In Hawaii, New Jersey, and Puerto Rico, private plan benefits must be at least as favorable as those under the government plans. Hawaii also permits deviation from statutory benefits if the aggregate benefits provided under the private plan are actuarially equal or better. In New York, adherence to precise statutory benefits is not required; the benefit package provided by alternate private plans must be "actuarial equivalent" to the statutory formula and must meet certain minimum standards. Some features of an alternate private plan can be inferior to the standards of state law if other features are more favorable. Moreover, the New York law also provides that medical, hospital, and surgical care benefits may be substituted for cash sickness benefits for up to 40 percent of the statutory benefits.

Private plans may also deviate from the statute with respect to conditions under which benefits will be paid, as long as benefits are not denied in any case in which they would have been paid under the statute. In fact, financial considerations tend to operate as a restrictive force on the liberalization of private plans in relation to state-operated plans or statutory formulas. To exceed the statutory formula would mean higher costs for the average employer, since the law forbids requiring employees to pay higher premiums for private plan coverage than for state plan coverage.

Loss of Employment

In areas where private plan participation is permitted, special arrangements are needed to ensure continuity of coverage for an employee who changes employers or experiences periods of unemployment. In New York, the law requires that an employee be covered by a private plan for four weeks after termination of employment, unless the employee is re-employed, in which case the employee will be covered by the new employer without a waiting period. Puerto Rico requires that benefits under a private plan be payable for periods of disability that begin during unemployment or employment in uninsured work. In the other three states that allow private plans — California, Hawaii, and New Jersey — the employer's responsibility for coverage lasts only two weeks after separation.

After such coverage lapses, the employee may be eligible for continued disability benefits through the state fund. Special benefit and eligibility provisions are also in effect for disabled unemployed employees in Hawaii, New Jersey, and New York.

In Rhode Island, there is no reason to make a distinction between employed and unemployed employees because all benefits are paid from a single fund and employees are assured of continuous protection during short periods of unemployment and job turnover.

Employee Contributions

Under each of the laws, employees may be required to contribute to the cost of the temporary disability insurance. In all of the jurisdictions except California and Rhode Island, employers are also required to contribute. In general, the government does not contribute.

Under programs in California, New Jersey, and Puerto Rico, employees covered by approved private plans are relieved from contributing to the government-operated fund; but when they are asked to contribute to the private plan, they may not pay more than they otherwise would be required to pay for the state fund. When benefit costs exceed this amount, employers must pay the balance. In Hawaii and New York, higher contributions than specified in the law may be required of employees if the level of benefits provided bears a reasonable relationship to costs.

Under Physician Care

All state laws require the claimant to be under the care of a physician (or, in California and Hawaii, the claimant may be under the care of an authorized religious practitioner of the claimant's faith). The first claim must be supported by a physician's certification. It must include the following:

- A diagnosis.
- The date of treatment
- An opinion as to whether the illness or injury prevents the claimant from carrying on customary work.
- An estimate of the date when the claimant will be able to work again.

Denial of a Claim

An individual whose claim for benefits is denied, in whole or in part, has the right to appeal the determination through the state courts. Decisions by private carriers are also subject to appeal to the state administrative agency and then to the courts. If a carrier should fail to pay promptly in accordance with a decision on appeal, the benefits may be paid by the state agency and assessed against the employer.

Federal Social Security Disability Benefits

The federal government provides disability benefits under the following two programs, which are collectively referred to as Social Security disability benefits:

- The Supplemental Security Income program (SSI), authorized under Title XVI of the Social Security Act.
- The SSDI benefits program (SSDI), authorized under Title II of the Social Security Act.

SSI provides benefits to disabled individuals whose income and assets fall below a specified level. SSI may provide monthly disability income for those who meet Social Security rules for disability and who have limited income and resources.

SSDI provides benefits to disabled employees, dependents, and surviving spouses and is a wage replacement income for those who pay FICA taxes when they have a disability meeting Social Security disability rules. In addition, the following points are true of the SSDI program:

- It provides a variety of benefits to family members when a primary wage earner in the family becomes disabled or dies.
- It is financed with Social Security taxes paid by employees, employers, and self-employed persons.
- Its benefits are payable to disabled employees, widows, widowers, and children or adults disabled since childhood who are otherwise eligible.

