INCOME PROTECTION PLUS

nea Member Benefits
www.neamb.com

nea
NATIONAL
EDUCATION
ASSOCIATION

American Fidelity Assurance Company
A member of the American Fidelity Group

2000 North Classen Boulevard
Oklahoma City, OK 73106
www.afadvantage.com

SB-19927-0610

NEA Member Benefits is a
wholly owned subsidiary of
the National Education Association

900 Clopper Road, Suite 300
Gaithersburg, MD 20878-1356
(301) 251-9600 Fax (301) 527-8210

Dear NEA Member,

Thank you for your interest in the NEA Income Protection Plan®, underwritten by American Fidelity Assurance Company.

Your request for information about this plan shows that you are already concerned about the consequences that could result from the loss of earning power. Here are some highlights about this plan. (See the enclosed brochure for more detailed information on policy provision, limitations and exclusions.)

The NEA Income Protection Plan® is designed specifically to meet the needs of members like you.

Here are just a few of the benefits we offer:

- Monthly benefits are paid during a period of Total Disability or Partial Disability.
- NEA Reserve Dues Benefit.
- NEA Strike Waiver of Premium.

You have the choice of four available benefit options.

Short-Term Disability Plan - Choose from one of four plan options and your benefits will begin on the 8th, 15th, 31st, or 91st day of disability. Benefits last for up to 2 years.

Your choice depends on which plan blends best with those benefits provided by your employer and/or your State Plan. Benefits are based on your salary. You can receive up to 66 2/3 percent of your monthly salary up to a maximum of $6,000 per month. Benefits are paid directly to you, not to a doctor or your employer.

Here's your chance to upgrade your existing benefits...

If you already have the NEA Income Protection Plan®, you know the value of this coverage. You may wish to consider this enhanced plan. You should also verify that your current coverage level covers any salary increases you may have received since you started your Disability Income Insurance. Increasing your coverage helps to protect your current lifestyle.

Sincerely,

NEA Member Benefits

PS: Your earning power is your single largest asset. Maintaining your lifestyle depends on your continued ability to earn an income. Don't delay taking this important step in securing your financial future. The sooner you apply, the sooner you start protecting your most valuable asset - your ability to earn an income.

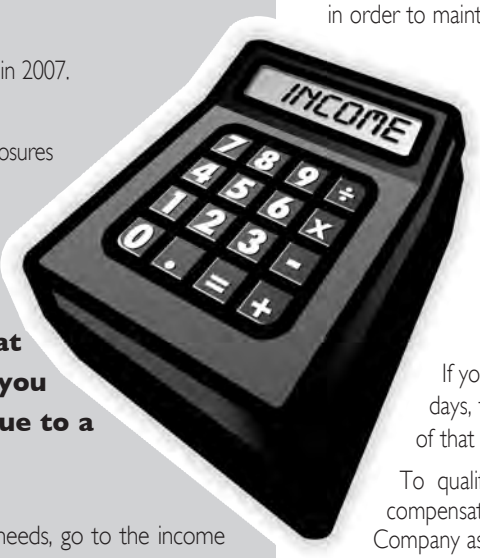
**If you have any questions, call your NEA Income Protection Plan® Representative at: 1-888-461-1612
Monday - Friday 9:00 a.m. to 6:00 p.m. Eastern Time or visit our web site at www.neamb.com.**

Protect Your Salary - Protect Your Dreams, with the NEA Income Protection Plan®

Why Do You Need Income Protection?

Did you know...

- On average, a disabling injury occurs every 1.2 seconds.
  Source: National Safety Council, Injury Facts, 2009 Edition, page 2
- There were 26.3 million disabling injuries suffered in 2007.
  Source: National Safety Council, Injury Facts, 2009 Edition, page 2
- Disability causes nearly 50% of all mortgage foreclosures each year.
  Source: Council for Disability Awareness, Worker Disability Planning & Preparedness Study, 2008



The NEA Income Protection Plan® is a Short-Term Disability plan that can help provide an income when you are disabled and unable to work due to a covered Accident or Sickness.

For an easy-to-use calculator to determine your needs, go to the income protection area on www.neamb.com.

What would happen...

to you and your family if you were unable to work because of an unexpected disability?

