

AFSCME Local 685

BENEFIT HIGHLIGHTS

Discover new ways to protect what you love



Find your benefits here.



AFSCME LOCAL 685

POLICY #: 913395

If you're reading this, it must be enrollment time. But don't sweat it, because we've got you covered. We'll provide you with the right information to get the coverage that's best for you and your family. Some of our offerings might be new to you. Take some time to read through this booklet, so that you feel confident about your choices. And keep in mind that any benefits you choose are easily paid for through payroll deduction.

BENEFITS AT A GLANCE:

- ▶ **Long-Term Disability insurance** to protect your savings - once your claim is approved - when you can't work for an extended time.

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Long-Term Disability Insurance

VOLUNTARY

COMMON CAUSES OF DISABILITY

- ✓ Musculoskeletal conditions
- ✓ Circulatory conditions
- ✓ Cancer
- ✓ Nervous system disorders
- ✓ Injuries

▶ HELPS YOU KEEP YOUR LIFE ON TRACK.

If you're unable to work because of a covered disability, Long-Term Disability insurance replaces a portion of your income. After your claim is approved, you will receive a monthly check for your benefits that helps you pay everyday expenses like your mortgage or rent, childcare and groceries.

▶ HELPS YOU RETURN TO WORK.

If you are able, Sun Life has benefits and services, including guidance from vocational rehabilitation counselors, to help you return to work.

BENEFITS (You can purchase this coverage at a group rate.)

Monthly benefit after your claim is approved	Get a monthly check of \$500 to \$5,000 , in any \$100 increment you choose, to replace a portion of your income—up to 60% of your Total Monthly Earnings.
When benefits begin	Benefits begin as soon as 30 days from the date of your disability.
Benefits may be paid for	Up to 2 years if you are under age 66 at the start of disability. If you become disabled at age 66 or after, a reduced benefit duration applies.
Additional plan information	This plan provides a benefit for covered disabilities resulting from illness or injury that occur on or off the job.

LONG-TERM DISABILITY FAST FACTS

34.6 months
The length of the average long-term disability claim.¹

You may receive additional benefits if your covered disability begins with a hospital stay of 14 days or more.

Frequently asked questions

Do I need to answer any health questions to enroll?

If you contribute to the cost of your insurance, you may need to complete health questions if you don't elect coverage when it's first available to you and you want to elect at a later date, or if you want to increase coverage. To answer health questions, please fill out our Evidence of Insurability application. Health questions must be approved by Sun Life before coverage takes effect. Please see your Certificate for details.

How do I file a Long-Term Disability claim?

If you become disabled after the effective date of coverage, check with your employer to make sure you are eligible for benefits. You can file a claim with us by downloading forms from our website. We'll ask you and your doctor to provide information about your medical condition and your expected recovery.

How do I qualify for benefits?

You'll start receiving disability payments if you satisfy the Elimination Period (see "When benefits begin" in the table) and meet the policy's definition of disability. Generally, disability is defined as your inability to perform some or all of your job duties due to your injury, illness or pregnancy and may require that you have also had a certain percentage of earnings loss due to your disability. Please see your Certificate for details.

What if I have a pre-existing condition?

If you become disabled within 12 months of your insurance taking effect or 12 months following any increase in your amount of insurance, we will not pay any benefit for any pre-existing condition. A pre-existing condition includes anything you have sought treatment for in the 6 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine.

Can I work while I'm disabled?

Your plan is designed to encourage and support your return to work. If you are able to work part-time, for example, you may receive part of your benefit while working.

Will income from other sources affect my benefit?

Your benefit may be reduced by Social Security benefits; disability benefits from retirement, government plans or state disability income; other group disability plans; no-fault benefits, salary continuance or sick leave; and return-to-work earnings. For more information or to determine if this coverage is appropriate for you, contact your benefits administrator.

How is my benefit taxed?