Determining Disability

While the eligibility criteria differ under the two programs, many of the standards and procedures required in determining disability are virtually identical in both. Under both programs, persons are disabled if they are unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, which meets either of the following criteria:

- Can be expected to result in death.
- Has lasted or can be expected to last for a continuous period of not less than 12 months.

To meet this definition, an SSI or SSDI applicant must have "physical or mental impairments of such severity that they are not only unable to do their previous work but cannot, considering their age, education, and work experience, engage in any other type of substantial gainful work existing in the national economy."

Substantial gainful activity (SGA) means any significant activity, physical or mental, performed over a reasonable period of time for which an individual receives remuneration or profit. To qualify, an individual's monthly earned income for 2015 must be less than $1,090 or $1,820 if blind. SGA dollar amounts are adjusted every January, a process called indexing.

Social Security has separate rules for those who are blind. SGA is $1,640 for blind beneficiaries.

Methods of Determination

An individual may be able to support the disability claim and meet the above definition by:

- Qualifying under the Listing Level of Impairments outlined in the Social Security Administration's (SSA) Disability Evaluation Under Social Security (commonly referred to as the Blue Book).
- Qualifying under SSA's sequential evaluation rules for determining disability.

Under the latter method, disability is determined using a five-step sequential evaluation process conducted by the SSA. If at any point an applicant is found not to be disabled, the evaluation process terminates, and the claim for disability insurance benefits is denied. Following are the five requirements in determining disability:

- **Substantial gainful activity.** If the applicant is currently engaged in substantial gainful activity, there is no disability, regardless of medical condition, age, or work experience.
- **Severe impairment.** If the applicant is not engaged in substantial gainful activity, the SSA determines whether the applicant has a severe impairment. An impairment is considered severe if it significantly limits a person's physical or mental ability to do basic work activities. If there is a finding of severity, the evaluation proceeds to the third step.
- **Listing of impairments.** If the applicant's condition meets the requirements, or is the equivalent of a disability on the SSA's Listing Level of Impairments, then the applicant is ruled disabled. If the applicant does not meet the requirements, the sequential evaluation process continues to the fourth step.
- **Past relevant work.** A medical assessment is performed to determine whether the impairment prevents the applicant from performing the applicant's past relevant work. If the applicant is found to be able to perform past relevant work, the claim will be denied. If not, the evaluation process continues to the final step.
- **Other work.** The SSA evaluates whether the applicant can perform other available work existing in significant numbers in the national economy. The evaluation considers the applicant's **residual functional capacity** (what the applicant is able to do in a work setting despite the impairment), age, education, and past work experience. If an applicant cannot perform other work, they will be found disabled.

The SSA provides information for individuals applying for benefits on the SSA website at https://www.ssa.gov/benefits/disability/

The SSA's complete definition of disability is also published on the website at https://www.ssa.gov/disability/professionals/bluebook/evidentiary.htm

HIV/AIDS

Individuals living with HIV/AIDS may also qualify under the SSA definition of disability by meeting the criteria for one of the 41 opportunistic infections listed in the Blue Book's Adult Listing of Impairments (Immune Systems). A PDF version of the book is available on the SSA website at www.ssa.gov/disability/professionals/bluebook/adultlistings.pdf.

If an individual qualifies under one of the opportunistic infections, the Social Security Form SSA-4814 can be used. This form is not currently available online, but can be obtained at a local Social Security office. This form may be found at HIV/AIDS service organizations as well.

Supplemental Security Income

Requirements and Benefits

Contribution Requirements

There are no contribution requirements for Supplemental Security Income (SSI). The program provides a supplemental income when the definition of disability is met and financial need is demonstrated.

Residency Requirement

An individual must be a legal United States resident in order to access the SSI program. The SSA provides an explanation of the residency rules at www.ssa.gov/pubs/11051.html.

Resource Levels and Requirements

Other requirements that must be met include the following:

- An individual may not have liquid assets (accessible money) in excess of $2,000 ($3,000 for a couple). Ownership of one house, occupied by the individual, and one car will not be considered when determining the individual's resource levels.
- An individual's or couple's monthly unearned income, such as disability income, must be less than the current SSI maximum plus a $20 general income exclusion.

An individual should also apply for other programs, such as state disability insurance and SSDI.