Many people take for granted the ability to earn an income. We live everyday underestimating the chance that we may suffer a disabling condition. The chance that any one of us could become disabled is very real.

Income Protection That Pays You For:

Total Disability

Totally Disabled means for the first 24 months monthly disability benefits are paid, you are disabled and unable to perform each of the material duties of your regular occupation on a full-time basis.

Partial Disability

If you are able to perform at least one of the material duties of your regular or another occupation on a part-time or full-time basis and earning currently at least 20% less per month than your Indexed Pre-disability Compensation due to that same Accident or Sickness, you could be eligible for Partial Disability Benefits.

This benefit can allow you to earn and receive up to a maximum of 100% of your pre-disability earnings during the first 12 months of disability with a proportionate reduction thereafter.

Pregnancy

If you suffer any disabilities caused or contributed to by pregnancy, childbirth, or related medical conditions, payments will be subject to the same conditions as any other Sickness.

Special Benefits For NEA Members Only

Annual Reserve Dues Benefit

If you are Totally Disabled for 6 consecutive months, the Company will pay either the value of your NEA unified reserve dues or the amount you are required to pay in order to maintain your NEA status, whichever is less.

Waiver of Premium During Total Disability

The premium for your coverage will be waived, provided you've satisfied your Elimination Period or you have been Totally Disabled for a continuous six-month period, whichever is later. You are no longer eligible for waiver of premium if your eligibility for coverage terminates. Regular payments resume after you are no longer disabled.

Waiver of Premium During a Strike

If you are on an NEA supported strike that has lasted more than 60 days, the Company will waive premium payments for the remainder of that strike.

To qualify for this benefit, you must be eligible for unemployment compensation from your state and submit a written request to the Company asking for premium to be waived.

Physical Examination Requirement Benefit

Pays up to $100 (once each calendar year) of the Physician's charges for any physical examination as required by the state teacher's retirement system, once you have been Totally Disabled for 12 consecutive months.

Benefits Designed to Meet Your Needs

The Short-Term Disability Plan benefits are payable up to the period of time shown in the table below, based on your age as of the date benefits begin:

Age	Maximum Benefit Period
68 or younger	up to 2 years
68	to age 70
69 or older	up to 1 year

Adding the Long-Term Disability Option can extend your benefits up to age 67, or longer (see LTD option).

Eligibility

All active full-time NEA employees/members working 15 hours or more per week, including Educational Support Personnel and Staff Members.

Effective Date of Coverage

The applicant must meet the Company's underwriting requirements (if any) and be on Active Service (actively at work, or able to be at work if school were in session) on the date his or her coverage would become effective, otherwise the insurance will become effective on the first day of the next month following the date the applicant resumes full-time Active Service. Insureds who elect to apply for insurance under the Policy may not make application for coverage which will provide benefits in excess of $66^{2}/_{3}$% of his or her annual compensation.

Exclusions

No benefits will be paid for loss due to:

(a) intentionally self-inflicted injury while sane or insane;
(b) an act of war, declared or undeclared;
(c) Accident sustained or Sickness contracted while in the service of the armed forces of any country;
(d) committing a felony;
(e) participation in a sport involving a contest of speed;
(f) Accident or Sickness arising out of and in the course of any occupation for wage or profit or for which you are entitled to Workers' Compensation.

Pre-existing Condition Limitation

Pre-existing Condition means an injury or Sickness for which you've received treatment, incurred expenses, taken prescription drugs or received a diagnosis or advice from a Physician during the six consecutive months immediately preceding your Effective Date of coverage.

Pre-existing Condition also includes any condition which is related to such injury or Sickness.

The Company will not pay a Monthly Disability Benefit for a Pre-Existing Condition until you have gone treatment free, incurred no expense, taken no medication, or received no diagnosis or advice from a Physician for a period of 12 consecutive months from your Effective Date of coverage. Any disability beginning after 24 months from your Effective Date of Coverage is not subject to the Pre-Existing Condition Limitation.

Limitations

The sum of the Monthly Disability Benefits paid to you, and the payments you and your dependents are entitled to receive from the sources described below, may not exceed 66$^{2}/_{3}$% of your monthly salary (one-twelfth of your annual salary).

