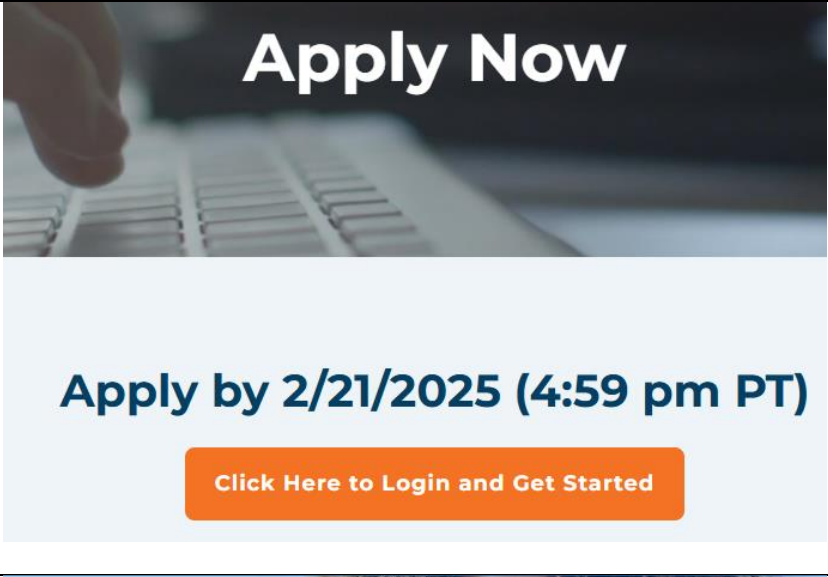
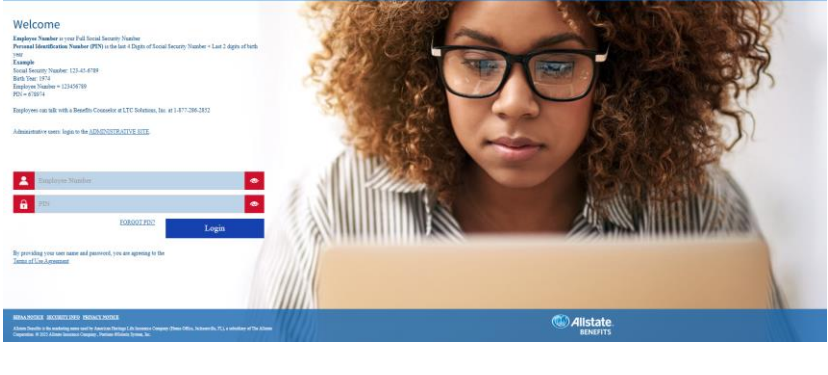
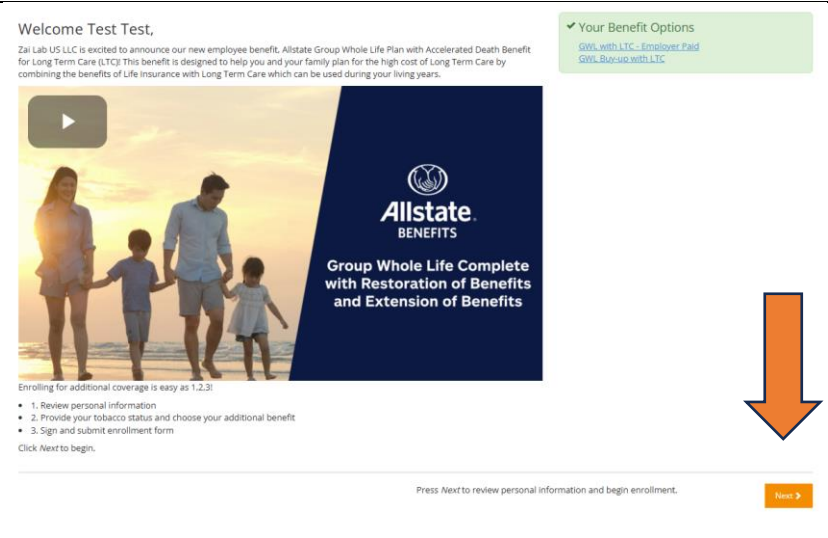