Benefits Integration

The SSI program is designed to provide a supplemental income. Other unearned income will be considered before SSI pays a benefit. Examples include either of the following:

- State disability insurance pays first, and then SSI pays a supplement up to allowable limits.
- SSDI pays first, and then SSI pays a supplement up to allowable limits.

Waiting Periods

There is no waiting period for SSI. Benefits begin from the date the application process began with Social Security or the date the disability began according to Social Security rules — whichever is later.

Application

Processing an SSI claim should take one to six months if all required documentation is provided. If a claim is denied by Social Security and an appeal is filed, the SSI claim process may take longer.

To file an application for the SSI program, the following forms must be completed:

- Form SSA-3368, Disability Report.
- Form SSA-827, Medical Releases.
- Form SSA-3369, Vocational Report.
- Form SSA-827-BK, Authorization to Disclose Information to the Social Security Administration.

Additional forms may be required. Employers should check with the local Social Security office for details.

The following documents may also need to be supplied:

- Social Security number and proof of age, such as certified copy of a birth certificate.
- Names, addresses, and phone numbers of doctors, hospitals, clinics, and institutions where an individual was treated, and the dates of treatment.
- Names of all medications an individual is currently taking.
- Medical records from doctors, therapists, hospitals, clinics, and caseworkers.
- Laboratory and test results.
- Summary of work history and the kind of work performed.
- Most recent Form W-2 or tax return if self-employed.
- Marriage information including dates of any prior marriages.
- Proof of application to other public benefits programs, such as state disability insurance or workers' compensation.
- Information about living arrangements, such as a mortgage or lease with the landlord's name.
- Payroll slips, bank books, insurance policies, car registration, burial fund records, and other information about income and resources.

Additional Information

Individuals should inform their medical providers that they are in the process of applying for benefits. This will ensure that medical providers will recognize the need to clearly document medical findings that will support disability claims and that they can be prepared to submit medical records when requested by Social Security.

Payments

Presumptive Eligibility Payments

Social Security may grant immediate SSI payments for a maximum of six months, called presumptive eligibility. This provision applies only to certain medical conditions among the list of impairments found in the Blue Book.

Individuals living with HIV/AIDS may qualify for presumptive disability benefits if they meet SSI's eligibility requirements and complete a Form SSA-4814. Presumptive disability payments provide the SSI cash benefit while the claimant awaits the full Social Security review of the claim Repayment of presumptive disability benefits is not required even if Social Security denies the SSI claim.

Retroactive Payments

SSI cash benefits are paid from the application date on file with Social Security, called the protective filing date, or from the onset of disability, whichever is later. The initial contact made to Social Security by phone or in person to apply for SSI becomes the protective filing date.

Social Security Disability Insurance Benefits (SSDI)

Requirements and Benefits

SSDI requires an employee to pay FICA taxes for specified lengths of time, called credits. One SSDI credit is one quarter of the year (three months); four SSDI credits are available in a year (12 months).

The number of work credits needed to qualify for SSDI depends on the age at disability onset. Generally, an individual will need 40 credits (10 years), 20 of which were earned in the last 10 years before they become disabled. The following are examples of qualifying credits:

- Before age 24: An individual may qualify if they have credit for one and one-half years of work (six credits) within the past three years.
- Ages 24 to 31: An individual may qualify if they have credit for three years of work (12 credits) out of the past six years.
- Age 31 or older: (See table). Unless an individual is blind, the individual must have earned at least 20 of the credits in the last 10 years before an individual became disabled.

Work Credits Required for SSDI Eligibility for Those Born After 1929	
Age When Individual Became Disabled	**Number of Credits Needed**
31 through 42	20
44	22
46	24
48	26
50	28
52	30
54	32
56	34
58	36
60	38
62 or older	40

Individuals that are eligible for benefits include the following:

- A wage earner in a family who becomes disabled according to Social Security's rules and who has paid FICA taxes for the required length of time.
- An employee's dependent widow or widower.
- An employee's childhood disability beneficiary (CDB), formerly referred to as a disabled adult child (DAC).

Residency Requirement

Individual must be a legal U.S. resident. SSA provides an explanation of the residency rules.

Benefits

The monthly disability benefit amount is based on the Social Security earnings record of the insured employee. Eligibility for monthly SSDI benefits begins five months after Social Security determines the onset of disability.

Payments are made one month in arrears (behind payment date). For example, January's payment due will be received in early February.