(a) group insurance coverage or similar arrangements of coverage for individuals in a group;
(b) Federal Social Security Act including benefits payable to you and your dependents on account of your disability;
(c) state or federal government disability or retirement plan or increases thereof which begin on or after the date of Total Disability;
(d) pension plan with respect to which the Policyholder or Employer contributes or makes payroll deductions;
(e) salary or wage continuation plans such as sick leave or sick leave bank provided through the Employer which extend beyond 60 days from the date disability commenced;
(f) Federal Old Age Benefits or increases which begin on or after the date of Total Disability, under the Federal Social Security Act on your behalf; and
(g) loss benefits provided under the mandatory portion of any group or individual automobile insurance policy written under the "no fault" insurance provision of the law of any jurisdiction.

For the purposes of items (b) and (f) only, unless you show proof to the Company that payments under these applicable programs or acts have been applied for but will not be paid, the Company will assume each Insured who is covered under the Federal Social Security Act is receiving such payments and estimate the monthly benefit you are entitled to receive under the Federal Social Security Act.

In no event will the minimum Monthly Disability Benefit be less than $100 or 25% of your Monthly Disability Benefit, whichever is greater.

Please Note: The Authorization to Disclose Protected Health Information form included in this package authorizes the release of information from the Medical Information Bureau (MIB) for use with American Fidelity Assurance Company's standard application process. In compliance with standards desired by the NEA Member Benefits Board of Directors, please note the MIB is not used in the application process for the NEA Income Protection Plan.

Long-Term Disability Income Option

If you add the Long-Term Disability Income Option to your Plan, you can extend your protection. After monthly disability benefits have been paid for the Maximum Disability Period of the Short-Term Disability Plan, benefits can continue if you qualify under the Long-Term Disability Income Option.

You will be considered Totally Disabled under the Long-Term Disability Option for 36 months if you are disabled and unable to perform each of the material duties of your regular occupation on a full-time basis. After that, Disability means you are disabled and unable to perform each of the material duties of any gainful occupation or employment for which you are reasonably qualified by training, education or experience. Benefits will be payable up to the period of time shown in the following table, based on your age as of the date benefits begin:

Age	Maximum Benefit Period
61 or younger	to age 67
62 through 64	five years
65 through 68	to age 70
69 or older	one year

Mental Illness, Alcoholism, and Drug Addiction

If you remain Totally Disabled as a result of Mental Illness, alcoholism or drug addiction, after the Maximum Benefit Period has been provided under the Short-Term Disability Policy, you will receive payments only if hospitalized.

Mental Illness means disability due to or resulting from psychiatric or psychological conditions, regardless of cause, such as schizophrenia, depression, manic depressive or bipolar illness, anxiety, personality disorders and/or adjustment disorders or other conditions, usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

This limitation does not apply to dementia, if due to stroke, trauma, viral infection, Alzheimer's disease or other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar modalities.

Adjustments

The Company will directly reduce your Monthly Disability Benefit under the Long-Term Disability Option by the payments you and your dependents are entitled to receive from the sources described in items (a) through (g) under the Limitations in the Short-Term Disability section.

Payment & Billing Options

You may choose the following billing frequencies:

- Monthly - choose premium on chart below,
- Quarterly - Multiply monthly premium times 2.925,
- Semi-Annual - Multiply monthly premium times 5.725,
  or
- Annual - Multiply monthly premium times 11.125.

If you choose a billing frequency other than monthly, please be sure to recalculate your new rate based on the factors provided above.

You have two payment options for your policy premiums; a description of each is shown with the following:

1. The Pre-Authorized Check Plan is a very convenient way to make monthly premium payments. You don't have to worry about writing and mailing a check each month. We do that for you. This form simply gives us authority to do so. You may also use the Pre-Authorized Check plan for payment on a quarterly, semi-annual, or annual basis.
2. A direct billing option is also available. If you would like to make your payments on a quarterly, semi-annual, or annual basis we will send you a billing statement for your premium. Please note: this option is not available for monthly payments.

Now that you know the plans, choose the one you need

Available benefit options beginning on: the 8th, 15th, 31st, or 91st day of Disability due to a covered Accident or Sickness provided you are on Active Service on the scheduled effective date of your coverage. You may participate in the Plan under any one of the benefit levels outlined below, provided the Monthly Disability Benefit level selected does not exceed 66⅔% of your regular monthly salary. Your monthly salary is defined as your annual compensation divided by 12.