If you or your employer pays for all or part of the cost of coverage on a pre-tax basis, all or part of your benefit amount will be Form W-2 taxable income. In these situations, FICA tax deductions may reduce the amount we will pay you.

Can I take my insurance with me if I leave my employer?

Depending upon state variations and your employer's plan, you may have an option to continue group coverage when your employment terminates. Your employer can advise you about your options.

The group disability insurance policies described in this advertisement provide disability income insurance only.

1. "Chances of disability," Council for Disability Awareness, disabilitycanhappen.org, last accessed April 2019.

Read the *Important information* section for more details including limitations and exclusions.

Rates

Employee - Coverage and **monthly** cost for Long-Term Disability.

Rates are effective as of July 1, 2025.

The chart below shows possible coverage amounts and their **monthly** costs.

Find your age bracket (as of the effective date of coverage) to see the cost for the coverage amount you choose.

Monthly coverage amounts	Age and cost										
	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
\$500	7.37	8.97	9.69	10.46	11.29	12.18	17.05	23.47	46.64	46.64	46.64
\$600	8.84	10.76	11.62	12.55	13.54	14.62	20.46	28.16	55.96	55.96	55.96
\$700	10.32	12.56	13.56	14.64	15.80	17.05	23.87	32.86	65.29	65.29	65.29
\$800	11.79	14.35	15.50	16.73	18.06	19.49	27.28	37.55	74.62	74.62	74.62
\$900	13.27	16.15	17.43	18.82	20.31	21.92	30.69	42.25	83.94	83.94	83.94
\$1,000	14.74	17.94	19.37	20.91	22.57	24.36	34.10	46.94	93.27	93.27	93.27
\$1,100	16.21	19.73	21.31	23.00	24.83	26.80	37.51	51.63	102.60	102.60	102.60
\$1,200	17.69	21.53	23.24	25.09	27.08	29.23	40.92	56.33	111.92	111.92	111.92
\$1,300	19.16	23.32	25.18	27.18	29.34	31.67	44.33	61.02	121.25	121.25	121.25
\$1,400	20.64	25.12	27.12	29.27	31.60	34.10	47.74	65.72	130.58	130.58	130.58
\$1,500	22.11	26.91	29.06	31.37	33.86	36.54	51.15	70.41	139.91	139.91	139.91
\$1,600	23.58	28.70	30.99	33.46	36.11	38.98	54.56	75.10	149.23	149.23	149.23
\$1,700	25.06	30.50	32.93	35.55	38.37	41.41	57.97	79.80	158.56	158.56	158.56
\$1,800	26.53	32.29	34.87	37.64	40.63	43.85	61.38	84.49	167.89	167.89	167.89
\$1,900	28.01	34.09	36.80	39.73	42.88	46.28	64.79	89.19	177.21	177.21	177.21