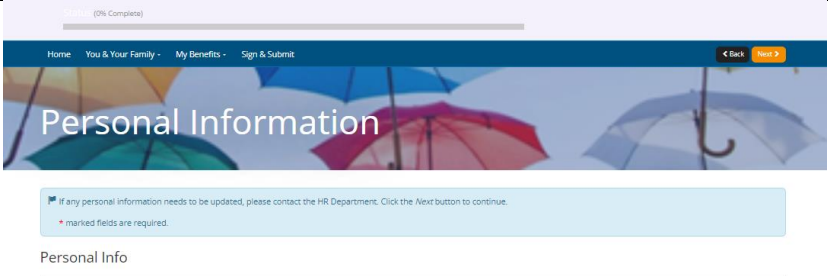
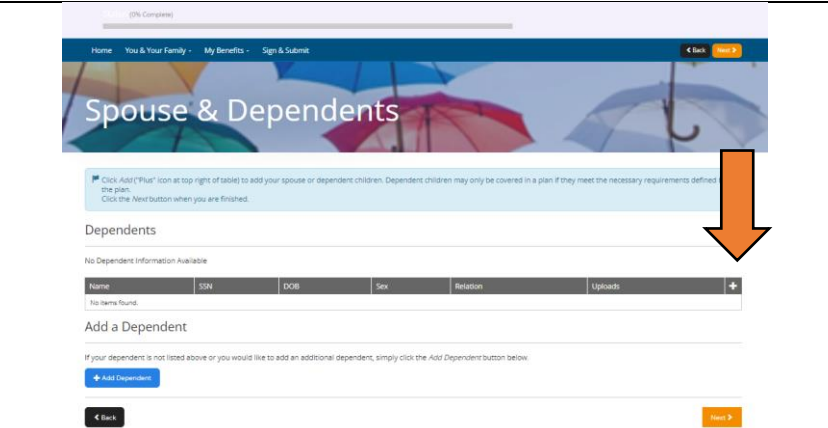
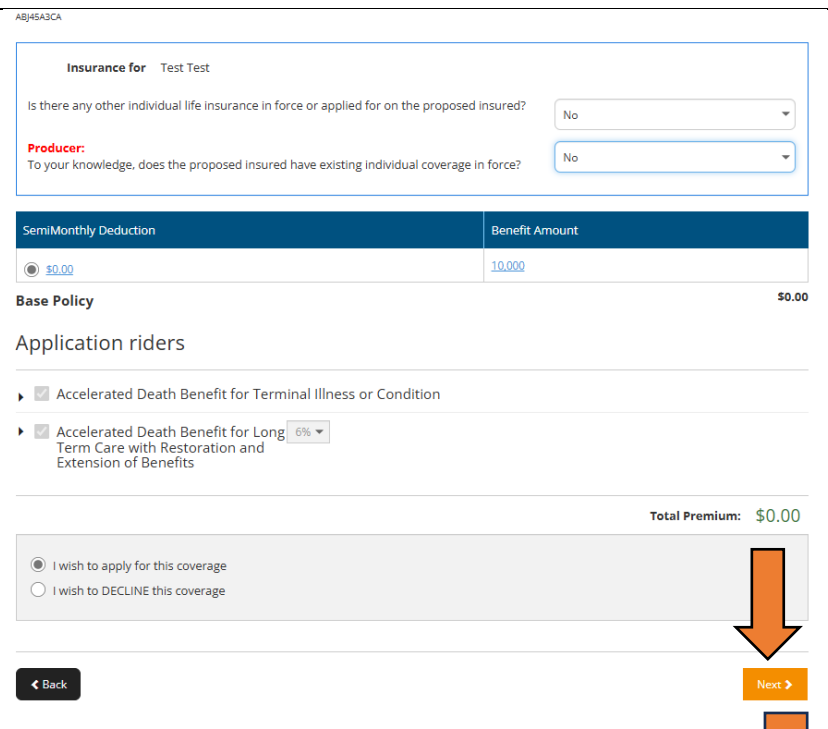
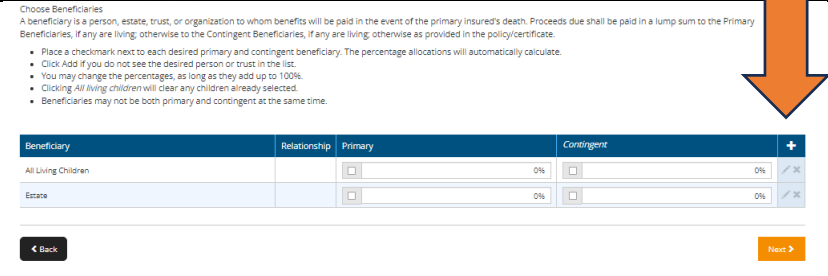