Monthly Rates

Gross Monthly Salary	Monthly Benefit	8th day Plan 1	15th day Plan 2	31st day Plan 3	91st day Plan 4	LTD Rider
$600.00 - $749.99	$400	$10.72	$8.40	$6.40	$3.20	$5.60
$750.00 - $899.99	$500	13.40	10.50	8.00	4.00	7.00
$900.00 - $1,049.99	$600	16.08	12.60	9.60	4.80	8.40
$1,050.00 - $1,199.99	$700	18.76	14.70	11.20	5.60	9.80
$1,200.00 - $1,349.99	$800	21.44	16.80	12.80	6.40	11.20
$1,350.00 - $1,499.99	$900	24.12	18.90	14.40	7.20	12.60
$1,500.00 - $1,649.99	$1,000	26.80	21.00	16.00	8.00	14.00
$1,650.00 - $1,799.99	$1,100	29.48	23.10	17.60	8.80	15.40
$1,800.00 - $1,949.99	$1,200	32.16	25.20	19.20	9.60	16.80
$1,950.00 - $2,099.99	$1,300	34.84	27.30	20.80	10.40	18.20
$2,100.00 - $2,249.99	$1,400	37.52	29.40	22.40	11.20	19.60
$2,250.00 - $2,399.99	$1,500	40.20	31.50	24.00	12.00	21.00

Additional Plans and Rates on Next Page

Monthly Rates (continued)

Gross Monthly Salary	Monthly Benefit	8th day Plan 1	15th day Plan 2	31st day Plan 3	91st day Plan 4	LTD Rider
$2,250.00 - $2,399.99	$1,500	40.20	31.50	24.00	12.00	21.00
$2,400.00 - $2,549.99	$1,600	42.88	33.60	25.60	12.80	22.40
$2,550.00 - $2,699.99	$1,700	45.56	35.70	27.20	13.60	23.80
$2,700.00 - $2,849.99	$1,800	48.24	37.80	28.80	14.40	25.20
$2,850.00 - $2,999.99	$1,900	50.92	39.90	30.40	15.20	26.60
$3,000.00 - $3,149.99	$2,000	53.60	42.00	32.00	16.00	28.00
$3,150.00 - $3,299.99	$2,100	56.28	44.10	33.60	16.80	29.40
$3,300.00 - $3,449.99	$2,200	58.96	46.20	35.20	17.60	30.80
$3,450.00 - $3,599.99	$2,300	61.64	48.30	36.80	18.40	32.20
$3,600.00 - $3,749.99	$2,400	64.32	50.40	38.40	19.20	33.60
$3,750.00 - $3,899.99	$2,500	67.00	52.50	40.00	20.00	35.00
$3,900.00 - $4,049.99	$2,600	69.68	54.60	41.60	20.80	36.40
$4,050.00 - $4,199.99	$2,700	72.36	56.70	43.20	21.60	37.80
$4,200.00 - $4,349.99	$2,800	75.04	58.80	44.80	22.40	39.20
$4,350.00 - $4,499.99	$2,900	77.72	60.90	46.40	23.20	40.60
$4,500.00 - $4,649.99	$3,000	80.40	63.00	48.00	24.00	42.00
$4,650.00 - $4,799.99	$3,100	83.08	65.10	49.60	24.80	43.40
$4,800.00 - $4,949.99	$3,200	85.76	67.20	51.20	25.60	44.80
$4,950.00 - $5,099.99	$3,300	88.44	69.30	52.80	26.40	46.20
$5,100.00 - $5,249.99	$3,400	91.12	71.40	54.40	27.20	47.60
$5,250.00 - $5,399.99	$3,500	93.80	73.50	56.00	28.00	49.00
$5,400.00 - $5,549.99	$3,600	96.48	75.60	57.60	28.80	50.40
$5,550.00 - $5,699.99	$3,700	99.16	77.70	59.20	29.60	51.80
$5,700.00 - $5,849.99	$3,800	101.84	79.80	60.80	30.40	53.20
$5,850.00 - $5,999.99	$3,900	104.52	81.90	62.40	31.20	54.60
$6,000.00 - $6,149.99	$4,000	107.20	84.00	64.00	32.00	56.00
$6,150.00 - $6,299.99	$4,100	109.88	86.10	65.60	32.80	57.40
$6,300.00 - $6,449.99	$4,200	112.56	88.20	67.20	33.60	58.80
$6,450.00 - $6,599.99	$4,300	115.24	90.30	68.80	34.40	60.20
$6,600.00 - $6,749.99	$4,400	117.92	92.40	70.40	35.20	61.60
$6,750.00 - $6,899.99	$4,500	120.60	94.50	72.00	36.00	63.00
$6,900.00 - $7,049.99	$4,600	123.28	96.60	73.60	36.80	64.40
$7,050.00 - $7,199.99	$4,700	125.96	98.70	75.20	37.60	65.80
$7,200.00 - $7,349.99	$4,800	128.64	100.80	76.80	38.40	67.20
$7,350.00 - $7,499.99	$4,900	131.32	102.90	78.40	39.20	68.60
$7,500.00 - $7,649.99	$5,000	134.00	105.00	80.00	40.00	70.00
$7,650.00 - $7,799.99	$5,100	136.68	107.10	81.60	40.80	71.40
$7,800.00 - $7,949.99	$5,200	139.36	109.20	83.20	41.60	72.80
$7,950.00 - $8,099.99	$5,300	142.04	111.30	84.80	42.40	74.20
$8,100.00 - $8,249.99	$5,400	144.72	113.40	86.40	43.20	75.60
$8,250.00 - $8,399.99	$5,500	147.40	115.50	88.00	44.00	77.00
$8,400.00 - $8,549.99	$5,600	150.08	117.60	89.60	44.80	78.40
$8,550.00 - $8,699.99	$5,700	152.76	119.70	91.20	45.60	79.80
$8,700.00 - $8,849.99	$5,800	155.44	121.80	92.80	46.40	81.20
$8,850.00 - $8,999.99	$5,900	158.12	123.90	94.40	47.20	82.60
$9,000.00 and over	$6,000	160.80	126.00	96.00	48.00	84.00