\$2,000	29.48	35.88	38.74	41.82	45.14	48.72	68.20	93.88	186.54	186.54	186.54
\$2,100	30.95	37.67	40.68	43.91	47.40	51.16	71.61	98.57	195.87	195.87	195.87
\$2,200	32.43	39.47	42.61	46.00	49.65	53.59	75.02	103.27	205.19	205.19	205.19
\$2,300	33.90	41.26	44.55	48.09	51.91	56.03	78.43	107.96	214.52	214.52	214.52
\$2,400	35.38	43.06	46.49	50.18	54.17	58.46	81.84	112.66	223.85	223.85	223.85
\$2,500	36.85	44.85	48.43	52.28	56.43	60.90	85.25	117.35	233.18	233.18	233.18
\$2,600	38.32	46.64	50.36	54.37	58.68	63.34	88.66	122.04	242.50	242.50	242.50
\$2,700	39.80	48.44	52.30	56.46	60.94	65.77	92.07	126.74	251.83	251.83	251.83
\$2,800	41.27	50.23	54.24	58.55	63.20	68.21	95.48	131.43	261.16	261.16	261.16
\$2,900	42.75	52.03	56.17	60.64	65.45	70.64	98.89	136.13	270.48	270.48	270.48
\$3,000	44.22	53.82	58.11	62.73	67.71	73.08	102.30	140.82	279.81	279.81	279.81
\$3,100	45.69	55.61	60.05	64.82	69.97	75.52	105.71	145.51	289.14	289.14	289.14
\$3,200	47.17	57.41	61.98	66.91	72.22	77.95	109.12	150.21	298.46	298.46	298.46
\$3,300	48.64	59.20	63.92	69.00	74.48	80.39	112.53	154.90	307.79	307.79	307.79
\$3,400	50.12	61.00	65.86	71.09	76.74	82.82	115.94	159.60	317.12	317.12	317.12
\$3,500	51.59	62.79	67.80	73.19	79.00	85.26	119.35	164.29	326.45	326.45	326.45
\$3,600	53.06	64.58	69.73	75.28	81.25	87.70	122.76	168.98	335.77	335.77	335.77
\$3,700	54.54	66.38	71.67	77.37	83.51	90.13	126.17	173.68	345.10	345.10	345.10
\$3,800	56.01	68.17	73.61	79.46	85.77	92.57	129.58	178.37	354.43	354.43	354.43
\$3,900	57.49	69.97	75.54	81.55	88.02	95.00	132.99	183.07	363.75	363.75	363.75
\$4,000	58.96	71.76	77.48	83.64	90.28	97.44	136.40	187.76	373.08	373.08	373.08
\$4,100	60.43	73.55	79.42	85.73	92.54	99.88	139.81	192.45	382.41	382.41	382.41
\$4,200	61.91	75.35	81.35	87.82	94.79	102.31	143.22	197.15	391.73	391.73	391.73
\$4,300	63.38	77.14	83.29	89.91	97.05	104.75	146.63	201.84	401.06	401.06	401.06
\$4,400	64.86	78.94	85.23	92.00	99.31	107.18	150.04	206.54	410.39	410.39	410.39
\$4,500	66.33	80.73	87.17	94.10	101.57	109.62	153.45	211.23	419.72	419.72	419.72
\$4,600	67.80	82.52	89.10	96.19	103.82	112.06	156.86	215.92	429.04	429.04	429.04
\$4,700	69.28	84.32	91.04	98.28	106.08	114.49	160.27	220.62	438.37	438.37	438.37
\$4,800	70.75	86.11	92.98	100.37	108.34	116.93	163.68	225.31	447.70	447.70	447.70

