EIT BENEFIT FUNDS
SERVING THE CHICAGO ELECTRICAL INDUSTRY SINCE 1930

Disability Procedures

Your Disability Application MUST be submitted to EIT within 90 DAYS of your Disability

PLEASE READ CAREFULLY

EIT has retained CorVel Corporation, an experienced disability case management company, to case manage all disability claims. All disability benefits will be issued by EIT after certification from CorVel.

Enclosed is the application necessary to file a claim for Short Term disability benefits under the terms of the EIT Disability Plan. To be eligible for **Short-Term Disability** benefits, **you must be eligible for coverage under the EIT Health & Welfare Plan at the time of your disability**. For **Long Term Disability** benefits, **you must have continuous EIT health coverage based on Contributed Hours for the 12 consecutive months prior to your disability date**.

Please note: You must submit your application for Short Term Disability benefits within either 90 days of the date of your last contributed hours, or 90 days of the date of your injury, whichever is later. You are eligible for two periods of coverage within any rolling or consecutive 60-month period. If you have been injured at work, please contact the Workers' Compensation Department for a Workers' Compensation Disability Statement form. The same 90 day application rules apply to work-related injuries.

A completed application consists of the following:

- ☐ **Application for Disability Benefits**
  - Section 1: Must be completed by you
  - Section 2: Must be completed by your most recent employer
  - Section 3: Must be completed by your attending physician
- ☐ **HIPAA Authorization for Disclosure of Protected Health Information**
- ☐ **Notice of Privacy Practices** - you must return the signed acknowledgement to EIT Benefit Funds
- ☐ **Form W-4S** for Federal tax withholding
- ☐ **Form IL-W-4** for State tax withholding

Your fully completed application, HIPAA authorization, acknowledgement that you've received and read the privacy notice, and tax forms (optional) must be returned to EIT Benefit Funds before your claim for benefits can be processed. EIT Benefit Funds will forward the completed forms to CorVel for certification of disability. CorVel will notify you directly concerning the certification of disability and the number of days/weeks you may be entitled to receive benefits. As case manager, CorVel will be in regular contact with you and your physician concerning your treatment and the need for updated medical information. Should you be eligible for Long Term Disability Benefits after you reach the maximum Short Term Disability Benefits, you will not be required to complete another Disability application, but it may be necessary for you to complete some additional forms.

Your disability benefit is fully taxable; however EIT Benefit Funds is required to withhold only FICA and Medicare taxes during the first six (6) months that you do not work. If you would like Federal tax withheld, the enclosed W-4S must be completed. You can choose to have any amount withheld; however, the withholding must be at least $20.00 and must be in whole dollars.

In accordance with the Illinois Department of Revenue, Illinois income tax must be withheld if and when Federal tax is withheld. Therefore, you must complete the IL-W-4 if you wish to have income tax withheld.
If both forms are not returned, neither federal nor state tax will be withheld. Your withholding decisions will affect your taxable income when you file your yearly tax return. You may wish to discuss it with a qualified tax adviser.

Return your completed Disability Application to:

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Short-Term Disability Application

Section 1: Participant – *To be completed by you.*

Name:	**Last 4 of SSN:**	**Birth Date:**
Street Address:		**Apt #:**
City:	**State:**	**Zip Code:**
Cell Phone: ( )	**Home Phone:** ( )	**E-mail:**
Employer:	**Occupation:**	

☐ Please check box if the address indicated above is a new address

Spouse Information: *If married, please complete the information below with your spouse's information*

Spouse Name:	**Is Your Spouse Employed?** ☐ Yes ☐ No
Employer:	**Employer Phone:** ( )
Employer Address:	

Disability Information: *Complete disability information below*

Date of Injury or Illness:	**Last Day Worked:**
Place Treated:	**Date Treated:**
Nature of Illness, Injury, Diagnosis or Medical Call *(REQUIRED):*	
If injured, explain how & where injury occurred:	
Has a Worker's Compensation Claim been filed? ☐ Yes ☐ No	

Authorization: *Please read carefully. Sign and date below*

I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agency, the Social Security Administration, the Medical Bureau, insurance or reinsurance of reinsurance company, or employer to release any and all medical and non-medical information in its possession about me to CorVel Corporation, Electrical Insurance Trust and/or its legal representative. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me. I understand that the Electrical Insurance Trust will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. The Electrical Insurance Trust will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons organizations performing business or legal services in connection with my application, claim or as may be lawfully required or permitted, or as I may further authorize. I know that I may request and receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for the duration of my claim.

Any person who knowingly and with the intent to defraud any insurance company Employee benefit plan or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act which is a crime. In New York, the person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. In California, any person who knowingly files a statement of claim containing any false information or misleading information is subject to criminal and civil penalties.

Participant Signature: **Date:**

Section 2: Employer – *To be completed by your most recent employer with your information.*

Employer Name:	
Employer Address:	
Last Day Employee Worked:	**Date Employee Returned to Work:**
Representative Name:	**Representative Title:**
Representative Signature:	**Date:**

Section 3 continued on pages 2, 3 and 4.

EIT BENEFIT FUNDS
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Short-Term Disability Application

Section 3: Attending Physician's Statement – *To be completed by your doctor. You are responsible for any cost associated with the completion of this form.*

Patient Name:

Diagnosis

Primary:	**ICD.10**
Secondary:	**ICD.10**
Other:	**ICD.10**
Other:	**ICD.10**

Objective Findings *(which substantiate or contribute to this patient's disease including results of x-rays, MRIs, EKGs, etc.)*:

Subjective Symptoms:

Condition History

Patient's symptoms are the result of *(check all that apply):*

☐ Employment ☐ Pregnancy ☐ Other Accident
☐ Illness ☐ Motor Vehicle Accident
☐ Other:

Date symptoms first appeared or accident occurred:	**Date you feel this patient is first unable to work:**	**Date of first visit for this condition:**
Frequency of treatment: ☐ Weekly ☐ Monthly ☐ Other :	**Date of most recent visit/treatment for this condition:**	**Date of last comprehensive examination:**
		Date of next examination:
Has this patient ever had a similar or related condition? ☐ Yes ☐ No	*If YES, provide date and explanation:*	
Was patient referred to you by another physician? ☐ Yes ☐ No	*If YES, please supply physician's complete name and address:*	
Did you refer this patient to another physician for treatment for this or related condition? ☐ Yes ☐ No	*If YES, please supply physician's complete name and address:*	

Section 3 continued on pages 3 and 4.

Short-Term Disability Application

Section 3: Attending Physician's Statement – *Continued from previous page.*

Patient Name:

Physician History - *Please supply complete names, type of practice and addresses of any treating physicians or hospitals:*

Physician Name	Practice	City & State	Treatment Dates *(From and To)*

Treatment

Describe this patient's treatment program *(including any surgeries, medications or therapies)*:

Progress

Patient has:

- ☐ Recovered
- ☐ Not Changed
- ☐ Improved
- ☐ Regressed

Patient is:

- ☐ Ambulatory
- ☐ House
- ☐ Bed Confined
- ☐ Hospital
- ☐ Confined

Limitations

Is patient able to perform the duties of his/her job? ☐ Yes ☐ No

If NO, which level of function as defined by the U.S. Department of Labor best describes the patient's ability to perform his/her job duties?