AMERICAN FIDELITY ASSURANCE COMPANY
2000 N. Classen Boulevard
Oklahoma City, Oklahoma 73106

Short Term Disability Income Insurance Application

ISSUED EXCLUSIVELY TO ACTIVELY WORKING NEA MEMBERS
THIS APPLICATION IS FOR NEA MEMBERS - APPLICATION FOR GROUP INSURANCE

1. Tell Us About Yourself (Please Print)

Last Name (maiden name)	First Name	Full Middle Name	Suffix
Harris	Jacqueline		

Age	Date of Birth Mo Day Yr	Sex	Soc Sec Number	Requested Eff Date Mo Day Yr	Date of Employment Mo Day Yr
	09/21/1949	M☐ F☐		/ /	/ /

Number and Street	Work Phone #	Home Phone #
510 Brookletts Ave., Unit 204	( )	( )

City	State	Zip	State of Birth
Easton	MD	21601	

Employer	Annual Salary	Occupation
	$	

a. I am participating in Social Security through my employer Yes ☐ No ☐
b. I am a current NEA member in good standing, actively working at least 15 hours per week. Yes ☐ No ☐
c. I am currently insured by an American Fidelity Disability Income Plan. Yes ☐ No ☐

2. Select Your Plan

a. Please check the plan you prefer: Plan I ☐ Plan II ☐ Plan III ☐ Plan IV ☐

- Plan I ■ Benefits begin on the 8th day of Total Disability due to a covered Accident or Sickness.
- Plan II ■ Benefits begin on the 15th day of Total Disability due to a covered Accident or Sickness.
- Plan III ■ Benefits begin on the 31st day of Total Disability due to a covered Accident or Sickness.
- Plan IV ■ Benefits begin on the 91st day of Total Disability due to a covered Accident or Sickness.

b. Check Payment Plan Preferred (see brochure for details):
Monthly (Pre-Authorized Check) ☐ Quarterly ☐ Semi-annually ☐ Annually ☐

c. Monthly Benefit Amount Selected: $_____ Premium Amount: $_____(1)
(See Rate Table in the brochure for the plan you prefer.)

