Frequently Asked Questions

I already have disability insurance through my employer. Should I still consider this insurance?

Yes, for three reasons:

First, over time your income has probably increased, and the level of protection you now carry may no longer be enough to help cover the living expenses that would continue should you be disabled. Using this plan to increase your total coverage can help you avoid having to deplete savings and investments intended for other purposes, including retirement.

Second, even if you have disability income insurance through your employer, there's a good chance it only covers between 50% and 60% of your monthly income* and it's likely to be taxable, reducing the true amount of protection the coverage provides. In contrast, the benefits of this plan would come to you free of income tax when you pay the premiums with your own, after-tax dollars.

Third, unlike many employer-provided plans, this coverage is yours to keep without interruption, even if you change jobs or become self-employed.

*Kaiser Health News, Employers Increasingly Trimming or Cutting Disability Benefits. Retrieved June 2014 from http://www.kaiserhealthnews.org/features/insuring-your-health/michelle-andrews-on-disability-coverage.aspx

How does this plan define "total disability"?

Some disability plans limit their definition of "disabled" to the inability to work in any occupation. This means you might not be eligible for benefits if you are sick or injured but still able to, say, stuff envelopes or answer phones.

Under this plan, you will be considered totally disabled if, during the waiting period and up to the next 60 months, you are completely unable to perform the material and substantial duties of your regular occupation (that which you were performing immediately prior to onset of disability) as the result of a covered illness or injury (as certified by a physician). Thereafter, total disability means your complete inability to perform any gainful employment.

How much coverage can I apply for?

You and your spouse/domestic partner** may apply for up to $10,000 in monthly benefits. The maximum amount that can be issued depends on your earned income and other disability insurance you have in force, if any. Monthly benefits from this plan, when added to any other disability insurance or income from other sources, cannot exceed 66 2/3% of your monthly pre-tax income.

**Wherever the term spouse appears will read as Domestic Partner throughout.

What is the benefit of group rates?

As an APTA member, you are part of a large group of people nationwide, so you enjoy group purchasing power that brings you the convenience of coverage that is quick and easy to apply for while also keeping your cost competitive.

What is the "waiting period"?

The waiting period is the amount of time between onset of disability and when you would receive your first monthly benefit payment. The longer the waiting period, the lower your cost.

Under this plan, you may choose a waiting period of 60, 90 or 180 days (spouse coverage is subject to a 90-day waiting period).

Is the monthly benefit sent to my healthcare providers?

No. This insurance is designed to help replace your income while you're unable to work; the money is sent directly to you, and you may use it any way you wish.

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How long will my benefits last?

That depends on which plan you select when you apply.

Under Plan 1, if you are disabled prior to age 63, benefits will be paid until you reach age 65. If total disability begins on or after age 63, but prior to age 70, benefits will be paid for two years.

Under Plan 2, if you are disabled prior to age 60, benefits will be paid for five years. If your disability begins on or after age 60, but prior to age 64, benefits will be paid until you reach age 65. If total disability begins on or after age 64, but prior to age 70, benefits will be paid for one year.

(If you are disabled due to a mental illness (as defined by the policy) or substance abuse, benefits are payable for a maximum of 24 months.)

What if my health declines? Will my rates go up?

No. You can never be singled out for a rate increase or have your coverage cancelled due to your health. You are also assured that your rates will never increase as a result of the number of claims you've made. Individual rate increases can be made only as you move from one age bracket to the next. The insurance company can only change premium rates if the change applies to all individuals covered under the group policy.

What if I apply now and then change my mind?

Once your application is approved and coverage is issued, you'll receive a Certificate of Insurance. Then you'll have 30 days to decide if you're completely satisfied with your coverage. If you decide this coverage isn't right for you, return your certificate within that 30-day period (without claim) and you'll be under no further obligation.

Do I have to pay my first premium when I apply?

No. You don't need to send any money until you've reviewed your Certificate of Insurance and confirmed that it meets your needs. Your first premium notice will be enclosed with your Certificate of Insurance, and you will have 30 days to pay it.

This plan is underwritten by New York Life Insurance Company, NAIC # 66915, domiciled in the state of New York with a principal place of business of 51 Madison Avenue, New York, NY 10010 (policy form GMR).

New York Life is licensed/authorized to transact business in all the 50 United States, the District of Columbia, Puerto Rico, and Canada. However, not all group plans it underwrites are available in all states.

This is a brief summary of benefits only and is subject to the terms, conditions, exclusions and limitations of Group Policy No G-30374-0/ GMR-FACE on policy form GMR issued to the American Physical Therapy Association. Coverage may vary or may not be available in all states.

Provided by: HPSO®

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