Rates

Monthly coverage amounts	Age and cost										
	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
\$4,900	72.23	87.91	94.91	102.46	110.59	119.36	167.09	230.01	457.02	457.02	457.02
\$5,000	73.70	89.70	96.85	104.55	112.85	121.80	170.50	234.70	466.35	466.35	466.35

Important information

The following coverage(s) do not constitute comprehensive health insurance (often referred to as “major medical coverage”). They do NOT provide basic hospital, basic medical, or major medical insurance.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Refer to the Certificate for details.

Limitations and exclusions

Exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

Long-Term Disability

We will not pay a benefit that is caused by, contributed to in any way or resulting from: intentionally self-inflicted injuries; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection; operation of a motorized vehicle while intoxicated. We will not pay a benefit if you do not submit proof of your loss as required by us (this covers medical examination, continuing care, death certificate, medical records, etc.); or for any Period of disability during which you are incarcerated. Disability benefits may be limited for certain conditions.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

Sun Life companies include Sun Life and Health Insurance Company (U.S.) and Sun Life Assurance Company of Canada (collectively, “Sun Life”).

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 93P-LH, 98P-ADD, 12-GP-01, 15-GP-01, 15-LF-C-01, 15-ADD-C-01, 16-DEN-C-01, 16-VIS-C-01, 12-DI-C-01, 16-DI-C-01, 12-AC-C-01, 16-AC-C-01, 13-SD-C-01, 16-SD-C-01, 16-CAN-C-01, 20-HI-C-01, 12-GPPort-P-01, 20-HIPORT-C-01, TDBPOLICY-2006, and TDI-POLICY.

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Group Enrollment Form

Sun Life Assurance Company of Canada
 One Sun Life Executive Park
 Wellesley Hills, MA 02481

Employer use (check one): New employee Change COBRA

1. General Information

Employer Name AFSCME Local 685	Account / Policy Number 913395	Location <input type="text"/>
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2. Employee Information

Employee's Full Legal Name (First, M.I., Last) <input type="text"/>		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth <input type="text"/>
Street Address <input type="text"/>	City <input type="text"/>	State <input type="text"/>	Zip Code <input type="text"/>
Occupation <input type="text"/>	Eligibility Class (if applicable) <input type="text"/>	Social Security Number <input type="text"/>	Phone Number <input type="text"/>
Date employed: <input type="checkbox"/> Full-Time Date: <input type="text"/> <input type="checkbox"/> Part-Time Date: <input type="text"/>	<input type="checkbox"/> Return from layoff Date: <input type="text"/> <input type="checkbox"/> Rehire		
Current Active Employment Type <input type="text"/> # of hours <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Earnings \$ <input type="text"/> <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually <input type="checkbox"/> Other: <input type="text"/>		

3. Benefit Elections

You need to complete all sections of the enrollment form including electing or refusing insurance coverage below and sign it. This must be done either during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer ("non-contributory benefits") cannot be refused. Not all of the benefit options listed below will be necessarily available to you. Your employer will tell you which benefits are available and what your Maximum Guaranteed Issue amount is.

Elect	Refuse	Coverage	
<input type="checkbox"/>	<input type="checkbox"/>	Voluntary Long-Term Disability (LTD)	\$ <input type="text"/>

4. Signature and authorization information

I understand that:

- I am requesting coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates, subject to any portability or continuation provisions available under the Group Insurance policy.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- If applying for coverage more than 31 days past my eligibility date, Evidence of Insurability may be required.
- For Long-Term Disability insurance, Evidence of Insurability will be required for amounts over my Guarantee Issue for this enrollment.
- Increases to current Long-Term Disability benefits may require Evidence of Insurability.
- If I decline coverage for myself or, if applicable, for my family now and want it at a later date, I/we will have to submit an Evidence of Insurability application, if required for the elected coverage(s), to be approved by Sun Life Assurance Company of Canada (Wellesley, MA).
- Coverages include limitations, exclusions and a pre-existing conditions provision that may affect my entitlement to benefits.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- When required by the coverage, if my spouse or any of my dependent children are confined due to an injury or illness, on the date that any initial or increased coverage is scheduled to start under the plan, such coverage may not start until the date they are no longer confined and are able to perform their normal activities.
- California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

By signing below, I am representing that the information I have provided is true and correct to the best of my knowledge and belief.

I confirm by signing below that I have minimal essential coverage (major medical coverage).

X _____
Employee Signature Today's Date

To the Employee: Make a copy of this form for your records before submitting it to your employer.

To the Employer: This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another copy of the Enrollment Form.

Agent, Broker, and/or Enroller information:

Agent name	<input type="text"/>
Agent / Broker name	<input type="text"/>
Enroller name	<input type="text"/>

Contact us



By mail

Sun Life
One Sun Life Executive Park
Wellesley Hills, MA 02481



www.sunlife.com/us



Customer Service **800-247-6875** M-F 8:00 a.m.-8:00 p.m., ET

**Talk to your benefits administrator
today to learn more about your
choices.**

96 Worcester St.
One Sun Life Executive Park
Wellesley Hills, MA 02481

[sunlife.com/us/](https://www.sunlife.com/us/)

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