Benefits may continue as long as the individual continues to be disabled and otherwise meets employment or other eligibility requirements. However, benefits can stop for specific reasons, events, or activities.

Review

A SSDI beneficiary will be periodically reviewed to determine if there has been any medical improvement in an individual's condition and to determine whether the individual continues to be eligible for benefits. These reviews are called a medical continuing disability review (CDR).

Retirement

When an individual reaches full retirement age, generally at age 65, the individual enrolls in the Social Security retirement program instead of SSDI.

An individual is eligible for retirement benefits depending on their year of birth. For example, individuals born before 1938 are eligible for retirement benefits at age 65.

Since January 2000, there is no limit on the amount individuals can earn while collecting Social Security retirement benefits. Before age retirement benefits, disability benefits may be reduced depending on the amount earned.

Benefits Integration

A SSDI beneficiary may qualify for other public benefits, such as state disability insurance or workers' compensation. SSDI benefits will be reduced if the combination of the SSDI benefit plus any workers' compensation payment and/or public disability payment exceeds 80 percent of what SSA considers average current earnings. The SSA uses formulas to determine average current earnings. For example, the SSA looks at earnings in the year prior to start of SSDI benefits.

More information can be found in the SSA's document, How Workers' Compensation And Other Disability Payments May Affect Your Benefits, available at www.ssa.gov/pubs/10018.html.

Waiting Period

There is a full five-month waiting period after the onset date of the disability before benefits are paid to a beneficiary. A month is considered to be a part of the waiting period when the individual has not earned any income or their income is below substantial gainful activity (SGA) ($1,090 in 2015). The individual is eligible for benefits starting in the sixth month.

Benefits are paid for the preceding month; in other words, they are paid one month in arrears. Thus, the SSDI beneficiary receives the first payment in the seventh month.

Application

Processing the SSDI claim should take between one and six months if all required documentation is provided. If a claim is denied by Social Security and an appeal is filed, the SSDI claim process may take longer.

As with the SSI program, the applicants may apply online or contact Social Security to schedule an appointment by phone or at the local office. To file an application for the SSDI program, the following forms must be completed:

- Form SSA-3368, Disability Report.
- Form SSA-827, Medical Releases.
- Form SSA-3369, Vocational Report.
- Form SSA-827-BK, Authorization to Disclose Information to the Social Security Administration.

Additional forms may be required. Applicants should check with the local Social Security office for details.

The following documents may also need to be supplied:

- Social Security number and proof of age, such as certified copy of a birth certificate.Form SSA-827, Medical Releases.
- Names, addresses, and phone numbers of doctors, hospitals, clinics, and institutions where an individual was treated, and the dates of treatment.
- Names of all medications an individual is currently taking.
- Medical records from doctors, therapists, hospitals, clinics, and caseworkers.
- Laboratory and test results.
- Summary of work history and the kind of work performed.
- Most recent Form W-2 or tax return if self-employed.
- Marriage and dependent(s) information including dates of any prior marriages.
- Proof of application to other public benefits programs, such as state disability insurance or workers' compensation

Retroactive Payments

Although Social Security may determine that an individual became disabled prior to the application date for SSDI, retroactive payments covering the period before the application date cannot exceed 12 months.

Additional Information

Individuals should inform the medical provider that the individual is in the process of applying for benefits to ensure that medical providers will recognize the need to clearly document medical findings that will support disability claims so that they can be prepared to submit medical records when requested by the Social Security Administration.

SSDI Work Rules

Social Security work incentives, as well as the new Ticket-to-Work program (discussed later), may support an individual's efforts to re-enter the workforce.

As an individual considers working, these essential Social Security definitions should be considered.

- Disability. A disability an inability to work due to a disabling condition that will last for at least one year or more. Disability will be questioned if an employee works during the first year of receiving benefits.
- Work. Work is any activity that generates earned income.
- Earned income. Salaries, wages, tips, professional fees, and other amounts received as pay for physical or mental work performed are earned income. For purposes of Social Security benefits, earned income is the individual's gross income (before taxes).

Terms

This section explains some of the terms involved in SSDI.

Timeframes

The following are the two timeframes that Social Security defines when a SSDI beneficiary begins earning income and can continue to receive benefits:

- Trial work period.
- Extended period of eligibility.

