

GROUP VOLUNTARY LONG-TERM DISABILITY INSURANCE BENEFIT HIGHLIGHTS



Just over 1 in 4 of today's 20 year-olds will become disabled before they retire (age 67).¹

UPS Management Pilots as Members of the Aviation Health Association

A disability can happen to anyone. Long-term disability insurance helps protect your paycheck if you're unable to work for a long period of time after a serious condition, injury or sickness.



To learn more about Long-Term Disability insurance, visit thehartford.com/employeebenefits

COVERAGE INFORMATION

BENEFIT PERCENTAGE (PERCENT OF YOUR EARNINGS)	MAXIMUM	MINIMUM (BASED ON MONTHLY INCOME LOSS BEFORE THE DEDUCTION OF OTHER INCOME BENEFITS)	BENEFIT STARTS (ELIMINATION PERIOD)	BENEFIT DURATION
30%	\$6,000	The greater of \$100 or 10% of the benefit	After 365 days disabled	Disabled before: Age 63 Benefit duration: As long as you are disabled Benefit duration maximum: The greater of your Social Security Normal Retirement Age or 3.5 years

PREMIUMS

See the Premium Worksheet.²

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full time employee who works at least 30 hours per week on a regularly scheduled basis.

AM I GUARANTEED COVERAGE?

If this is the first time you are eligible to elect coverage, evidence of insurability is not required.

If you did not elect coverage the first time it was offered to you, evidence of insurability is required to elect coverage.

This coverage is subject to a pre-existing condition exclusion, which is detailed on the Limitations & Exclusions sheet.³

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?

Premium is provided on the Premium Worksheet.

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don't have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

You may enroll during any scheduled enrollment period, or within 31 days of the date you have a change in family status.

WHEN DOES THIS INSURANCE BEGIN?

Insurance will become effective in accordance with the terms of the certificate (usually the first day of the month following the date you elect coverage).

You must be actively at work with your employer on the day your coverage takes effect.

WHEN DOES THIS INSURANCE END?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you leave your employer, or the coverage is no longer offered.

WHAT DOES IT MEAN TO BE DISABLED?

Disability is defined in The Hartford's certificate with your employer.

Typically, disability means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical condition covered by the insurance, and as a result, your current monthly earnings are less than 80% of your pre-disability earnings

Pre-disability earnings are defined in your policy.

¹U.S. Social Security Administration Fact Sheet. Web. 30 June 2017 <https://www.ssa.gov/news/press/factsheets/basicfact-alt.pdf>

²Rates and/or benefits may be changed.

³The Long Term Disability policy contains a Pre-Existing Condition Exclusion. Please refer to the certificate for more information on exclusions and limitations, such as Pre-Existing Conditions.

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This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. **Benefits are subject to state availability. Policy terms and conditions vary by state.** Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding Hartford's compensation practices, please review our website <http://thehartford.com/group-benefits-producer-compensation>. Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.

ADDITIONAL SERVICES



UPS Management Pilots as Members of the Aviation Health Association

If you are enrolled in insurance coverage with The Hartford, you may also be eligible to receive additional services at no cost to you. These services help with challenges that come before and after a claim. Be sure to read the information provided below; The Hartford wants to be there when you need us.

SERVICES AVAILABLE

COVERAGE ENROLLED IN	ADDITIONAL SERVICES AVAILABLE
Disability	Ability Assist Counseling Services Health Champion Travel Assistance Services with ID Theft Protection and Assistance

ASKED & ANSWERED

WHAT IS ABILITY ASSIST COUNSELING SERVICES?

Ability Assist^{®4} Counseling Services provides access to Master's- and PhD-degreed clinicians for 24/7 assistance if you're enrolled in our long term disability plan. This includes 3 face-to-face visits per occurrence per year for emotional concerns and unlimited phone consultations for financial, legal, and work-life concerns.

For more information on Ability Assist[®] Counseling Services:

Call 1-800-964-3577

Visit www.guidanceresources.com

Company name: **Abili** Company ID: **HLF902**

WHAT IS HEALTHCHAMPION?