- ☐ Sedentary Work
- ☐ Light Work
- ☐ Medium Work
- ☐ Heavy Work
- ☐ Other/Restrictions:

If not able to return to work full duty, when do you anticipate a release? Date:

Degree of Cardiac Functional Capacity:

Blood pressure at last visit: Systolic: _____ **Diastolic:** _____

Current Cardiac Status:

- ☐ No Limitations
- ☐ Slight Limitations
- ☐ Marked Limitations
- ☐ Complete Limitations

Define stress as it applies to this patient's occupation and day-to-day life:

Section 3 continued on page 4.

Short-Term Disability Application

Section 3: Attending Physician's Statement – *Continued from previous page.*

Patient Name:

Do you believe that this patient is competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

Degree of mental/nervous impairment:

Current GAF *(Global Assessment of Functioning)*: **/90**

☐ **Class 1:** Patient is able to function under stress and engage in interpersonal relationships *(no limitations)*

☐ **Class 2:** Patient is able to function in most stress situations and engage in most interpersonal relationships *(slight limitations)*

☐ **Class 3:** Patient is able to engage in only limited stress and engage in only limited interpersonal relationships *(moderate limitations)*

☐ **Class 4:** Patient is unable to engage in stress situations or engage in interpersonal relationships *(marked limitations)*

☐ **Class 5:** Patient has significant loss of psychological, physiological, personal and social adjustments *(severe limitations)*

Remarks:

Rehabilitation

Is the patient a suitable candidate for:

☐ Work Hardening ☐ Cardiac Rehabilitation ☐ Vocational Rehabilitation

☐ Physical Therapy ☐ None of these ☐ Other:

What modifications do you feel could be made to this patient's job to enable him/her to return to work?

Remarks

Any additional pertinent information?

Physician Information

Physician Name:		**Specialty:**
Street Address:		
City:	**State:**	**Zip Code:**
Phone:		**Fax:**
Physician's Signature:		**Date:**

Return your completed Disability Application to:

IMPORTANT NOTICE

Short Term Disability (STD) and Long Term Disability (LTD) Benefits

This notice describes a change in the STD and LTD payment process.

Dear Participant:

Please be advised that EIT now sends all STD and LTD payments electronically to your financial institution via direct deposit (ACH). **Enrollment in direct deposit is MANDATORY.** This allows immediate access to your funds and prevents lost or delayed payments.

Please return your completed Direct Deposit form as soon as possible to avoid any delays in your payments. You may fax it to (312) 782-0799, email it to askeit@fundoffice.org or send via mail to EIT BENEFIT FUNDS, 6195 W. 115th St., Alsip, IL 60803.

To complete the form, please provide your bank's information, **including the Bank Name**, your **routing number** and **account number**. We recommend that you submit a voided check or a copy of a voided check to ensure that we have accurate routing and account numbers to make your electronic deposit.

If you are choosing to have your payment directly deposited into a Savings Account, it is very important that a bank representative complete and sign ***Section 3: Savings Account Deposits***. By doing so, you will give your bank an opportunity to verify the routing number, account number and to acknowledge that the institution does participate in the Automated Clearing House (ACH) system. Direct Deposits cannot be made to financial institutions that are not members of the ACH system.

Be sure to sign and date the form in *Section 4: Participant Signature*. We cannot make an electronic deposit without your written authorization.

Once your account information has been received and updated by EIT, our bank will provide a test deposit (pre-note) in which no actual money is transferred. This pre-note verifies the accuracy of your account and your bank information. Provided the information is correct, your next STD or LTD payment will be electronically deposited into your specified bank account.

If your bank information changes or you close your account, please notify EIT immediately of any change in your account status by completing a new Direct Deposit form.

IMPORTANT CHANGE: **In order for your payment to be deposited on Wednesday, your recertification from CorVel (if necessary), must be received by EIT no later than 4:30 p.m. the Friday prior to the payment.** If EIT receives your recertification information after this deadline, your payment may be deposited the following Wednesday.

If you have any questions or concerns, please feel free to contact the Disability Department by calling (312) 782-5442, ext. 271 to speak with Annette Grango in our Disability Department.

EIT BENEFIT FUNDS
SERVING THE CHICAGO ELECTRICAL INDUSTRY SINCE 1930

Direct Deposit Form

For Office Use Only: Disability

❑ New ❑ Change ❑ Termination

Section 1: Participant Information *- Complete this section with your personal information. (please print)*

Name:		**Last 4 of SSN:**
Street Address:		**Apt #:**
City:	**State:**	**Zip Code:**
Cell Phone: ( )	**Home Phone: ( )**	**E-mail:**

☐ Please check box if the address indicated above is a new address

Section 2: Bank Information *– Complete this section with your bank information.*

Select a Type of Account *(check one):*

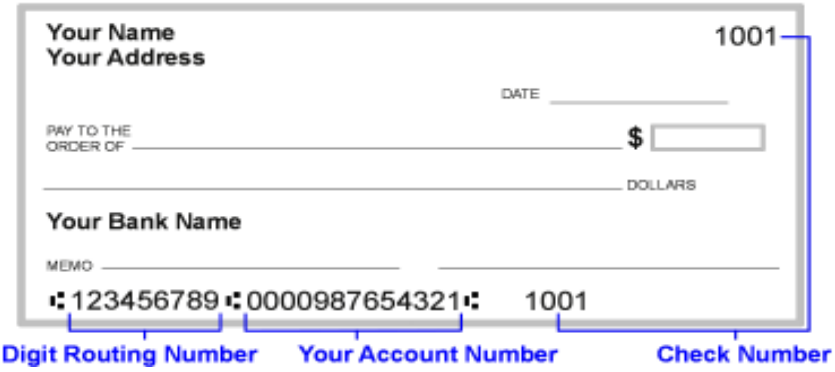
☐ Checking ☐ Savings *(you MUST have a representative from your bank complete Section 3: Savings Account Deposits)*

Name of Your Financial Institution:

9 Digit Routing Number:	**Your Account Number:**

Please include a copy of a canceled or voided check for accuracy. You may copy it directly over the sample.

<u>Do not</u> provide a copy of a deposit slip, as the routing number will be incorrect for Direct Deposit purposes.



Section 3: Savings Account Deposits: *For Financial Institution Use Only* *- A bank representative must complete this section only if you will be having your check direct deposited to a Savings Account.*

I certify that this financial institution agrees to accept ACH credits from the Fund Office for the depositor listed above. I also certify that the bank account number and routing number above are correct. In addition, this institution agrees to notify the Fund Office when it receives notification of the account holder's death.

Bank Representative's Signature: **Date:**

Bank Representative's Name: (Printed):

Bank Representative's Title:

Section 4: Participant Signature *- Read carefully. Sign*

By signing this form, I authorize the Fund Office to initiate, terminate or change deposits to my account with the financial institution listed above. In addition, the financial institution is authorized by me to credit my account for the amount of the entry. These deposits will remain in effect until I provide the Fund Office with written notification, within a reasonable time period, to stop payments to my account.

Participant Signature: **Date:**

Return your completed Direct Deposit form to:

EIT BENEFIT FUNDS • 6195 W. 115th St., Alsip, IL 60803 • (312) 782-5442 • Fax (312) 782-0799 • www.fundoffice.org

HIPAA AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, authorize the health care providers who have treated me as follows to disclose protected health information ("PHI") about me as described below in this Authorization:

1. With this authorization, I allow all medical records and information to be released that relates to my eligibility for medical disability benefits from the EIT Benefit Funds.