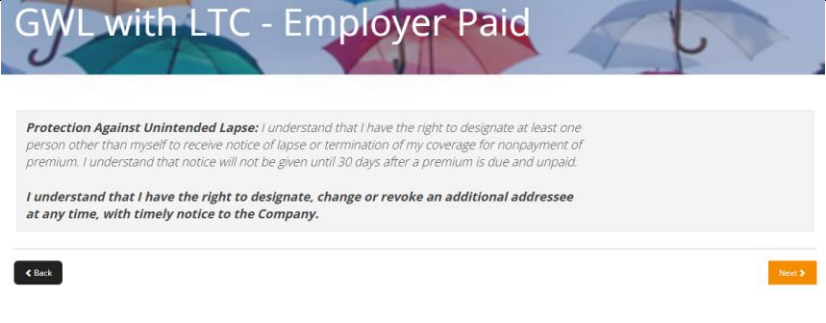
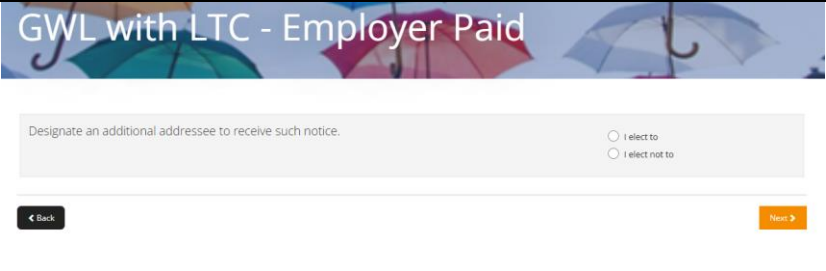
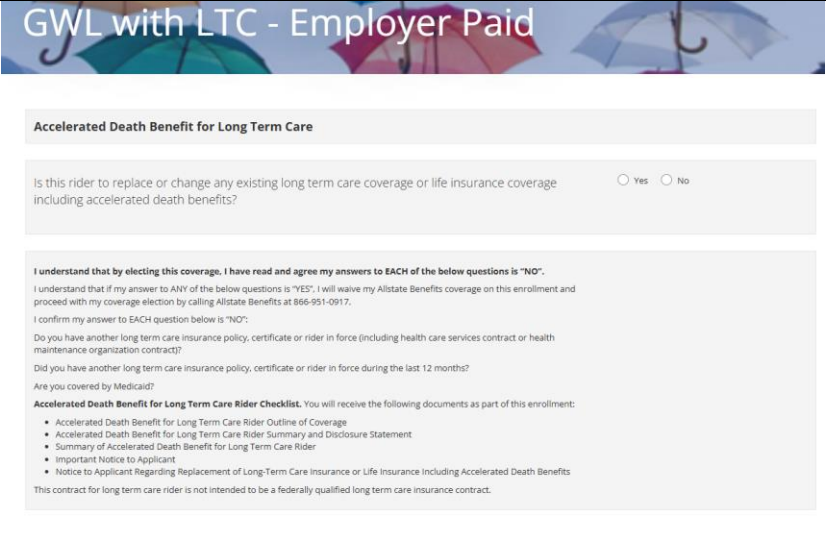