HealthChampion^{SM5} offers unlimited access to benefit specialists and nurses for administrative and clinical support to address medical care and health insurance claims concerns if you're enrolled in our long term disability plan. Service includes: guidance on health insurance claims and billing support, explanation of benefits, cost estimates and fee negotiation, information related to conditions and available treatments, and support to help prepare for medical visits.

For more information on HealthChampionSM Services

Call 1-800-964-3577

Visit www.guidanceresources.com

Company name: **Abili** Company ID: **HLF902**

WHAT IS TRAVEL ASSISTANCE SERVICES WITH ID THEFT PROTECTION AND ASSISTANCE?

Travel Assistance Services with ID Theft Protection and Assistance³ includes pre-trip information to help you feel more secure while traveling. It can also help you access medical professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less when unexpected detours arise. The ID theft services are available to you and your family at home or when you travel.

For more information on Travel Assistance Services or ID Theft Services:

Call from United States: 1-800-243-6108

Call collect from other locations: 202-828-5885

Fax: 202-331-1528

Email: idtheft@europassistance-usa.com

Travel Assistance Identification Number: **GLD-09012**

You'll be asked to provide your employer's name, a phone number where you can be reached, nature of the problem, Travel Assistance Identification Number, and your company policy number which can be obtained through your Human Resources/Personnel department.

If you have a serious medical emergency, please obtain emergency medical services first, and then contact Europ Assistance USA for follow-up.

LIMITATIONS & EXCLUSIONS



This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LONG TERM DISABILITY INSURANCE

LIMITATIONS AND EXCLUSIONS

GENERAL EXCLUSIONS

- You must be under the regular care of a physician to receive benefits.
- You cannot receive disability insurance benefit payments for disabilities that are caused or contributed to by:
 - War or act of war (declared or not)
 - The commission of, or attempt to commit a felony
 - An intentionally self-inflicted injury
 - Your being engaged in an illegal occupation

PRE-EXISTING CONDITIONS

- Your insurance excludes the benefits you can receive for pre-existing conditions. In general, if you were diagnosed or received care for a condition before the effective date of your certificate, you will be covered for a disability due to that condition only if:
 - You have not received treatment for your condition for 3 months before the effective date of your insurance, or
 - You have been insured under this coverage for 12 months prior to your disability commencing, so you can receive benefits even if you're receiving treatment, or
 - You have already satisfied the pre-existing condition requirement of your previous insurer

LIMITATIONS

- Mental Illness Limitation.** If you are disabled because of Mental Illness, benefits will be payable for a maximum of 24 months in your lifetime, unless at the end of that 24 months, you are confined to a hospital or other place licensed to provide medical care for your disability.
- Substance Abuse Limitation.** If you are disabled because of alcoholism or use of narcotics, sedatives, stimulants, hallucinogens or other similar substance, benefits will be payable for a maximum of 24 months in your lifetime, unless at the end of that 24 months, you are confined to a hospital or other place licensed to provide medical care for your disability.

OFFSETS

- Your benefit payments will be reduced by other income you receive or are eligible to receive due to your disability, such as:
 - Social Security disability insurance (please see next section for exceptions)
 - Workers' compensation
 - Other employer-based insurance coverage you may have
 - Unemployment benefits
 - Settlements or judgments for income loss
 - Retirement benefits that your employer fully or partially pays for (such as a pension plan)
- Your benefit payments will not be reduced by certain kinds of other income, such as:
 - Retirement benefits if you were already receiving them before you became disabled
 - Retirement benefits that are funded by your after-tax contributions your personal savings, investments, IRAs or Keoghs profit-sharing
 - Most personal disability policies
 - Social Security cost-of-living increases

This example is for purposes of illustrating the effect of the benefit reductions and is not intended to reflect the situation of a particular claimant under the Policy:

Insured's monthly [Pre-Disability Earnings/Basic Monthly Pay] \$3,000
Long term disability benefits percentage x 60%
Unreduced maximum benefit \$1,800
Less Social Security disability benefit per month - \$900
Less state disability income benefit per month - \$300
Total amount of long term disability benefit per month \$600

This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York Department of Financial Services.

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This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. Benefits are subject to state availability. Policy terms and conditions vary by state. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder.



Employer Group Benefits Coverage Information

Thank you for choosing The Hartford. All sections of this form must be completed and received by The Hartford within 30 days of the signature date.