Trial Work Period

The trial work period is the nine months of re-employment, which occurs within a five-year window when an individual works and continues to receive full SSDI benefits. These work months can occur consecutively or intermittently. A trial work month is any month when gross earnings (income before taxes) equal $780 or more (in 2015). In other words, if an individual works for six months and stops working, the individual will still have three more months remaining of the trial work period. The nine trial work months count as the trial work period if the months are used within a five-year window (60 months).

SSDI Five-Year Window

The SSDI five-year window is the five-year (60 consecutive months) period of time that begins immediately after an individual is eligible to receive SSDI benefits. Each month, the five-year window rolls forward whether or not an individual works. This window stays open until the individual has worked nine trial work months in the five-year window.

If an individual does not work a total of nine months within the five-year window, the window rolls or moves forward until the individual has worked nine trial work months. Once an individual's trial work period ends, the extended period of eligibility (EPE) automatically begins.

Trial work months are indexed annually for increases or decreases in the cost of living.

Extended Period of Eligibility (EPE)

The extended period of eligibility (EPE) is the 36 consecutive months that start at the end of the trial work period. During the EPE, any month in which gross earnings (income before taxes for 2015 are $1,090, or $1,820 for blind beneficiaries. An individual's wages are considered substantial gainful activity (SGA). When an individual's earning first reach SGA, a three-month grace period begins, allowing a beneficiary to continue receiving SSDI payments regardless of wages. However, after the three-month grace period, an individual will not receive SSDI income benefits if wages are at or above SGA. However, if wages fall below SGA, SSDI payments will resume. Beneficiaries who continue to earn SGA income after the EPE will no longer be eligible for SSDI payments.

The SSDI Work Rules Closeup, showing examples of how trial work periods, EPEs, and grace periods work, is available on the website at www.db101.org.

Note: Social Security rules allow an individual's gross earnings to be reduced by any impairment related work expenses (IRWEs) during the EPE, but not during a trial work period month.

For the five years after the EPE, if an individual's earnings fall below SGA due to a disabling condition, the individual may request to be reinstated without a new application. The provision is called expedited re-instatement to Social Security benefits.

Substantial Gainful Activity (SGA)

SGA is a guide used by Social Security to evaluate earned income and work activity of individuals applying for or receiving disability benefits. The following two issues determine SGA:

- **Substantial activity:** Work that involves doing significant physical or mental work or a combination of both that is productive and for profit.
- **Gainful work activity:** Work performed for pay or profit; work of a nature generally performed for pay or profit; or work intended for profit, whether or not a profit is realized.

SGA is a monthly amount that is specified by Social Security for individuals who are employed or self-employed. SGA may be determined by work performed or hours worked in a month. Monthly SGA earnings limits are adjusted annually based on fluctuations in the national average wage index. The SGA level is higher for persons who are determined by Social Security to be blind.

For 2015, SGA is $1,090 and $1,820 for the blind.

Overpayments

Underreporting earnings to Social Security may result in overpayment where the beneficiary will be responsible to pay back those benefits. Individuals should report all gross income. Individuals who are self-employed should report earnings based on the most recent IRS tax return.

To avoid overpayments, earnings must be reported to the Social Security Administration at 800-772-1213 (voice) or 800-325-0778 (TTY).

Other Rules

An impairment related work expense (IRWE) is a documented expense for services or items related to an individual's impairment for which the beneficiary paid in order to support work activity. Some examples of IRWEs include, but are not limited to, the following:

- Wheelchair repairs.
- Out-of-pocket payments for prescription drugs or medical expenses.
- A computer screen reader.

IRWEs must be verified with original receipts or canceled checks and are approved at the local Social Security field office on a case-by-case basis. There is no fixed list of approved IRWEs.

Ticket-to-Work Program

The goal of the Ticket-to-Work and Self-Sufficiency Program (Ticket Program) is to expand the options Social Security disability beneficiaries have for employment. The Social Security Administration mails a ticket-to-work that enables beneficiaries to access organizations that provide employment services and supports. However, the Ticket Program does not guarantee job placement.

The Ticket Program is for individuals who receive SSI and/or SSDI and meet certain eligibility criteria.

History

Improvement Act of 1999. In 2000, the federal government began to establish the Ticket Program. Since September 2004, the Ticket Program has been available in all 50 states and U.S. territories.

Basic Features

After receiving a ticket, a participant can choose a designated service provider called an Employment Network (EN). An individual may utilize only one EN at a time. Individuals can locate an EN at www.yourticketowork.com.