2. Any health care provider or facility who treats/treated me for my medical condition or medical illness ("Identified Health Care Providers") may disclose the above-described information to a Disability Management Case Manager, for the EIT Benefit Funds, employed by CorVel Corporation.

3. This disclosure is made for the purposes of qualifying the Disability Claim as requested by The EIT Benefit Funds.

4. I understand that the Identified Health Care Providers are not conditioning my treatment, payment, enrollment, or eligibility for benefits on whether I agree to sign this authorization.

5. I understand that the information disclosed pursuant to this authorization may no longer be protected by the federal health privacy rule (otherwise known as HIPAA) and may be subject to re-disclosure by the recipient.

6. I understand that I have the right to revoke this authorization in writing at any time by sending a letter to the Privacy Officer of the Identified Health Care Providers for my medical condition or medical illness as described above, and that the effective date of my revocation will be the date the Privacy Officer receives it. I further understand that any revocation will be effective only to the extent that Identified Health Care Providers has not already taken action in reliance on this authorization.

7. This authorization allows for the release of medical records produced as the result of treatment provided prior to the date of expiration of this authorization.

8. This authorization shall expire one year from the date of my signature to this authorization, below.

_____ Printed Name (of person giving authorization)

_____ Name of personal representative (if applicable)/ Relationship to Claimant

_____ Signature (of person giving authorization)

_____ Signature of personal representative

_____ Date

_____ Date

(If applicable, Power of Attorney, Guardian or Conservator. Attach copy of document granting authority.)

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

COMMITMENT TO PRIVACY

CorVel Corporation ("CorVel") is committed to protecting the privacy of your protected health information ("health information"). Health information is information that identifies you and relates to a physical or mental condition, or to the provision or payment of health services for you. CorVel also pledges to provide you with certain rights related to your health information.

By this Notice of Plan's Privacy Practices ("Notice"), CorVel informs you that it has the following legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- to maintain the privacy of your health information;
- to provide you with this Notice of its legal duties and privacy practices with respect to your health information; and
- to follow the terms of this Notice currently in effect.

This Notice also informs you how CorVel uses and discloses your health information and explains the rights that you have with regard to your health information maintained by CorVel.

For HIPAA purposes, CorVel is a hybrid entity. This means that HIPAA only applies to certain lines of service or "health care components" and not all of the lines of service offered by CorVel. Specifically, this Notice applies to directed care services such as independent medical examinations, durable medical equipment, prescription drug network and certain case management services. You will receive a separate Notice of Privacy Practices if you are receiving imaging services.

INFORMATION SUBJECT TO THIS NOTICE

CorVel collects certain health information about you to help provide health care to you, as well as to fulfill legal requirements. CorVel collects this information, which identifies you, from applications and other forms that you complete, through conversations you may have with CorVel's administrative staff and health care providers, and from reports and data provided to CorVel by other health care service providers. The health information CorVel has about you includes, among other things, your name, address, phone number, birth date, social security number, employment information, and medical and other health information. This is the information that is subject to the privacy practices described in this Notice.

This Notice does not apply to health information collected or maintained by CorVel on behalf of the lines of service that are not considered "health care components" for HIPAA purposes, including, but not limited to, case management involving disability, auto and workers' compensation claims.

SUMMARY OF CORVEL'S PRIVACY PRACTICES

CorVel's Uses and Disclosures of Your Health Information

CorVel uses your health information to process and pay your health service claims, and to administer its operations. In some cases, your health information may only be disclosed with your written authorization, while in other instances, your authorization is not required. For example, CorVel may disclose your health information, without your authorization, to certain claims handlers, case managers and health care providers for treatment, payment and health care operations purposes. CorVel also may disclose your health information, without your authorization, to third parties that assist CorVel in its operations, to government and law enforcement agencies, to your family members in limited instances, and to certain other persons. The details of CorVel's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with access to your health information and with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request to receive your health information through confidential communications;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;
- Request certain restrictions related to the use and disclosure of your health information;
- File a complaint with CorVel or the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated; and
- Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below.

Changes in CorVel's Privacy Policies

CorVel reserves its right to change its privacy practices and revise this Notice as described below.

Contact Information

If you have any questions or concerns about CorVel's privacy practices, or about this Notice, or you wish to obtain additional information about CorVel's privacy practices, please contact: ***HIPAA Privacy Officer*, 3010 Highland Parkway, Suite 600, Downers Grove, Illinois 60515**

CORVEL'S USES AND DISCLOSURES

Except as described in this section, as provided for by federal, state or local law, or as you have otherwise authorized, CorVel only uses and discloses your health information to provide you with health care services, to process and receive payment for health care rendered to you, and to administer its operations. The uses and disclosures that do not require your written authorization are described below.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

For Treatment. CorVel may use and disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you. For example, if CorVel maintains information about your independent medical examination or prescriptions that you have filled, CorVel may disclose this information to your case manager for your treatment purposes.

Notice of Privacy Practices

For Payment. CorVel may use and disclose your health information so that your claims for health care services can be paid. For example, CorVel may disclose your health information to your insurance carrier to receive payment.
For Health Care Operations. CorVel may use or disclose your health information so it can operate efficiently and in the best interests of its clients. For example, CorVel may disclose health information to its auditors to conduct an audit involving the accuracy of claim payments. ***Uses and Disclosures to Business Associates***
CorVel may disclose your health information to third parties that assist CorVel in its operations. For example, CorVel may share your health information with its business associate if the business associate is responsible for giving CorVel legal advice. CorVel's business associates have the same obligation to keep your health information confidential as CorVel does. CorVel must require its business associates to ensure that your health information is protected from unauthorized use or disclosure.
Other Uses and Disclosures That May Be Made Without Your Authorization
The federal health privacy law provides for specific uses or disclosures of your health information that CorVel may make without your authorization, which are described below.
Required by Law. CorVel may use and disclose health information about you as required by federal, state or local law. For example, CorVel may disclose your health information for the following purposes:

- For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority.
- To report information related to victims of abuse, neglect, or domestic violence.
- To assist law enforcement officials in their law enforcement duties.