Employers: Please completely fill out **Section 1 and Section 2 on this page** and forward the entire form to the employee. Refer to your Policy and employee records for this information. These records are your property and are not on file with The Hartford. An incomplete form will result in a delay in processing your employee's request for insurance.

Employees: Please completely fill out the **Applicant Information section on the 2nd page** even if you are not applying for coverage.

Section 1: Employer Details *(to be completed by Employer)*

PLEASE PRINT CLEARLY

Employer Name: Ups Management Pilots As Members Of The Aviation Health Asso	Policy Number: 805292
Employer Mailing Address (Street, City, State, Zip Code):	
Division/Location/Subsidiary with Mailing Address <i>(if applicable)</i> :	
Benefits Contact Name (First, Last):	
Benefits Contact Email Address:	Benefits Contact Phone:

Section 2: Employee Details *(to be completed by Employer)*

PLEASE PRINT CLEARLY

Employee Name (First, MI, Last):	Date of Hire (mm/dd/yyyy):
Base Annual Earnings*:	Coverage Effective Date* (mm/dd/yyyy):

* As described in the contract with The Hartford

Disability Insurance Coverage Requested

- Check Yes if employee is requesting Long Term Disability coverage that is subject to EOI

Long Term Disability	<input type="checkbox"/> Yes, EOI is required
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EVIDENCE OF INSURABILITY

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza, Hartford, CT 06155

Applicant Information

	First Name	Last Name	Social Security #	Gender	Height (ft./in.)	Weight (lbs.)*	Date of Birth (mm/dd/yyyy)
Employee				<input type="checkbox"/> Male <input type="checkbox"/> Female			

* If currently pregnant, please provide pre-pregnancy weight

Employee	Street Address		Day Time Phone	
	City		Evening Phone	
	State, Zip Code		Email Address	

Medical Information

Each Applicant must answer each of the following questions to the best of their knowledge and belief.

	Employee
Within the past 5 years, have you been diagnosed with or treated by a licensed medical physician for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the Human Immunodeficiency Virus (HIV) infection or other sickness or condition derived from such infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 consecutive work days due to a disability, injury, or sickness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the past 5 years, have you used any controlled substances, with the exception of those taken as prescribed by your physician, been diagnosed or treated for drug or alcohol abuse (excluding support groups), or been convicted of operating a motor vehicle while under the influence of drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Within the past 5 years, have you been diagnosed with or treated by a licensed member of the medical profession for:

	Employee		Employee
Heart Disease (Do not check "Yes" if you only have High Blood Pressure or a Heart Murmur)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disease, injury or surgery of Joint, Ligaments, Knee, Back, or Neck (including Arthritis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart-Related Surgery or Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure If you checked "Yes" to High Blood Pressure, have you had a change in medication within the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (Do not check "Yes" for Hepatitis A) or Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blocked Arteries (Arteriosclerosis, Atherosclerosis, Aneurysm, or Deep Vein Blood Clot)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical Information (continued)

	Employee		Employee
Stroke or transient ischemic attack (TIA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alzheimer's or Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Obstructive Pulmonary Disease (COPD) or Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Major Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Fatigue Syndrome or Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Narcolepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer (Do not check "Yes" for Basal Cell Carcinoma only) If "Yes", Date of Diagnosis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcerative Colitis or Crohn's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychotic, Psychiatric, Personality, or Bi-Polar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Failure or Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No

Notice

To the best of your knowledge, you are required to notify Hartford Life and Accident Insurance Company in writing of any changes in your medical condition between the date you sign this form and the date the coverage is approved.

In order to complete the evaluation of this application, Hartford Life and Accident Insurance Company may contact you, through the mail or over the telephone:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form;
3. to ask additional questions of you or your physician about the information that you have provided; or
4. to request a paramedical exam.

We may also use information about you obtained from other sources, including our claim files, evidence of insurability applications you have previously submitted to us, copies of medical records which you have authorized us to review, and information obtained from MIB, Inc. Only information that is relevant to determining Evidence of Insurability for the coverage which you are currently requesting will be considered.

