The Trust

Office Overhead Plan

Staying In Business Is The Key To Your Earning Power!

An illness or injury can have a devastating effect upon your ability to earn a living and serve the needs of your clients. Those monthly expenses associated with running an office continue to pour in as you struggle to recover. How will you continue to pay the rent, taxes, utilities and salaries needed to keep the office doors open?

The Simple Affordable Answer!

Trust Office Overhead Insurance is just what the doctor ordered to help you get well. While you are totally disabled from a serious illness or injury, Office Overhead Insurance will keep the practice going by paying the normal recurrent office expenses. For instance, a practitioner age 40 can be reimbursed for $1,500 of monthly office expenses for just $157 a year. Trust Office Overhead Insurance is a group program with very affordable low rates.

Plan Highlights

- Monthly benefits to reimburse up to $5,000 of office overhead expense
- Monthly benefits payable for up to 24 months per disability
- May be maintained regardless of age as long as you work 20 hours per week
- "Your own Occupation" definition of disability
- Pays APA membership dues and other professional association dues
- Benefit Bank can boost reimbursement when your actual overhead expenses exceed your monthly benefit

Monthly Expense Worksheet

Rent or mortgage interest	$_________
Employee's salaries and payroll taxes	$_________
Business automobile leasing costs (within IRS limits)	$_________
Telephone	$_________
Electricity	$_________
Water	$_________
Heat	$_________
Office cleaning services	$_________
Telephone answering services	$_________
Total fixed monthly expenses	$_________

Monthly Prorated Expenses

Accountant's services	$_________
Property, state and local business taxes	$_________
Business Insurance (office, auto, professional liability)	$_________
Interest charges on business loans	$_________
Dues to professional associations	$_________
Miscellaneous	$_________
Total monthly prorated expenses	$_________

Grand Total of Monthly Overhead Expense	$_________

What is covered?

Things such as office rent or mortgage interest payments, employee salaries, ***professional association dues,*** office telephone bills, office utilities, janitorial services, telephone answering service charges, business liability and casualty insurance premiums *(**including professional liability**)* and other regularly occurring business expenses are all considered reimbursable expenses. And if you think of anything not mentioned, just ask us and we'll let you know!

It is important to accurately estimate your expenses so as not to pay for more protection than you need (we can only reimburse you for actual expenses incurred that you can substantiate). The worksheet listing various office expenses will help you determine the correct amount of coverage for your situation.

What happens if my expenses are less than my total benefit?

Not to worry. Liberty will create a ***Benefit Bank*** to allow any unused portion of the benefit you purchased to be used during a month in the same period of disability when actual expenses exceed your benefit limit.

Why Trust Office Overhead Insurance?

Trust Office Overhead Insurance is designed for psychologists by psychologists who understand the commitment it takes to have a career in the profession and the duties associated with the practice of psychology. ***All plans may be maintained for as long as you work at least 20 hours per week on a regular basis. You can keep the coverage regardless of age and benefits are payable to reimburse your office expenses while you are disabled and unable to perform the duties of your "occupation."*** The Trustees are your ombudspersons in working with Liberty making Trust Office Overhead coverage the insurance of choice among thousands of psychologists.

Plan Provisions, Exclusions and Limitations

Benefits begin at the end of ***28 continuous days*** of total disability and continue for up to 24 months per period of disability. If unused benefits have accumulated in the Benefit Bank, they will be paid in a month in which your expenses exceed your benefit. Benefits will end when you are no longer totally disabled; when the maximum benefit has been paid; or when you close or sell your office. Benefits are payable only for periods of disability for which you are under the care of a fully licensed physician and you cannot perform the duties of your occupation or profession.

Successive Periods of Disability

If you become totally disabled from the same or related cause within 6 months, that disability is considered to be part of the same period of disability. In this case, the covered person will not have a new waiting period. Benefits are payable for the remaining months in the period of disability subject to the overall 24 month maximum for a disability.

If you return to work for at least 6 continuous months and become totally disabled again from the same or related cause, this is a new period of disability and the covered person must complete a new waiting period before benefits are payable.

Expenses Not Covered:

- Expenses in excess of your portion when expenses are shared with others in a professional corporation or a partnership;
- State or federal income taxes or payroll taxes incurred by the member;
- All or part of the principal portion of any loan of any kind;
- The cost of equipment or merchandise of any kind including books, periodicals, stamps, or photocopying;
- Interest payments which fall due before the end of the waiting period;
- Those which are covered under any other group or group type insurance providing benefits for Office Overhead expenses;
- Salaries of your immediate family or for a person employed to perform your duties;
- Office Overhead expenses incurred more than 3 months after the covered person's death.