Health and Safety. Your health information may be disclosed to avert a threat to the health or safety of you, any other person, or the public, pursuant to applicable law. Your health information also may be disclosed for public health activities, such as preventing or controlling disease or disability.
Government Functions. Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, and protection of public officials. Your health information also may be disclosed to health oversight agencies that monitor the health care system for audits, investigation, licensure, and other oversight activities.
Active Members of the Military and Veterans. Your health information may be used or disclosed to comply with laws related to military service or veterans' affairs.
Workers Compensation. Your health information may be used or disclosed in order to comply with laws related to Workers' Compensation. **Emergency Situations**. Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency, or to a disaster relief entity in the event of a disaster.
Others Involved In Your Care. In limited instances, your health information may be used or disclosed to a family member, close personal friend, or others who CorVel has verified are involved in your care or payment for your care. For example, if you are seriously injured and unable to discuss your case with CorVel, CorVel may so disclose your health information. Also, upon request, CorVel may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.
Personal Representatives. Your health information may be disclosed to people you have authorized or people who have the right to act on your behalf. Examples of personal representatives are parents for minors, and those who have Power of Attorney for adults.
Treatment and Health-Related Benefits Information. CorVel and its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services or medication.
Research. Under certain circumstances, CorVel may use or disclose your health information for research purposes, as long as the procedures required by law to protect the privacy of the research data are followed.
Organ and Tissue Donation. If you are an organ donor, your health information may be used or disclosed to an organ donor, eye, or procurement organization to facilitate an organ or tissue donation or transplantation.
Deceased Individuals. The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.
Uses and Disclosures for Fundraising and Marketing Purposes
CorVel does not use your health information for fundraising or marketing purposes.
Any Other Uses and Disclosures Require Your Express Authorization
Uses and disclosures of your health information ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization in writing. If you do so, CorVel will not use or disclose your health information authorized by the revoked authorization, except to the extent that CorVel already has relied on your authorization.
Once your health information has been disclosed pursuant to your authorization, the federal privacy protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your or CorVel's knowledge or authorization.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your health information that CorVel maintains. If you are required to submit a written request related to these rights, as described below, you should address such requests to: ***HIPAA Privacy Officer*, 3010 Highland Parkway, Suite 600, Downers Grove, Illinois 60515**
Right to Inspect and Copy Health Information
You have the right to inspect and obtain a copy of your health record. This includes, among other things, health information about your care, treatment and billing records. To inspect and copy your health record maintained by CorVel, submit your request in writing. A fee will be charged to you for the cost of copying your health record and mailing it to you. In certain limited circumstances, CorVel may deny your request to inspect and copy your health record. If CorVel does so, it will inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.
Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location
You have the right to request that CorVel communicate your health information to you in confidence by alternative means or in an alternative location. For example, you can ask that CorVel only contact you at work or by mail, or that CorVel provide you with access to your health information at a specific location. To request confidential communications by alternative means or at an alternative location, submit your request in writing. Your written request should state the alternative means by or location at which you would like to receive your health information. CorVel will accommodate reasonable requests and will notify you appropriately.

Notice of Privacy Practices

Right to Request That Your Health Information Be Amended

You have the right to request that CorVel amend your health information if you believe the information is incorrect or incomplete. To request an amendment, submit a detailed request in writing that provides the reason(s) that support your request. CorVel may deny your request if you have asked to amend information that:

- Was not created by CorVel, unless you provide CorVel with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of your heath information maintained by or for CorVel;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

CorVel will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If CorVel denies your request, it will explain the reason(s) for the denial, and describe how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by CorVel to others, except that disclosures for treatment, payment or health care operations, disclosures made to or authorized by you, and certain other disclosures are not part of the accounting. The accounting covers up to six years prior to the date of your request, except that the accounting will not include disclosures CorVel made before April 14, 2003. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit your request in writing. The first accounting that you request within a twelve month period will be free. For additional accountings in a twelve month period, CorVel will charge you for the cost of providing the accounting, but CorVel will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred. ***Right to Request Restrictions***

You have the right to request restrictions on your health care information that CorVel uses or discloses about you to carry out treatment, payment or health care operations. Also, you have the right to request restrictions on your health information that CorVel discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. CorVel is not required to agree to your request for such restrictions, and CorVel may terminate its agreement to the restrictions you requested. To request restrictions, submit your request in writing, and advise CorVel as to what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. CorVel will notify you in writing as to whether it agrees to your request for restrictions. CorVel will also notify you in writing if it terminates an agreement to the restrictions that you requested.

Right to Complain

You have the right to complain to CorVel and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with CorVel, submit your complaint in writing to: ***HIPAA Privacy Officer***, **3010 Highland Parkway, Suite 600, Downers Grove, Illinois 60515**

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with CorVel or with the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to: ***HIPAA Privacy Office***, **3010 Highland Parkway, Suite 600, Downers Grove, Illinois 60515**

You may also obtain a copy of this Notice at CorVel's website, www.CorVel.com.

CHANGES IN CORVEL'S PRIVACY PRACTICES

CorVel reserves the right to change its privacy practices and make the new practices effective for all health information that it maintains, including your health information that it created or received prior to the effective date of the change and your health information it may receive in the future. If CorVel materially changes any of its privacy practices covered by this Notice, it will revise this Notice, and post the Notice at its location. In addition, copies of the revised Notice will be made available to you upon your written request, and any revised Notice will also be available at CorVel's website, www.CorVel.com.

EFFECTIVE DATE

This Notice is effective as of April 14, 2003, and will remain in effect unless and until CorVel publishes a revised Notice.

Please note that this is an important notice related to privacy of your personal healthcare information. Please review the provided information carefully. CorVel requests that you acknowledge receipt of this notice. Please sign below and mail to the CorVel HIPAA Privacy Officer at the following address: 3010 Highland Parkway, Suite 600, Downers Grove, Illinois 60515 If you have any questions please feel free to contact the CorVel HIPAA Privacy Officer in writing.

Acknowledgement

I, _____ (printed name) have received CorVel Corporation's Notice of Privacy Practices.

Signature: _____

Date: _____

Return your signed CorVel Acknowledgment to:

EIT BENEFIT FUNDS • 6195 W. 115th St., Alsip, IL 60803 • (312) 782-5442 • Fax (312) 782-0799 • www.fundoffice.org

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Form **W-4S**

Department of the Treasury
Internal Revenue Service

Request for Federal Income Tax Withholding From Sick Pay

Give this form to the third-party payer of your sick pay.
Go to *www.irs.gov/FormW4S* for the latest information.

OMB No. 1545-0074

2024

Your first name and middle initial	Last name	**Your social security number**

Home address (number and street or rural route)

City or town, state, and ZIP code

Claim or identification number (if any)	
I request federal income tax withholding from my sick pay payments. I want the following amount to be withheld from each payment. (See **Worksheet** below.)	$

Employee's signature: Date:

---------- **Separate here and give the top part of this form to the payer. Keep the lower part for your records.** ----------

Worksheet (Keep for your records. Do not send to the IRS.)

1	Enter amount of adjusted gross income that you expect in 2024	**1**	
2	If you plan to itemize deductions on Schedule A (Form 1040), enter the estimated total of your deductions. See Pub. 505 for details. If you don't plan to itemize deductions, enter the standard deduction. (See the instructions on page 2 for the standard deduction amount, including additional standard deductions for age and blindness.) **Note:** There is no deduction for personal exemptions for 2024	**2**	
3	Subtract line 2 from line 1	**3**	
4	Tax. Figure your tax on line 3 by using the **2024** Tax Rate Schedule X, Y-1, Y-2, or Z on page 2. **Do not** use any tax tables, worksheets, or schedules in the 2023 Instructions for Form 1040	**4**	
5	Credits (child tax and higher education credits, credit for child and dependent care expenses, etc.) . .	**5**	
6	Subtract line 5 from line 4	**6**	
7	Estimated federal income tax withheld or to be withheld from other sources (including amounts withheld due to a prior Form W-4S) during 2024 or paid or to be paid with 2024 estimated tax payments . . .	**7**	
8	Subtract line 7 from line 6	**8**	
9	Enter the number of sick pay payments you expect to receive this year to which this Form W-4S will apply	**9**	
10	Divide line 8 by line 9. Round to the nearest dollar. This is the amount that should be withheld from each sick pay payment. Be sure it meets the requirements for the amount that should be withheld, as explained under *Amount to be withheld* below. If it does, enter this amount on Form W-4S above . .	**10**	

General Instructions

Purpose of form. Give this form to the third-party payer of your sick pay, such as an insurance company, if you want federal income tax withheld from the payments. You aren't required to have federal income tax withheld from sick pay paid by a third party. However, if you choose to request such withholding, Internal Revenue Code sections 3402(o) and 6109 and their regulations require you to provide the information requested on this form. Don't use this form if your employer (or its agent) makes the payments because employers are already required to withhold federal income tax from sick pay.