Authorization

I, an undersigned applicant, authorize Hartford Life and Accident Insurance Company, together with its affiliates, ("Company") to contact me, during the evaluation of this application, through the mail, secure e-mail, or over the telephone, at the address or telephone number identified in this application, or otherwise provided by me:

1. to clarify any information contained on this form;
2. to obtain any information missing from this form; or
3. to request a paramedical exam.

In the event that I cannot be reached via telephone, I authorize a representative of the Company to leave a voice message identifying his or her name, the Company name, and a return phone number, indicating that he or she is calling to obtain information necessary to complete my recent application for insurance. The message will also contain an underwriting ID number and the hours during which I may reach a representative of the Company by telephone.

- Yes, you may leave a message as indicated above. No, please do not leave a message.

In addition to the information that I have provided on this application, I authorize the Company to use information about me obtained from Company claim files, insurance applications and medical information I or my physician(s) have previously submitted to the Company. I further authorize my employer, any health or benefits plan, physician, medical professional, hospital, clinic, laboratory, MIB Group, Inc. (MIB, Inc), pharmacy or pharmacy benefits manager that possesses my protected personal health information ("PHI"), including copies of records concerning physical or mental illness, diagnosis, prognosis, prescription information, care or treatment provided to me (but excluding HIV and genetic testing), to furnish such protected

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health information to the Company or its representative. The Company may only use information disclosed under this authorization that is relevant to underwrite this or any other insurance application to the Company during the period that the Authorization is valid (as described below), at any time to aid in the detection of fraud, and for internal research purposes.

I authorize the Company to disclose the "PHI" in its files to its reinsurer(s) and affiliates, other insurance companies and their affiliates, other persons, representatives and/or organizations performing functions on behalf of the Company and their affiliates, my employer, or as required by law, including any mandated reporting to state agencies. I understand that I may request details about any of the information gathered about me that relates to this application and that such requested information and the identity of the source of the information shall be released to me or, in the case of medical information, to a licensed medical professional of my choice.

I/We authorize Hartford Life and Accident Insurance Company, or its reinsurers, to make a brief report of my/our personal health information to Medical Information Bureau.

I agree that a photocopy of this authorization is valid as the original and I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This authorization shall be valid for twenty-four (24) months from the date signed below. This authorization may be revoked upon written request to the Company, and will not remain valid beyond the date the revocation is received by the Company. I understand the revocation may be a basis for denying my insurance application, and that it does not alter the Company's right to use the application for purposes of determining misrepresentation once coverage has been issued.

I have received and read a copy of the Notice of Insurance Information Practices.

Fraud

For any Applicants that do not reside in the following states: Alabama, Colorado, District of Columbia, Florida, Kentucky, Maryland, Oregon, Pennsylvania, Puerto Rico, Tennessee and Washington: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Alabama: 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 restitution fines or confinement in prison, or any combination thereof.

For residents of 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.

For residents of District of Columbia: 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 fines and confinement in prison.

For residents of 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For residents of 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.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Premium Worksheet



Rates and/or benefits can change.

VOLUNTARY LONG TERM DISABILITY INSURANCE Monthly Premium Amount (Cost per Pay Period – 12/Year)

To calculate your monthly premium amount, use the following formula.

$$\frac{\text{Your Annual Earnings}}{\text{Maximum} = \$240,000} \div 12 = \frac{\text{Your Monthly Earnings}}{\text{Your Monthly Earnings}} \div 100 = \text{_____} \times \frac{\$1.0150}{\text{Rate}} = \text{_____} \text{ Premium Amount}$$

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³ Travel Assistance and ID Theft Protection and Assistance are provided by Europ Assistance USA. Europ Assistance USA is not affiliated with The Hartford and is not a provider of insurance services. Europ Assistance USA may modify or terminate all or any part of the service at any time without prior notice. None of the benefits provided to you by Europ Assistance USA as a part of the Travel Assistance and Identity Theft service are insurance. This brochure, the Travel Assistance and Identity Theft service Terms and Conditions of Use, and the Identity Theft Resolution Kit constitute your benefit materials and contain the terms, conditions, and limitations relating to your benefits. These services may not be used for business or commercial purposes or by any person other than the individual insured under The Hartford's group insurance policy.

⁴ Ability Assist® is offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services.

⁵ HealthChampionSM is offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services.

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