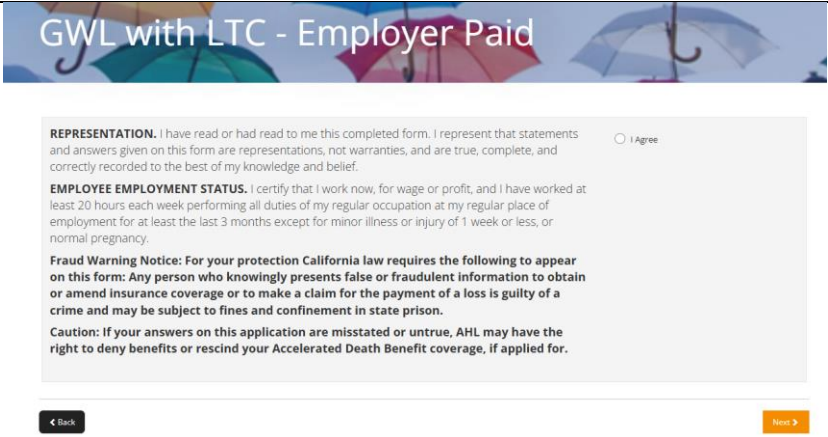
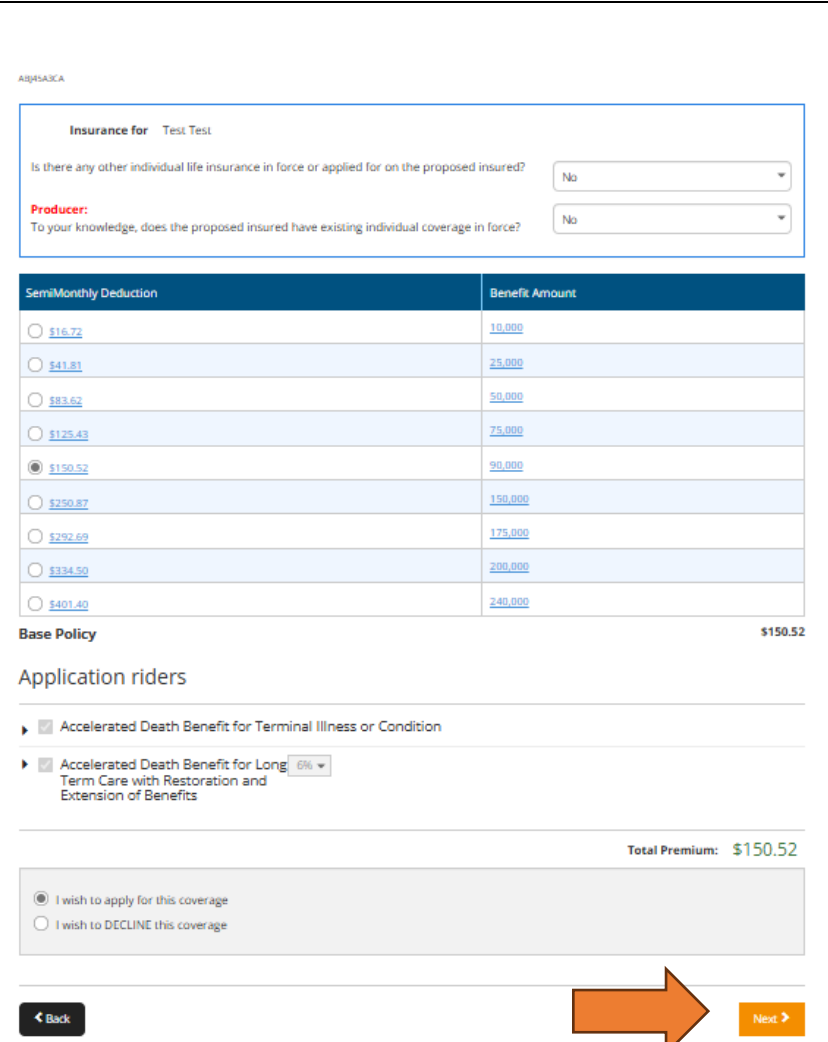
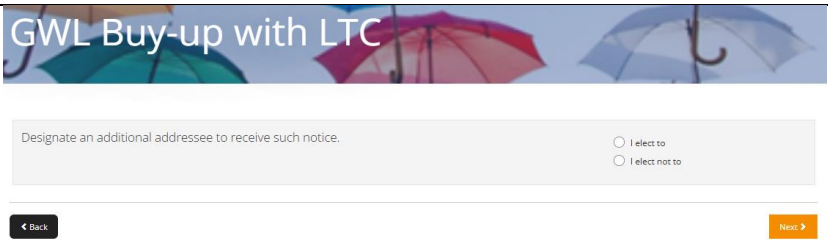