Note: If you receive sick pay under a collective bargaining agreement, see your union representative or employer.

Definition. Sick pay is a payment that you receive:

- Under a plan to which your employer is a party, and
- In place of wages for any period when you're temporarily absent from work because of your sickness or injury.

Amount to be withheld. Enter on this form the amount that you want withheld from each payment. The amount that you enter:

- Must be in whole dollars (for example, $35, not $34.50).
- Must be at least $4 per day, $20 per week, or $88 per month based on your payroll period.
- Must not reduce the net amount of each sick pay payment that you receive to less than $10.

For payments larger or smaller than a regular full payment of sick pay, the amount withheld will be in the same proportion as your regular withholding from sick pay. For example, if your regular full payment of $100 a week normally has $25 (25%) withheld, then $20 (25%) will be withheld from a partial payment of $80.

Caution: You may be subject to a penalty if your tax payments during the year aren't at least 90% of the tax shown on your tax return. For exceptions and details, see Pub. 505, Tax Withholding and Estimated Tax. You may pay tax during the year through withholding or estimated tax payments or both. To avoid a penalty, make sure that you have enough tax withheld or make estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. You may estimate your federal income tax liability by using the worksheet above.

Sign this form. Form W-4S **is not** valid unless you sign it.

Statement of income tax withheld. After the end of the year, you'll receive a Form W-2, Wage and Tax Statement, reporting the taxable sick pay paid and federal income tax withheld during the year. These amounts are reported to the IRS.

Changing your withholding. Form W-4S remains in effect until you change or revoke it. You may do this by giving a new Form W-4S or a written notice to the payer of your sick pay. To revoke your previous Form W-4S, complete a new Form W-4S and write "Revoked" in the money amount box, sign it, and give it to the payer.

(continued on back)

Specific Instructions for Worksheet

You may use the worksheet on page 1 to estimate the amount of federal income tax that you want withheld from each sick pay payment. Use your tax return for last year and the worksheet as a basis for estimating your tax, tax credits, and withholding for this year.

You may not want to use Form W-4S if you already have your total tax covered by estimated tax payments or other withholding.

If you expect to file a joint return, be sure to include the income, deductions, credits, and payments of both yourself and your spouse in figuring the amount you want withheld.

Caution: If any of the amounts on the worksheet change after you give Form W-4S to the payer, you should use a new Form W-4S to request a change in the amount withheld.

Line 2—Deductions

Itemized deductions. Itemized deductions include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your adjusted gross income. See Pub. 505 for details.

Standard deduction. For 2024, the standard deduction amounts are:

Filing Status	Standard Deduction
Married filing jointly or qualifying surviving spouse	$29,200*
Head of household	$21,900*
Single or Married filing separately	$14,600*

*If you're age 65 or older or blind, add to the standard deduction amount the additional amount that applies to you as shown in the next paragraph. If you can be claimed as a dependent on another person's return, see *Limited standard deduction for dependents*, later.

Additional standard deduction for the elderly or blind. An additional standard deduction of $1,550 is allowed for a married individual (filing jointly or separately) or a qualifying surviving spouse who is 65 or older or blind, $3,100 if 65 or older **and** blind. If both spouses are 65 or older or blind, an additional $3,100 is allowed on a joint return. If both spouses are 65 or older **and** blind, an additional $6,200 is allowed on a joint return. Additional standard deductions are also allowed on your separate return for your spouse who is 65 or older and/or blind if your spouse has no gross income and can't be claimed as a dependent by another taxpayer. An additional $1,950 is allowed for an unmarried individual (single or head of household) who is 65 or older or blind, $3,900 if 65 or older **and** blind. See the 2024 Estimated Tax Worksheet—Line 2 Standard Deduction Worksheet in Pub. 505.

Limited standard deduction for dependents. If you are a dependent of another person, your standard deduction is the greater of (a) $1,300 or (b) your earned income plus $450 (up to the regular standard deduction for your filing status). If you're 65 or older or blind, see Pub. 505 for additional amounts that you may claim.

Certain individuals not eligible for standard deduction. For the following individuals, the standard deduction is zero.

- A married individual filing a separate return if either spouse itemizes deductions.
- A nonresident alien individual. For exceptions, see Pub. 519, U.S. Tax Guide for Aliens.
- An individual filing a return for a period of less than 12 months because of a change in his or her annual accounting period.

Line 5—Credits

Include on this line any tax credits that you're entitled to claim, such as the child tax credit and credit for other dependents, higher education credits, credit for child and dependent care expenses, earned income credit, or credit for the elderly or the disabled. See the Tax Credits table in Pub. 505 for more information.

Line 7—Tax Withholding and Estimated Tax

Enter the federal income tax that you expect will be withheld this year on income other than sick pay and any payments made or to be made with 2024 estimated tax payments. Include any federal income tax already withheld or to be withheld from wages and pensions.

2024 Tax Rate Schedules

Schedule X—Single

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$11,600	**$0 + 10%**	**$0**
11,600	47,150	**1,160 + 12%**	**11,600**
47,150	100,525	**5,426 + 22%**	**47,150**
100,525	191,950	**17,168.50 + 24%**	**100,525**
191,950	243,725	**39,110.50 + 32%**	**191,950**
243,725	609,350	**55,678.50 + 35%**	**243,725**
609,350	and greater	**183,647.25 + 37%**	**609,350**

Schedule Z—Head of household

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$16,550	**$0 + 10%**	**$0**
16,550	63,100	**1,655 + 12%**	**16,550**
63,100	100,500	**7,241 + 22%**	**63,100**
100,500	191,950	**15,469 + 24%**	**100,500**
191,950	243,700	**37,417 + 32%**	**191,950**
243,700	609,350	**53,977 + 35%**	**243,700**
609,350	and greater	**181,954.50 + 37%**	**609,350**

Schedule Y-1—Married filing jointly or Qualifying surviving spouse

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$23,200	**$0 + 10%**	**$0**
23,200	94,300	**2,320 + 12%**	**23,200**
94,300	201,050	**10,852 + 22%**	**94,300**
201,050	383,900	**34,337 + 24%**	**201,050**
383,900	487,450	**78,221 + 32%**	**383,900**
487,450	731,200	**111,357 + 35%**	**487,450**
731,200	and greater	**196,669.50 + 37%**	**731,200**

Schedule Y-2—Married filing separately

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$11,600	**$0 + 10%**	**$0**
11,600	47,150	**1,160 + 12%**	**11,600**
47,150	100,525	**5,426 + 22%**	**47,150**
100,525	191,950	**17,168.50 + 24%**	**100,525**
191,950	243,725	**39,110.50 + 32%**	**191,950**
243,725	365,600	**55,678.50 + 35%**	**243,725**
365,600	and greater	**98,334.75 + 37%**	**365,600**

Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Illinois Department of Revenue

Form IL-W-4

Employee's and other Payee's Illinois Withholding Allowance Certificate and Instructions

Note: These instructions are written for employees to address withholding from wages. However, this form can also be completed and submitted to a payor if an agreement was made to voluntarily withhold Illinois Income tax from other (non-wage) Illinois income.