Pre-Existing Conditions

Benefits will not be paid for a disability caused by pre-existing conditions (conditions which existed prior to being insured by this insurance) for which treatment, including medications or prescriptions, was rendered or charges were incurred within six months before the effective date of insurance. However, pre-existing conditions are covered after six consecutive months (one year for mental illness or emotional maladjustment) has elapsed where no treatment has been rendered or charges incurred for the condition (this includes medication or prescriptions).

Exceptions

Benefits are not payable if a covered person becomes disabled due to:

- war or an act of war (declared or undeclared)
- pregnancy that is not a complicated pregnancy
- intentionally self-inflicted injuries, while sane or insane
- drugs that are voluntarily taken, ingested or injected, unless as prescribed or administered by a physician
- active participation in a riot or committing or attempting to commit an indictable offense

Waiver of Premium

Following the completion of ***six months*** of continuous disability, the next premium due will be waived until the first semiannual payment date which follows recovery or receipt of maximum benefits.

Termination of Coverage

Your insurance will terminate on the earliest of the following dates:

- The date the master policy held by the Trustees is terminated
- The date you fail to make any agreed payment of premium within the 31 day grace period
- The date you cease to be gainfully employed as a psychologist on a full-time basis (at least 20 hours per week on a regular basis), ***except for a continuing disability***
- the date you become a member of the armed services of any country

Application for Group Office Overhead Expense Insurance

Please Print

Member Name ______________________ APA Membership Number ______________________

Social Security No. ____________ Category of Membership: Full Member ________ Associate Member ________

Home Address ____
Street City State Zip Code

Mailing Address ____
Street City State Zip Code

Home Telephone No.(______) ______________ Business Telephone No.(______) ______________

Male____________ Female____________ Date of Birth ______________________
Month Day Year

First year you became a full/associate member of the American Psychological Association. ____________

Have you ever been enrolled in any APA Insurance Programs with Liberty Mutual? ______Yes ______ No

If yes, what type of coverage and is coverage still in effect?______________________________

Employer______________________________ Occupation ______________________________

Are you actively engaged in your occupation on a full-time basis? ______ Yes ______ No

Do you now carry or have an application pending for other group or individual Office Overhead Insurance?

______ Yes ______ No If yes, please indicate below.

Insuring Company	Amount of Monthly Benefit	How Long Are Benefits Payable? Accident Sickness
______________	______________	______________
______________	______________	______________

What was the average monthly office expense incurred by you during the preceding 6 months in the conduct and operation of your office? $________________ Note: Include only your share of expenses if office expenses are shared.

You may select a monthly benefit from $500 to $5,000 in increments of $100.

Monthly Benefit Desired: $ ____________

Detach and send back

(Please complete other side)

How You Can Review Your Personal Information

You have the right to review certain recorded personal information contained in our files. To do so, please write to us at the address appearing at the end of this notice. We need your full name and address, telephone number, and APA membership number. All information requested must be reasonably described by you and reasonably locatable and retrievable by us.

Within 30 business days of receipt of your request we will contact you and tell you the nature and substance of the recorded personal information in our files. If you wish, you may see and copy this information in person or obtain copies by mail, subject to the payment of a reasonable fee. We will disclose the identity of any persons or organizations to whom we have disclosed this information during the preceding two years.

Your doctor can best explain medical information to you. Therefore, if you have requested such information, our practice is to disclose it to a medical professional named by you and licensed to treat the condition to which this medical information relates.

We are not required to give you access to certain types of information. This information is usually collected in connection with a claim under an insurance policy or when the possibility of a lawsuit exists.

If You Disagree With Our Records

You have the right to request us to correct, amend or delete any recorded personal information that you feel is incorrect. To do so, write to us and tell us what is inaccurate and why.

We will reinvestigate the information you think is incorrect. If we agree, we will make the necessary corrections, amendments or deletions. We will also notify persons or organizations to whom we have previously disclosed the inaccurate information of the change.

If we disagree, we will give you our reasons for refusing to correct, amend or delete the information. If you are not satisfied, you have the right to send us a concise statement of what you believe is the correct information and why you disagree with our refusal to correct it. We will place your statement in our file and send a copy of it to any persons and organizations to whom we have previously disclosed this information. We will also include your statement with any future disclosure of information from your file.