Zai Lab | Allstate Enrollment User Guide

Instructions	Screen Shot
<p>ACCESSING THE ENROLLMENT:</p> <p>To enroll in Allstate Life + LTC, go to: www.myltcguide.com/zailab and click on CLICK HERE TO LOGIN AND GET STARTED</p>	
<p>ACCESSING THE ENROLLMENT:</p> <p>Log in with your Username and Password.</p> <p>Username: Employee SSN</p> <p>PIN: 6 Digits – Last 4 SSN/ Last 2 Birth Year</p>	
<p>BEGINNING THE ENROLLMENT PROCESS:</p> <p>Press NEXT on the bottom right-hand corner of the screen to review personal information and begin enrollment.</p>	

Instructions	Screen Shot
<p>PERSONAL INFO:</p> <p>Please review and update anything that is incorrect.</p> <p>Press NEXT on the bottom right hand corner of the screen to continue.</p>	
<p>DEPENDENT INFO:</p> <p>If you would like to enroll your spouse, you will need to add them as a dependent. To add a dependent, click the + icon. To edit a dependent click on the pencil icon. To delete a dependent click on the X icon.</p> <p>Press NEXT on the bottom right-hand corner of the screen to continue.</p>	
<p>ENROLL IN EMPLOYER PAID BENEFIT:</p> <p>Answer the required question about replacement.</p> <p>Press NEXT on the bottom right hand corner of the screen to continue.</p>	
<p>ASSIGN BENEFICIARIES FOR YOUR EMPLOYER PAID POLICY:</p> <p>You can add additional people to be beneficiaries – just click the + icon.</p>	

Instructions	Screen Shot
<p>If primary and contingent beneficiaries are not alive at time of claim, payment will be made to the estate.</p> <p>Press NEXT on the bottom right-hand corner of the screen to continue.</p>	
<p>PROTECTION AGAINST UNINTENDED LAPSE:</p> <p>Read the section.</p> <p>Press NEXT on the bottom right-hand corner of the screen to continue.</p>	 <p>The screenshot shows a header with the title "GWL with LTC - Employer Paid" and a background image of colorful umbrellas. Below the header, there is a text box containing the following text: "Protection Against Unintended Lapse: I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of my coverage for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid." Below this text box, there is a statement: "I understand that I have the right to designate, change or revoke an additional addressee at any time, with timely notice to the Company." At the bottom of the screen, there are two buttons: "Back" on the left and "Next" on the right.</p>
<p>DESIGNATE ADDRESSEE TO RECEIVE UNINTENDED LAPSE NOTICE:</p> <p>Make your selection.</p> <p>Press NEXT on the bottom right-hand corner of the screen to continue.</p>	 <p>The screenshot shows a header with the title "GWL with LTC - Employer Paid" and a background image of colorful umbrellas. Below the header, there is a text box containing the following text: "Designate an additional addressee to receive such notice." Below this text box, there are two radio buttons: "I elect to" and "I elect not to". At the bottom of the screen, there are two buttons: "Back" on the left and "Next" on the right.</p>
<p>ACCELERATED DEATH BENEFIT FOR LONG TERM CARE:</p> <p>Answer the replacement question.</p> <p>Press NEXT on the bottom right-hand corner of the screen to continue.</p>	 <p>The screenshot shows a header with the title "GWL with LTC - Employer Paid" and a background image of colorful umbrellas. Below the header, there is a section titled "Accelerated Death Benefit for Long Term Care". Below this section, there is a text box containing the following text: "Is this rider to replace or change any existing long term care coverage or life insurance coverage including accelerated death benefits?" Below this text box, there are two radio buttons: "Yes" and "No". Below this text box, there is a statement: "I understand that by electing this coverage, I have read and agree my answers to EACH of the below questions is 'NO'." Below this statement, there is a paragraph of text: "I understand that if my answer to ANY of the below questions is 'YES', I will waive my Allstate Benefits coverage on this enrollment and proceed with my coverage election by calling Allstate Benefits at 866-951-0917. I confirm my answer to EACH question below is 'NO':" Below this paragraph, there are two questions: "Do you have another long term care insurance policy, certificate or rider in force (including health care services contract or health maintenance organization contract)?" and "Did you have another long term care insurance policy, certificate or rider in force during the last 12 months?". Below these questions, there is a statement: "Are you covered by Medicaid?". Below this statement, there is a section titled "Accelerated Death Benefit for Long Term Care Rider Checklist. You will receive the following documents as part of this enrollment:" Below this section, there is a list of documents: "Accelerated Death Benefit for Long Term Care Rider Outline of Coverage", "Accelerated Death Benefit for Long Term Care Rider Summary and Disclosure Statement", "Summary of Accelerated Death Benefit for Long Term Care Rider", "Important Notice to Applicant", and "Notice to Applicant Regarding Replacement of Long-Term Care Insurance or Life Insurance Including Accelerated Death Benefits". Below this list, there is a statement: "This contract for long term care rider is not intended to be a federally qualified long term care insurance contract."</p>