An individual and EN must make an agreement that outlines the services that are needed to reach a specific employment goal. This agreement is formalized into a written plan known as an Individual Work Plan (IWP). The ticket is assigned to an EN once the IWP is signed by both parties. As long as an individual makes timely progress towards an employment goal, the ticket is considered in use.

When a ticket is in use, the Social Security Administration will not conduct a medical continuing disability review (CDR). However, if administration determines that the participant is not making timely progress, the participant may be subject to a medical CDR. If a medical CDR is ordered, the individual can decide to continue working with the EN.

A participant can use a ticket for 60 months (five years) and in some cases longer. A ticket can be used only once during each period of a Social Security disability.

Eligibility

The Ticket Program is for Social Security disability beneficiaries between the ages of 18 and 64, who are currently receiving cash benefits. Individuals eligible for the Ticket Program include the following:

- Youth who have been determined disabled under Social Security's adult rules after age 18.
- Adult Social Security disability beneficiaries who are childhood disability beneficiaries (CDB), formerly referred to as disabled adult children (DAC).
- Adults under age 65 who receive SSI and/or SSDI.

Individuals who are ineligible for the Ticket Program include the following:

- Youths not yet considered disabled under Social Security's adult rules for disability.
- Those awarded benefits whose medical condition is expected to improve (medical improvement expected) before their first medical CDR.

Timely Progress and Use of a Ticket Determinations

The requirements in this section are used to determine if a participant is making timely progress towards self-supporting employment for purposes of continued ticket use. If the participant is making timely progress, the Social Security Administration will not initiate a medical CDR. Social Security defines timely progress as the following:

- Active participation in the individual work plan (IWP) during the initial 24-month period (years one and two).
- Increased work activity and earnings during each subsequent 12-month progress review periods (years three through five). (See Increased Work Activity and Earnings chart.)

Active participation is defined as regularly working towards the employment goals stated in the IWP. The participant must adhere to the basic steps outlined in the plan. During the initial 24-month period, employment activity is optional unless specified in the IWP.

The initial 24-month period begins on the first day of the month following the date the participant and EN have signed the IWP. For example, if the IWP was signed on January 18, 2010, then the initial 24-month period would have begun on February 1, 2010. A ticket is assigned when the individual and EN sign an IWP. As stated previously, participants must make timely progress to prevent a medical CDR. Social Security does not count months when a ticket is unassigned or not in use, such as when an individual is ill.

The program manager conducts progress reviews at specified intervals. It is the responsibility of the EN to notify the program manager if the participant is not following the IWP. If the beneficiary disagrees with the review, the beneficiary may ask Social Security to review the program manager's decision.

Increased Work Activity and Earnings

Once the participant successfully completes the initial 24-month progress review, the participant must engage in some work activity within the following 12 months (year three) and have earnings at or above SGA ($1,090 for 2015). The chart shows guidelines that the program manager uses when conducting a progress review.

Guidelines for Ticket-to-Work Progress Review	
Four Review Periods Over Five Years (60 Months)	**Participation Criteria for Making Timely Progress in the IWP and Using Assigned Ticket**
Initial 24 months (years one and two)	Participant develops and implements the IWP with EN.
First 12-month period (year three; 25 – 36 ticket months)	Participant earns at least $1,090* per month for a minimum of three months with ticket in use. Some or all of these three months may occur in the initial 24-month period. Earnings for blind beneficiaries is $1,820.
Second 12-month period (year four; 37 – 48 ticket months)	Participant earns at least $1,090* per month for a minimum of six months with ticket in use. Earning for blind beneficiaries is $1,820.
Third and subsequent 12-month periods (year five; 49+ ticket months)	Beneficiary works at least 6 of the 12 months without SSDI and/or federal SSI cash payments due to earned income, or net employment from self-employment (NESE) is too high after Social Security work incentives are applied.

***Note:** Social Security uses SGA as a measurement for timely progress. 2015 rates shown. This rule applies to all beneficiaries.

Employment Networks (ENs)

ENs may offer a variety of services, such as the following:

- Job readiness.
- Job placement.
- Vocational rehabilitation.
- Training.
- Job coaches.
- Transportation
- Other supports.

ENs may be a single service provider such as a no-profit community based organization (CBO), a collaboration of providers, or a network of public and private services who agree to work with ticket holders.