d. I Would like To Add The Long Term Disability Income Option: Yes ☐ No ☐
Premium amount: $_____(2)
Total Premium Amount: $_____(1+2)

e. Enclose a Check For the First Premium Payable To: American Fidelity Assurance Company

3. Select Your Beneficiary (Example: Mary A. Doe, sister, NOT Mrs. John Doe, sister)

First Name	Full Middle Name	Last Name	Suffix	Relationship to Insured

4. Please Answer These Medical Questions

a. Within the past 10 years, have you received a diagnosis had treatment, and/or taken medication for: Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), Immunodeficiency disorder, Rheumatoid Arthritis, Fibromyalgia, Chronic Fatigue Syndrome, Lung Disease, Emphysema, Tuberculosis, Ulcerative Colitis, Crohn's Disease, Diabetes requiring Insulin, Heart or Circulatory disorder, Cancer or other malignancy, Organ Transplant, Systemic Lupus Erythematosus, Epilepsy, Seizures, Neurological disorder, Blood Clotting disorder, Alcohol treatment, Drug use, Liver disorder or Kidney disease? Yes ☐ No ☐

b. Within the past 12 months, have you received a diagnosis had treatment, and/or taken medication for: (a) back or neck disorder; (b) mental or nervous disorder; or (c) had surgery recommended that has not yet been performed? Yes ☐ No ☐

c. Are you currently pregnant? Yes ☐ No ☐

5. Provide Your Authorizing Signature

Authorization

To the best of my knowledge and belief, the statements and answers shown in this application are true and complete. I understand and agree: a) that the Company may rely upon such answers as the basis of my contract; and b) that no coverage will take effect until a Policy or Certificate is issued.

I understand that the coverage applied for: a) will take effect only if I am actively working on the effective date of my coverage; and b) may provide limited benefits for "Pre-Existing Conditions." I understand that I should read my Certificate for a more detailed explanation of this "Pre-Existing Condition" exclusion. A new Pre-Existing Condition period must be satisfied with respect to any increase applied for and approved by the Company. **I UNDERSTAND THAT OTHER INCOME I AM ENTITLED TO RECEIVE WILL REDUCE MY MONTHLY BENEFIT. I SHOULD READ MY CERTIFICATE FOR MORE DETAILED INFORMATION REGARDING HOW OTHER INCOME WILL REDUCE MY BENEFIT.**

I certify by signing this application that I am a member in good standing of the National Education Association.

Warning: Any person who knowingly, and with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Signature (Member / Applicant) Date

American Fidelity Assurance Company

2000 N Classen Boulevard Oklahoma City, Oklahoma 73106

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about me or my dependents' health including my or my dependents' entire medical record, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in processing my application or determining my eligibility for coverage for the purpose of determining eligibility in the insurance coverage(s) for which I have applied and to check for and resolve any issues that may arise regarding incomplete or incorrect information on my application. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) consumer reporting agencies; g) insurance companies; h) the Medical Information Bureau (MIB); and i) Department of Motor Vehicles. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. For Minnesota residents, please be advised that although the law allows insurance companies to obtain information about an HIV test, there are specific instances wherein the insurance company cannot ask whether the person has had an HIV test performed. In those specific circumstances, this law also restricts the use of HIV test results in order to make an underwriting decision, cancel, fail to renew, or take any other action with respect to a policy, plan, certificate or contract. For Vermont residents, this authorization EXCLUDES the release of any information about previously administered tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured/applicant IS NOT authorizing AFAC to forward the results from any new test requested by AFAC to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services. Nothing in this release authorizes the disclosure of data regarding AIDS, ARC or HIV. For Wisconsin residents, results of AIDS/HIV tests do not need to be reported if they were done at an anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, AFAC may refuse to issue insurance coverage. I understand that I may revoke this authorization at any time by writing to Privacy Official, American Fidelity Assurance Company, PO Box 25523, 2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73125, or by calling, toll-free, 1-866-55-HIPAA. I understand that my right to revoke this authorization is limited to the extent that: AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest my insurance coverage or a claim under my insurance coverage.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

This authorization will expire twenty-four months from the date shown below. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below. A copy of this authorization will be as valid as the original. I am aware that I, or my authorized representative, am entitled to and will receive a copy of this authorization.