Your Privacy Is Our Concern

Please be assured that we, at Liberty, are committed to the careful handling of your personal information. If you wish to exercise any of the above rights or have additional questions, please write to:

Administrator - APA Group
Liberty Mutual Insurance Company
P.O. Box 1525
Dover, N.H. 03821-1525

Detach and keep for your records

Liberty Mutual Insurance Company
Liberty Life Assurance Company Of Boston

Required Notice Of Information Practices

Collection Of Information

To properly underwrite and administer your group Insurance coverage, we must collect a certain amount of necessary Information. The amount and type of information collected may vary depending on the amount and type of coverage applied for, but, in general, we will be seeking information about your age, physical and mental condition, health history, and other insurance coverage.

Your application is our most important source of information. If we need additional medical information, we may ask you to have your attending physician complete a statement.

Disclosures By Liberty

In general, we do not disclose personal information about you to anyone without your consent. However, to the extent necessary to conduct our business, we may share information about you without your specific authorization. Following is a brief description of some of the persons or organizations to whom certain items of information might be disclosed:

- Persons or organizations which perform professional, business or insurance functions for us;
- Other insurance companies in connection with this application or with any other application, policy or claim involving you. For example, we would share information about you with other companies that have insured you;
- Our representatives, investigators, attorneys and other persons who are or will become involved in processing your application, providing you with service, or acting upon any claim;
- Insurance-support organizations or insurers *for the* purpose of detecting or preventing criminal activity, fraud, misrepresentation or nondisclosure;
- Insurance regulatory authorities, governmental authorities or law enforcement agencies to protect our interest in cases of suspected fraud or illegal activities;
- Medical professionals or institutions for the purpose of verifying insurance coverage or benefits, informing an individual of a medical condition not known to the individual, or conducting an audit;
- Persons or organizations conducting bonafide actuarial or scientific research studies, audits or evaluations; however, you will not be individually identified in any research report and the material we provide will be returned to us or destroyed when no longer needed;
- Our affiliates for auditing or marketing purposes; and
- A group policyholder for the purpose of reporting claims experience or conducting an audit of our operations or services.

The above describes some of the disclosures which “MAY” be made, not disclosures which are always or even often made. In any event, the information disclosed will be limited to that which is reasonably necessary to accomplish the intended purpose.

Important: All boxes must be filled with either "Yes" or "No". Do not leave boxes blank as failure to complete all boxes with either a **Yes** or **No** response will cause application to be returned.

1. Have you ever been treated for, or had knowledge that you were afflicted with: (answer "Yes" or "No")

a.	Mental or emotional disorder		l.	Severe headaches	
b.	Heart, circulatory trouble, or high cholesterol		m.	Disease of prostate	
c.	High blood pressure		n.	Back trouble, arthritis, bone or joint disorders	
d.	Urinary disease		o.	Any surgical operations	
e.	Diabetes		p.	Convulsions or epilepsy	
f.	Cancer, tumor, or cyst		q.	Disorder of breast or reproductive organ or function	
g.	Varicose veins, hemorrhoids or hernia		r.	Liver disorder or kidney disorder	
h.	Disorder of eyes, ears, nose or throat		s.	Sexually transmitted disease	
i.	Thyroid disorder		t.	Asthma, respiratory disorders or lung disease	
j.	Muscular disorder		u.	Ulcers or digestive disorder	
k.	Treatment or recommended treatment for alcohol or drug abuse		v.	AIDS, ARC (AIDS related complex), or ever tested positive for the HTLV-III antibodies	

2. Do you have any disease, disability or deformity, congenital or otherwise, except as stated above? ________Yes ________No

3. For all "Yes" answers above, give details, by item, of any conditions recorded. Give dates, treatment, duration, severity and any recurrence.
If space is inadequate, complete a statement on a separate sheet, sign and date.

____

____

____

4. Have you smoked in the past 12 months? ________Yes ________No **If "Yes", packs per day** ________

5. Are you currently taking any prescription medicine? ________Yes ________No
If "Yes", explain on a separate sheet the type of medication, dosage, how long you have been taking it, and for what condition.

6. During the past 5 years, have you, to the best of your knowledge, been treated for or been advised of any condition which may require hospitalization, medical care, or surgical treatment? ________Yes ________No **If "Yes", explain on a separate attached sheet.**

7. To the best of your knowledge and belief, are you now pregnant? ________Yes ________No

8. Have you ever been rejected, deferred or discharged by the military because of physical or mental conditions? ________Yes ________No
If "Yes", explain on a separate attached sheet.

9. Have you ever had any life, disability, or health insurance declined, cancelled, not renewed or not approved as applied for? ________Yes ________No
If "Yes", explain on a separate attached sheet.