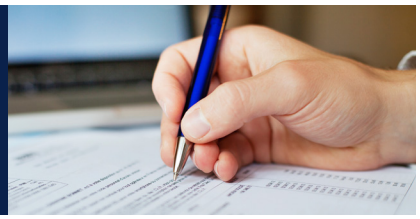
Some EN examples include the following:

- Employers.
- Employers offering or arranging for job training.
- An employer collaborating with a community based organization.
- Transportation providers.
- Staffing and placement agencies.
- Consumer groups.
- California Department of Rehabilitation.
- Private providers of rehabilitation services.
- One stop career centers.
- Vocational rehabilitation service projects for Native American Indians with disabilities authorized under special sections in Title I of the Rehabilitation Act of 1973, as amended.
- Cottage industries, such as benefits planning services combined with other services.
- Public or private schools providing transitional education or career development services.
- Organizations working with ethnic, disability, or religious groups.

Ticket Program Manager

The day-to-day administration of the Ticket Program is the responsibility of the program manager. The Social Security Administration contracted with an outside firm called MAXIMUS to handle administrative functions. As program manager, MAXIMUS provides outreach, recruitment, training, and payment processing for ENs. The MAXIMUS website is located at www.yourtickettowork.com.

Life Insurance Benefits



Life insurance is one of the most common employer-provided benefits. It is especially popular with employees who have dependents and with older employees who may have difficulty getting reasonably priced life insurance elsewhere.

Group-term life insurance is the most common type of employer-sponsored life insurance. Other types of group and individual life insurance do not offer the tax break that group-term life insurance provides; however, they do provide employees with permanent life insurance protection that they may carry into retirement. These programs include the following:

- Whole life insurance.
- Split-dollar life insurance.
- Group universal life insurance.

Group-Term Life Insurance

Group-term life insurance is where the employer pays a low group rate for the coverage, and the employee pays no tax on the first $50,000 of coverage.

Most employers offer group-term life insurance as an employee benefit, although other types can be offered. Term insurance is life insurance that is in effect for a certain period of time only. Generally, in the case of employer-provided term life insurance, the term is for as long as the employee is employed. Group-term life insurance can be offered to employees only, not to employee's spouses and children.

To take advantage of the tax deduction for group-term life insurance (for instance, the value of up to $50,000 in insurance is tax-exempt for the employee), an employer must have at least 10 full-time employees. The 10-employee restriction does not apply if the following occur:

- The employer provides coverage to all full-time employees.
- The method for computing the amounts of insurance is set (such as a uniform percentage of the employee's annual salary).
- No physical exams are required to obtain coverage.

There are other types of insurance that employers can offer besides group-term life, including the following:

- **Group accidental death and dismemberment.** Commonly known in the industry as AD&D, this coverage pays benefits to the employee's beneficiary if death occurs due to an accident or if the employee loses use of portions of the body (loss of one arm and leg, for example, may result in payment of a percentage of the total benefits).
- **Business travel accident insurance.** This insurance covers only a narrow occurrence — the death of the employee while traveling on business. If employees do not travel or travel infrequently, this may not be a suitable investment.
- **Split-dollar life insurance.** This insurance pays the employee's beneficiary when the employee dies and returns the premiums paid to the employer. The insurance is paid by both the employer and employee and has a substantial investment element to it. Employers may wish to consider this option for key employees only, as opposed to an entire employee group.

Plans may offer an infinite number of riders that can be added to the plan and that allow employers to customize the plan to a degree. A rider is an additional feature or benefit that may be added to an existing insurance policy. For example, in the case of health insurance, a mental health coverage rider could be purchased that would add some coverage for mental health treatments to the basic medical insurance. In the case of life insurance, an accidental death and dismemberment rider could be added to a group-term life insurance policy that would pay double the death benefit if the employee died due to an accident. An insurance agent can explain the various riders available in conjunction with plans.

Employee Coverage

Once an employer has decided to offer life insurance, the employer must decide which employees will be eligible. Employers may want to offer group-term life insurance benefits to all full-time employees, particularly if lower rates are available (and individual medical exams are avoidable) with a larger group. If the employer plans to offer it as a special benefit to a few key employees, the employer will not be able to deduct the premiums for federal tax purposes, unless special nondiscrimination requirements can be met.