Who must complete Form IL-W-4?

If you are an employee, you must complete this form so your employer can withhold the correct amount of Illinois Income Tax from your pay. The amount withheld from your pay depends, in part, on the number of allowances you claim on this form.

Even if you claimed exemption from withholding on your federal Form W-4, U.S. Employee's Withholding Allowance Certificate, because you do not expect to owe any federal income tax, you may be required to have Illinois Income Tax withheld from your pay (see Publication 130, Who is Required to Withhold Illinois Income Tax). If you are claiming exempt status from Illinois withholding, you must check the exempt status box on Form IL-W-4 and sign and date the certificate. Do not complete Lines 1 through 3.

If you are a resident of a Iowa, Kentucky, Michigan, or Wisconsin, or a military spouse, see Form W-5-NR, Employee's Statement of Nonresidence in Illinois, to determine if you are exempt.

If you are an Illinois resident who works for an employer in a non-reciprocal state but you work from home or in locations in Illinois for more than 30 working days, you may need to adjust your withholding or begin making estimated payments. For additional information, go to **tax.illinois.gov.**

Note If you do not file a completed Form IL-W-4 with your employer, if you fail to sign the form or to include all necessary information, or if you alter the form, your employer must withhold Illinois Income Tax on the entire amount of your compensation, without allowing any exemptions.

When must I submit this form?

You should complete this form and give it to your employer on or before the date you start work. You must submit Form IL-W-4 when Illinois Income Tax is required to be withheld from compensation that you receive as an employee. You may file a new Form IL-W-4 any time your withholding allowances increase. If the number of your claimed allowances decreases, you **must** file a new Form IL-W-4 within 10 days. However, the death of a spouse or a dependent does not affect your withholding allowances until the next tax year.

When does my Form IL-W-4 take effect?

If you do not already have a Form IL-W-4 on file with your employer, this form will be effective for the first payment of compensation made to you after this form is filed. If you already have a Form IL-W-4 on file with this employer, your employer may allow any change you file on this form to become effective immediately, but is not required by law to change your withholding until the first payment of compensation is made to you after the first day of the next calendar quarter (that is, January 1, April 1, July 1, or October 1) that falls at least 30 days after the date you file the change with your employer.

Example: If you have a baby and file a new Form IL-W-4 with your employer to claim an additional allowance for the baby, your employer may immediately change the withholding for all future payments of compensation. However, if you file the new form on September 1, your employer does not have to change your withholding until the first payment of compensation is made to you after October 1. If you file the new form on September 2, your employer does not have to change your withholding until the first payment of compensation made to you after December 31.

How long is Form IL-W-4 valid?

Your Form IL-W-4 remains valid until a new form you have submitted takes effect or until your employer is required by the Department to disregard it. Your employer is required to disregard your Form IL-W-4 if

- you claim total exemption from Illinois Income Tax withholding, but you have not filed a federal Form W-4 claiming total exemption, or
- the Internal Revenue Service (IRS) has instructed your employer to disregard your federal Form W-4.

What is an "exemption"?

An "exemption" is a dollar amount on which you do not have to pay Illinois Income Tax that you may claim on your Illinois Income tax return.

What is an "allowance"?

The dollar amount that is exempt from Illinois Income Tax is based on the number of allowances you claim on this form. As an employee, you receive one allowance unless you are claimed as a dependent on another person's tax return (*e.g.,* your parents claim you as a dependent on their tax return). If you are married, you may claim additional allowances for your spouse and any dependents that you are entitled to claim for federal income tax purposes. You also will receive additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind.

Note: For tax years beginning on or after January 1, 2017, the personal exemption allowance, and additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind, may **not** be claimed on your Form IL-1040 if your adjusted gross income for the taxable year exceeds $500,000 for returns with a federal filing status of married filing jointly, or $250,000 for all other returns. You may complete a new Form IL-W-4 to update your exemption amounts and increase your Illinois withholding.

How do I figure the correct number of allowances?

Complete the worksheet on the back of this page to figure the correct number of allowances you are entitled to claim. Give your completed Form IL-W-4 to your employer. Keep the worksheet for your records.

Note If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

How do I avoid underpaying my tax and owing a penalty?

You can avoid underpayment by reducing the number of allowances or requesting that your employer withhold an additional amount from your pay. Even if your withholding covers the tax you owe on your wages, if you have non-wage income that is taxable, such as interest on a bank account or dividends on an investment, you may have additional tax liability. If you owe more than $500 tax at the end of the year, you may owe a late-payment penalty or will be required to make estimated tax payments. For additional information on penalties see Publication 103, Uniform Penalties and Interest. Visit our website at **tax.illinois.gov** to obtain a copy.

Where do I get help?

- Visit our website at **tax.illinois.gov**
- Call our Taxpayer Assistance Division at **1 800 732-8866** or **217 782-3336**
- Call our TDD (telecommunications device for the deaf) at **1 800 544-5304**
- Write to
  ILLINOIS DEPARTMENT OF REVENUE
  PO BOX 19044
  SPRINGFIELD IL 62794-9044

Illinois Withholding Allowance Worksheet

General Information

Use this worksheet as a guide to figure your total withholding allowances you may enter on your Form IL-W-4.

Complete Step 1.

Complete Step 2 if

- you (or your spouse) are age 65 or older or legally blind, or
- you wrote an amount on Line 4 of the Deductions Worksheet for federal Form W-4.

If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

You may reduce the number of allowances or request that your employer withhold an additional amount from your pay, which may help avoid having too little tax withheld.

Step 1: Figure your basic personal allowances (including allowances for dependents)

Check all that apply:

☐ No one else can claim me as a dependent.

☐ I can claim my spouse as a dependent.

1 Enter the total number of boxes you checked. **1** _____

2 Enter the number of dependents (other than you or your spouse) you will claim on your tax return. **2** _____

3 Add Lines 1 and 2. Enter the result. This is the total number of basic personal allowances to which you are **entitled**. You are not required to claim these allowances. The number of basic personal allowances that you choose to claim will determine how much money is withheld from your pay. See Line 4 for more information. **3** _____

4 Enter the total number of basic personal allowances you choose to claim on this line and Line 1 of Form IL-W-4 below. This number may not exceed the amount on Line 3 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. **4** _____

Step 2: Figure your additional allowances

Check all that apply:

☐ I am 65 or older. ☐ I am legally blind.

☐ My spouse is 65 or older. ☐ My spouse is legally blind.

5 Enter the total number of boxes you checked. **5** _____

6 Enter any amount that you reported on Line 4 of the Deductions Worksheet for federal Form W-4 plus any additional Illinois subtractions or deductions. **6** _____

7 Divide Line 6 by 1,000. Round to the nearest whole number. Enter the result on Line 7. **7** _____

8 Add Lines 5 and 7. Enter the result. This is the total number of additional allowances to which you are **entitled**. You are not required to claim these allowances. The number of additional allowances that you choose to claim will determine how much money is withheld from your pay. **8** _____

9 Enter the total number of additional allowances you elect to claim on Line 2 of Form IL-W-4, below. This number may not exceed the amount on Line 8 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. **9** _____

IMPORTANT: If you want to have additional amounts withheld from your pay, you may enter a dollar amount on Line 3 of Form IL-W-4 below. This amount will be deducted from your pay in addition to the amounts that are withheld as a result of the allowances you have claimed.