Signature (Applicant) or Personal Representative (if applicable)	Printed Name (Applicant)
Relationship of Personal Representative to Applicant	SSN (Applicant) Date

MAKE YOUR LIFE SIMPLER WITH THIS CONVENIENT PAYMENT OPTION…

PRE-AUTHORIZED CHECK PLAN

WITH AMERICAN FIDELITY ASSURANCE COMPANY
AUTOMATIC ELECTRONIC FUNDS TRANSFER

You have options!

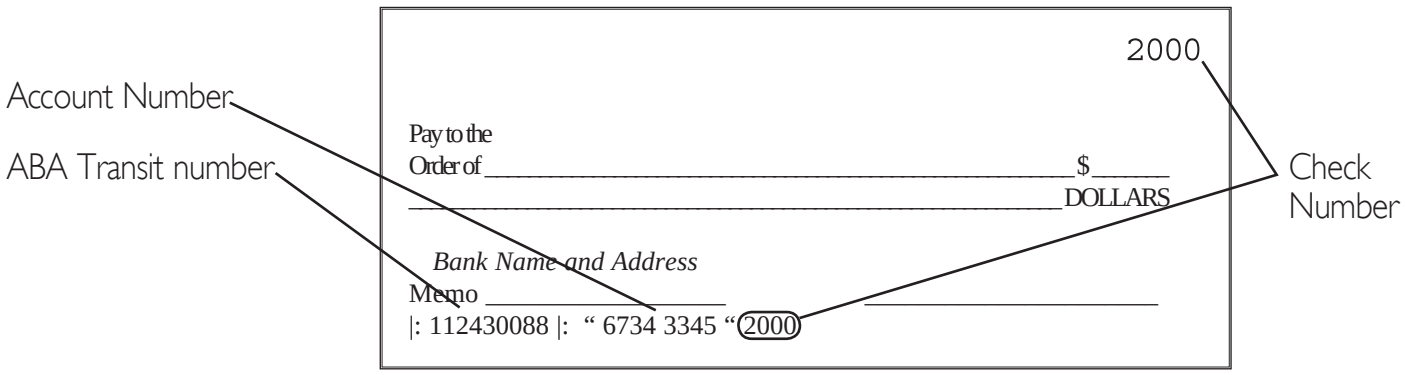
Your payment can be drafted electronically from your bank account saving you the effort of writing and mailing a check each month. Yearly, that can save you $4.00 in postage and your time.

In addition, you do not have to worry about forgetting to send your payment and possibly lapsing your coverage in the process.

We make it simple for you!

1. Read and complete each item on the authorization form below.
2. Include a voided unsigned check in order to allow verification of your information.
3. Include any payments due with your current statement.
4. Withdrawals will be around the 1st business day of each month.

Authorization for Pre-Authorized Check Payments



Please complete all information requested and return with your voided, unsigned check with your application to:
American Fidelity Assurance Company - AFES, PO Box 25523, Oklahoma City, OK 73125.

Insured Name(s) _____ Policy number _____

Daytime Phone _____

Date you want the draft to start _____/ 1 /_____
Month Year

ABA Transit Number _____ Account Number _____

Financial Institution Name _____

Address _____

City _____ State _____ Zip _____

As a convenience to me, I hereby request and authorize you to pay and charge my account checks drawn on my account by and payable to the order of the American Fidelity Assurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you actually receive such notice I agree that you shall be fully protected in honoring any such check.

I further agree that if such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____
Signature Date

American Fidelity Assurance Company
A member of the American Fidelity Group
2000 North Classen Blvd .• Oklahoma City, Oklahoma 73106
www.afadvantage.com

Protect Your Salary - Protect Your Dreams, with the NEA Income Protection Plan®

If you have any questions, call your
NEA Income Protection Plan® Representative at:

1-888-461-1612

Monday - Friday 9:00 a.m. to 6:00 p.m. (Eastern Time)
or visit our web site at

www.neamb.com

---

nea Member Benefits
www.neamb.com

American Fidelity Assurance Company
A member of the American Fidelity Group

2000 North Classen Boulevard
Oklahoma City, OK 73106
www.afadvantage.com

nea
NATIONAL
EDUCATION
ASSOCIATION