Nondiscrimination Requirements

Generally, nondiscrimination requirements are designed to discourage employers from providing benefits only to the most highly compensated employees or providing benefits that limit lower compensated employees from participating because of the price of the benefits. In the case of group-term life insurance, a plan does not discriminate as to an employee's eligibility to participate if any of the following conditions are met:

- The plan benefits at least 70 percent of all employees.
- At least 85 percent of all participating employees are not key employees.
- The plan benefits employees who qualify under a classification that is set up by the employer and found by the IRS not to discriminate in favor of key employees.

In the case of group-term life insurance an employer may offer life insurance to small subgroups of employees if the distinctions are based on the following:

- Marital status.
- Job duties.
- Compensation.
- Length of service.
- Participation in a pension, profit sharing, stock bonus, or accident and health plan.
- Other employment-related factors.

Amount of Coverage

Most group-term policies offer either a set amount of insurance (for example, a $10,000 policy for each employee) or are based on the employee's salary (for example, policy values of one, two, or three times the employee's yearly salary). In some cases, employers can allow employees to purchase life insurance in $1,000 increments, the cost of which is based on their age.

$50,000 Threshold

The cost of employer-provided group-term life insurance in excess of $50,000 is taxable to employees. This means that if an employer pays the premiums for employees' life insurance, any premiums paid for more than $50,000 in coverage for one employee count as taxable income for that employee. In addition to the employee paying income taxes, the employee and the employer will both have to pay payroll taxes on the amount as well. It is possible for the employee to waive coverage amounts in excess of $50,000.

Example: Sports Heaven, Inc. pays the premiums on a $200,000 group-term life insurance policy on Karen, who is 46 years old. The monthly rate for employees in the 45 to 49 age group under the plan is $.15 per thousand. If Karen makes no contribution toward the plan, the cost of the $150,000 coverage ($200,000 - $50,000 exclusion = $150,000) counts as taxable income for Karen. The amount included in taxable income would be $270 for the year (150,000 [thousand-dollar increments] x $.15 [per thousand] times 12 [months]).

If Karen contributes $10 per month toward the coverage, then the taxable amount included as gross income for the year is $150 ($270 - $120 (Karen's contribution) = $150).

Administering Life Insurance

On the whole, life group-term benefits are easy to administer because they do not require constant monitoring and may not generate many claims.

Enrolling Employees

The insurance company chosen to administer the plan should provide the employer with the necessary forms to enroll employees. A copy of the enrollment document should be kept in each employee's benefit file.

Designating a Beneficiary

The beneficiary is the designated person who will receive the money if an employee dies and the policy covers the death. Occasionally, the plan will allow people to designate several beneficiaries and to split the benefit into percentages. Employers should explain to employees the importance of keeping this information up to date by making changes to their beneficiary designation when appropriate; for example, when the employee does any of the following:

- Marries.
- Becomes legally separated.
- Becomes divorced.
- Has a child.
- When a spouse, parent, or other close relative dies.

The insurance company should provide employers with forms for designating beneficiaries.

Proof of Insurability

Generally, with group-term life insurance, employees will not be asked to complete a medical questionnaire.

However, if employers offer employees the option of purchasing additional life insurance to complement what is provided by the employer, employees choosing to purchase the additional insurance may be required to complete a medical questionnaire. The employee may either mail the questionnaire directly to the insurance company or may return it to the employer to submit to the insurance company.

Processing Claims

Part of the employer's duty includes filing for life insurance benefits.

The employer will often receive information about an employee's injury or death from the employee's family, and will then need to complete the necessary forms to begin the claims process.

Example: An employee's next of kin calls the employer to inform them that the employee has died or been killed. The employer must first notify the insurance company, which will provide the employer with the necessary forms to begin the claims process. The employer will need to obtain a certified death certificate, which is usually available from the funeral home/crematorium or directly from the deceased employee's executor or next-of-kin. The employer should make a copy of the completed claim form and any supporting documents for the employer's files. The claim should then be submitted to the insurance company via registered or certified mail.

Terminating Benefits

If an employer has group-term life insurance, some policies may allow a conversion privilege when an employee leaves or changes employment.

This means that if an employee leaves or the life insurance offered by the employer is otherwise terminated, the employee may be able to obtain a private policy through the insurance agency. Generally, these policies are much more expensive than the group-term policy that the employer will offer, and sometimes they have low coverage limits and require proof of insurability.