✂ — — — — — — — — Cut here and give the certificate to your employer. Keep the top portion for your records. — — — — — — — — ✂

Illinois Department of Revenue

IL-W-4 Employee's Illinois Withholding Allowance Certificate

___ ___ ___ - ___ ___ - ___ ___ ___ ___
Social Security number

Name

Street address

City State ZIP

Check the box if you are exempt from federal and Illinois Income Tax withholding and sign and date the certificate. ☐

1 Enter the total number of basic allowances that you are claiming (Step 1, Line 4, of the worksheet). **1** _____

2 Enter the total number of additional allowances that you are claiming (Step 2, Line 9, of the worksheet). **2** _____

3 Enter the additional amount you want withheld (deducted) from each pay. **3** _____

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Your signature Date

Employer: Keep this certificate with your records. If you have referred the employee's federal certificate to the IRS and the IRS has notified you to disregard it, you may also be required to disregard this certificate. Even if you are not required to refer the employee's federal certificate to the IRS, you still may be required to refer this certificate to the Illinois Department of Revenue for inspection. See Illinois Income Tax Regulations 86 Ill. Adm. Code 100.7110.

Printed by the authority of the State of Illinois -
PO Number: 2200208 - 500 copies
IL-W-4 (R-05/20)

This form is authorized under the Illinois Income Tax Act. Disclosure of this information is required. Failure to provide information may result in this form not being processed and may result in a penalty.

EIT BENEFIT FUNDS
SERVING THE CHICAGO ELECTRICAL INDUSTRY SINCE 1930

KIG
KOCHER INSURANCE GROUP

Accelerated Death Benefit Details

Group Name: Electrical Insurance Trustees **Group Policy #: 740641**

IMPORTANT: Before completing the VOYA Accelerated Benefit Claim form, please read below.

- *You are eligible for this benefit if you are diagnosed with a terminal illness with a limited life expectancy of 24 months or less. You can receive this benefit while still living.*
- This benefit is equal to 60% of your amount of Life Insurance in force, or $20,000, whichever is less.
- The remaining 40% of your amount of Life Insurance will be paid out to your designated beneficiary(ies) upon death.
- The Accelerated Death Benefit proceeds are paid in one lump sum and are paid only once. If an additional terminal diagnosis is given the benefit cannot be paid again.
- To receive the Accelerated Death Benefit, all of the following conditions must be met. You must:
    - request this benefit in writing while you are living. If you are unable to request this benefit yourself, your legal representative may request it for you.
    - be insured for Life Insurance benefits.
    - have Life Insurance benefits of at least $10,000 as shown on the Schedule of Benefits. Your current plan has a $20,000 benefit, which meets the minimum requirement
    - provide to ReliaStar Life a doctor's statement which gives the diagnosis of your medical condition; and states that because of the nature and severity of such condition, your life expectancy is no more than 24 months. ReliaStar Life may require that you be examined by a doctor of its choosing. If ReliaStar Life requires this, ReliaStar Life pays for the exam.
    - provide to ReliaStar Life written consent from any irrevocable beneficiary, assignee, and, in community property states, from your spouse.

Please note receipt of the accelerated benefit may be considered taxable. You should consult your personal tax advisor to assess the impact of this benefit.

Note: Your amount of life insurance will be reduced if you receive an accelerated death benefit.

If you have further questions regarding the Accelerated Death Benefit or wish to start a claim, please contact Kocher Insurance Group at:

888-212-7822

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of insurance and riders. All coverage is subject to the terms and conditions of the group policy. If there is any discrepancy between this document and the group policy documents, the Plan documents will govern. To keep coverage in force, premiums are payable up to the date of coverage termination. Group Term Life Insurance is underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. Policy form ICC LP14GP or LP00GP (may vary by state). Dated 02/23/2024

RESET FORM

ACCELERATED BENEFIT CLAIM

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY (outside NY)
Members of the Voya® family of companies
(the "Company")
Submit at voya.com/claims *(select Upload Documents)*
Phone: 888-238-4840; **Voya Life Claims:** PO Box 1548, Minneapolis, MN 55440
Overnight Address: 250 Marquette Ave., Suite 900, Minneapolis, MN 55401

Sections 1 - 4 must be completed and **signed** by the employer. Sections 5 - 8 must be completed and **signed** by the insured. Sections 9 and 10 must be completed and **signed** if there is an irrevocable beneficiary, assignee, or spouse in a community property state. The separate **Attending Physician's Statement of Terminal Condition or Continuous Confinement** must be completed by the Insured's attending physician. Return the completed forms and a copy of the Insured's enrollment documentation, to one of the above addresses. Missing or incomplete information may delay claim processing.

SECTION 1. GROUP INFORMATION

Group Name EIT

Group Policy Number 74061 Account Number _____

Claim Number *(if available)* _____

SECTION 2. EMPLOYEE / INSURED INFORMATION

Insured Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Birth Date _____ SSN _____ Gender: ☑ Male ☐ Female

Other Names the Insured May Have Been Known By _____

Address _____ City _____ State _____ ZIP _____

Marital Status: ☐ Married ☐ Domestic Partner/Civil Union ☐ Never Married ☐ Divorced ☐ Widowed

Date Last Actively at Work _____ **Employment Start Date** _____

Job Title _____

Salary $ _____ per: ☐ hour ☐ week ☐ month ☐ year Last Salary Change Date _____

Employment Status: ☐ Full Time ☐ Part Time Average Hours Per Week _____ Labor Status: ☐ Union ☐ Non Union

Employee Status: ☐ Active ☐ Retired ☐ Disability Waiver of Premium ☐ FMLA *(include FMLA documentation)*

Reason for Stopping Work _____

Have premiums been paid to the current date? ☐ Yes ☐ No If "no," to what date have premiums been paid? _____

If claim is for accelerated benefits on a dependent, complete the following information concerning dependent *(list amount below.)*

Relationship to the Insured: ☐ Spouse ☐ Domestic Partner/Civil Union ☐ Child Date This Dependent Insured _____

Dependent Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Address _____ City _____ State _____ ZIP _____

Marital Status: ☐ Married ☐ Domestic Partner/Civil Union ☐ Never Married ☐ Divorced ☐ Widowed

SECTION 3. COVERAGE INFORMATION

Coverage Type	Coverage Amount	Coverage Effective Date *(mm/dd/yyyy)*
Basic Life	$ 20,000.00	01/01/2024
Supplemental Life	$	
Optional Life	$	
Other:	$	

Group Policy Number 74061

Insured Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

SECTION 4. EMPLOYER CERTIFICATION *(The undersigned certifies that the above statements as to the insured are correct as reported on its records. See page 4 for Fraud Warnings.)*

Employer Name _____ Title _____

Employer Address _____ City _____ State _____ ZIP _____

Authorized Signature _____ Date _____

Email _____ Phone (_____)_____

SECTION 5. INSURED STATEMENT *(Read and sign below. Review the policy, certificate or rider to determine if continuous confinement is a qualifying event and if monthly payments are an option should you be eligible to receive a benefit. A copy of the certificate and any riders can be obtained from the Employer/Plan Sponsor. See page 4 for Fraud Warnings.)*