10. Your current height and weight: ___________Ft. ___________In. ___________Lbs.

11. Do you understand that the policy will not pay benefits for a disease or physical condition caused by pre-existing conditions (conditions which existed prior to being covered by this insurance) for which treatment was rendered or charges were incurred within six months before the effective date of insurance? However, do you understand that there is coverage for pre-existing conditions upon the elapse of six consecutive months free of such treatment (including taking medication) or charges (one year for mental illness or emotional maladjustment)?

☐ I do understand ☐ I do not understand ____

(Signature of Member) **(Date)**

Declaring that I am a member in good standing or an employee of the American Psychological Association and that all statements and answers, front and back, are complete and true to the best of my knowledge and belief, I hereby apply for coverage as specified on the front of this form, under the APA Office Overhead Insurance Plan. It is understood and agreed that the foregoing statements and answers are offered to Liberty Life Assurance Company of Boston as an inducement to grant insurance for which application is hereby made. It is further understood that Liberty Life Assurance Company of Boston reserves the right to request additional evidence of insurability, if necessary. Agreeing to pay the stipulated premium, I direct any such share of the divisible surplus of the Company as may be credited to the policy shall be paid to the Trustees of the APA Insurance Trust. I understand that I am applying for Office Overhead Insurance.

____

(Signature of Member) **(Date)**

AUTHORIZATION

LIBERTY MUTUAL INSURANCE COMPANY • LIBERTY LIFE ASSURANCE COMPANY OF BOSTON

I AUTHORIZE any medical practitioner having any information as to the diagnosis, treatment and prognosis of any physical or mental condition to give any and all such information to Liberty Mutual Insurance Company/Liberty Life Assurance Company of Boston, or both, or to its legal representatives.
I UNDERSTAND that the information obtained by use of this Authorization will be used for the purposes of evaluating any application for insurance and adjusting any claim for benefits, if insurance is provided.
I KNOW that I may request to receive a copy of this Authorization.
I AGREE that a photographic copy of this Authorization shall be as valid as the original.
I AGREE that this Authorization shall be valid for two years and one-half from the date shown below.

____

(Signature of Member) **(Date)**

Please carefully check that you have fully completed all information on this form. Missing information will cause a delay. Do not send payment with application

MAIL TO:
Administrator, APA Group Insurance Plans
Liberty Life Assurance Company of Boston
P.O. Box 1525
Dover, New Hampshire 03821-1525

Office Overhead Expense Insurance Semiannual Premium Rates Per $100 of Monthly Benefit

Premiums are determined by the member's age on the date of issue and by the member's age on renewal

Member's Age	*Rate per $100 of Monthly Benefit*
Under 30	2.622
30-34	3.270
35-39	4.242
40-44	5.220
45-49	6.840
50-54	9.444
55-59	12.690

About Insurability

APA members who are eligible to enroll in any of the programs of Office Overhead Insurance described in this brochure must submit evidence of insurability when making application. The insurance will not become effective until the first day of the calendar month following the date that Liberty Mutual determines that such evidence is satisfactory.

General Information

Who may apply for Office Overhead Insurance?

You are eligible to apply if you are a member of the American Psychological Association, are under age 65, reside in the United States and are working at least 20 hours per week.

Premium

Semiannual premiums are due each May 1 and November 1. In the event that you enter the plan on any date other than on the first day of a premium due date, the premium will be prorated to the next due date.

How to figure your premium

Simply divide the monthly benefit selected (i.e. $1,500) by 100. Multiply the number of units (i.e. 15) times the rate for your age in the rate table.

For Example:
Age: 40
Benefit: $1,500
Semi-annual premium: 15 units X $5.220 = $78.30

When You Have A Claim

Detailed information regarding claims procedures is issued with each new certificate. Promptly report all claims to Liberty Life's Home Office in Dover, NH.

Administration

This plan is underwritten and administered by Liberty Life Assurance Company of Boston, a member of the Liberty Mutual Group. It is the only Office Overhead program endorsed by the American Psychological Association Insurance Trust. The Trust and Liberty have been working together for over 50 years. A group Office Overhead policy has been issued to the Trustees of the APA Insurance Trust. Each participating member receives a certificate outlining the benefits to which one is entitled under the policy.

The descriptions in this brochure are necessarily brief and are subject to provisions that can only be expressed exactly in the certificates of insurance. Have any questions? Call Liberty Mutual at 1-888-287-8494.

Please detach and complete the attached application as soon as possible and mail to:

Administrator, APA Group Insurance Plans
Liberty Mutual Insurance Company
P.O. Box 1525
Dover, NH 03821-1525

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