Date Employee Last Worked Preceding Claim *(month, day, year)* _____

Describe Condition or Illness _____

What is the qualifying event for this claim? ☐ Terminal illness ☐ Continuous confinement in an Institution

If qualifying event is continuous confinement in an institution, how would you like to receive your benefit? ☐ Lump Sum ☐ Monthly Payments

Requested whole percentage for monthly accelerated benefit *(See rider for percentages available. The percentage chosen must be a minimum of $500 monthly.)* _____

For Connecticut Policies *(Select one.)*: ☐ 25% or ☐ Other Percentage indicated in policy

SECTION 6. ATTENDING PHYSICIAN(S) *(List your primary care physicians.)*

Physician Name _____

Physician Address _____ City _____ State _____ ZIP _____

Phone (_____)_____ Fax (_____)_____ Email _____

Cause _____

Last Date Seen by this Physician _____

Physician Name _____

Physician Address _____ City _____ State _____ ZIP _____

Phone (_____)_____ Fax (_____)_____ Email _____

Cause _____

Last Date Seen by this Physician _____

Physician Name _____

Physician Address _____ City _____ State _____ ZIP _____

Phone (_____)_____ Fax (_____)_____ Email _____

Cause _____

Last Date Seen by this Physician _____

SECTION 7. U.S. TAXPAYER CERTIFICATIONS

Under penalties of perjury, I certify that:

1. The Taxpayer Identification Number that appears on this form is correct.

2. I am not subject to backup withholding due to failure to report interest and dividend income;

☐ **If I am subject to backup withholding, I have checked here.**

3. I am a U.S. person.

NON-RESIDENT ALIEN STATUS

If you are a Non-Resident Alien, check the box and provide your country of residence below.

☐ Under penalties of perjury, I certify that I am a Non-Resident Alien and my country of residence is: _____.

The amount paid to you will be subject to 30% withholding, unless you submit an IRS Form W-8, and are entitled to claim a reduced rate of withholding under the applicable U.S. tax treaty.

Group Policy Number 74061

Insured Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

SECTION 8. ACKNOWLEDGEMENT AND AUTHORIZATION

For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, LLC (MIB) or employer to give ReliaStar Life Insurance Company or ReliaStar Life Insurance Company of New York ("the Company") or its agents, employees and authorized representatives acting on its behalf, ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or non-medical information regarding Social Security benefits or earnings information and other employment-related information as they apply to me, my spouse, or any of my children who are insured. I give my permission to the Company, and its reinsurers, to make a brief report of personal health information to MIB about these same persons.

I give my permission to the Company to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between the Company and its affiliates and may be sent to MIB. This information may be made available to any Company affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with the Company or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I or my authorized representative have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This authorization will be valid for the duration of my claim for benefits. I acknowledge that I have been given the Company's Consumer Privacy Notice and Insurance Information Practices Notice.

NOTE: Receipt of accelerated benefits may be taxable. Assistance should be sought from a personal tax advisor. Receipt of these accelerated benefits may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

Receipt of these accelerated benefits may adversely affect the recipient's eligibility for future increases in life insurance coverage. Refer to your certificate booklet for more information.

If accelerated benefits are paid, continued premium payments must be made, unless waived under the provisions of the policy, to keep life insurance coverage in force.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Insured Signature _____ Date _____

Phone (_____)_____ Email _____

SECTION 9. RELEASE

Release By Irrevocable Beneficiary or Assignee, or By Spouse in a Community Property State

If there is an irrevocable beneficiary or assignee, that person must sign this section and have it notarized. If you are married and live in a community property state, your spouse must sign this section and have it notarized.

The undersigned acknowledges and consents to this accelerated benefit claim; that if approved, payment of the accelerated benefit shall be made to the insured or his/her legal representative; and in consideration of such payment the undersigned agrees that the liability of the Company under the policy shall be discharged by the amount of the accelerated benefit paid.

Irrevocable Beneficiary or Assignee Signature _____ Date _____

Spouse Signature *(in Community Property State)* _____ Date _____

SECTION 10. NOTARY SECTION *(Required with the above release by irrevocable beneficiary or assignee or spouse.)*

State of _____

County of _____ ss.

On this _____ day of _____, 20 _____ before me personally appeared _____ to me known to be the same person who executed the above instrument and acknowledged that he/she executed the same as his/her free act and deed.

My commission expires _____ Notary Public _____

FRAUD WARNINGS

Alabama, Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Arizona: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures
For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices
Collecting Information
Your application or claim form is our main source of information. But we may:
- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, LLC., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, LLC." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports
Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use
We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure
We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, LLC, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information
If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, LLC.
We or our reinsurers may make brief reports to MIB, LLC (hereafter "MIB"). The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

RESET FORM

ATTENDING PHYSICIAN'S STATEMENT OF TERMINAL CONDITION OR CONTINUOUS CONFINEMENT

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies
(the "Company")
Submit at voya.com/claims *(select Upload Documents)*
Phone: 888-238-4840; **Voya Life Claims:** PO Box 1548, Minneapolis, MN 55440
Overnight Address: 250 Marquette Ave., Suite 900, Minneapolis, MN 55401

CLAIM CHECKLIST

- ☐ SIGN and DATE this completed form, then submit using one of the above methods.
- ☐ The Employee/Insured must complete Sections 1 and 2.
- ☐ The Attending Physician must complete Sections 3 through 5.
- ☐ The patient is responsible for the completion of this form without expense to the Company.

SECTION 1. GROUP INFORMATION *(This information is mandatory and can be obtained from the Employer.)*

Group Name EIT Group Policy Number 74061

SECTION 2. EMPLOYEE/INSURED INFORMATION

Patient Full Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Patient Birth Date _____ Patient Phone (_____) _____

Employee Full Name, if other than Patient *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Address _____ City _____ State _____ ZIP _____

SECTION 3. PRESENT CONDITION

On what date did symptoms first appear or accident happen? *(month, day, year)* _____

On what date did the patient stop working because of terminal condition or confinement in an institution? *(mm/dd/yyyy)* _____

Diagnosis _____

Is the patient's condition terminal? . . . . . ☐ Yes ☐ No

If "yes," provide life expectancy in months _____

Does the patient have a medical condition that is reasonably expected to require continuous confinement in an institution and will require the patient to remain there for the rest of his or her life? Institution means any hospital, convalescent hospital, health clinic, nursing home, extended care facility, or other institution devoted to the care of sick, infirm, or aged persons. . . . . ☐ Yes ☐ No

Is the patient competent to endorse checks and direct the use of the proceeds thereof? . . . . . ☐ Yes ☐ No

Is the condition the result of an intentionally self-inflicted injury? . . . . . ☐ Yes ☐ No

Functional Capacity: ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

Blood Pressure _____

SECTION 4. REMARKS

SECTION 5. PHYSICIAN INFORMATION AND SIGNATURE

Attending Physician Name _____ Degree _____

TIN _____ Phone (_____) _____ Fax (_____) _____

Email _____

Address _____ City _____ State _____ ZIP _____

Attending Physician Signature _____ Date _____

Order #121489 12/23/2022

FRAUD WARNINGS

Alabama, Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Arizona: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.