Instructions	Screen Shot
<p>REPRESENTATION & EMPLOYMENT STATUS:</p> <p>If you agree, click “I Agree”.</p> <p>Press NEXT on the bottom right-hand corner of the screen to continue.</p>	
<p>ENROLL IN EMPLOYEE PAID BENEFIT:</p> <p>Answer the required question about replacement.</p> <p>Your answers will cause the page to update with custom rates applicable to your age.</p> <p>Choose desired life insurance coverage amount. This amount is in addition to the \$10,000 employer funded amount.</p> <p>*If you wish to decline this one time opportunity for additional coverage up to \$90,000 with no health questions asked, choose “I wish to DECLINE this coverage.”</p> <p>Press NEXT on the bottom right-hand corner of the screen to continue.</p>	
<p>DESIGNATE ADDRESSEE TO RECEIVE UNINTENDED LAPSE NOTICE:</p> <p>Make your selection.</p> <p>Press NEXT on the bottom right-hand corner of the screen to continue.</p>	

Instructions

ASSIGN BENEFICIARIES FOR EMPLOYEE PAID BENEFIT:

You can add additional people to be beneficiaries – just click the + icon.

If primary and contingent beneficiaries are not alive at time of claim, payment will be made to the estate.

Press NEXT on the bottom right-hand corner of the screen to continue.

Screen Shot

Choose Beneficiaries

A beneficiary is a person, estate, trust, or organization to whom benefits will be paid in the event of the primary insured's death. Proceeds due shall be paid in a lump sum to the Primary Beneficiaries, if any are living; otherwise to the Contingent Beneficiaries, if any are living; otherwise as provided in the policy certificate.

- Place a checkmark next to each desired primary and contingent beneficiary. The percentage allocations will automatically calculate.
- Click Add if you do not see the desired person or trust in the list.
- You may change the percentages, as long as they add up to 100%.
- Clicking *All living children* will clear any children already selected.
- Beneficiaries may not be both primary and contingent at the same time.

Beneficiary	Relationship	Primary	Contingent	
All Living Children		<input type="checkbox"/>	<input type="checkbox"/>	0%
Estate		<input type="checkbox"/>	<input type="checkbox"/>	0%

[Back](#) [Next](#)

ENROLL SPOUSE:

To enroll a spouse (must have been entered on the dependent screen) click on their name to bring up their options for coverage.

Give up with LTC

Endorser currently covered is listed below. If you wish to make a change to the coverage, click the person's name.

Primary Insured	Relationship	DOB	Policy #	Benefits	Premium	Options	
Spouse Test	Employee	6/1/1970		90,000	\$150.52	GWCTI, GWLTCRE	Withdraw

Primary apply for coverage for any of the individuals listed below. To view prices or apply, click the name of the person in the list below.

Name	Relationship	Sex	DOB	Riders
Spouse Test	Spouse	M	7/1/1969	

☒ I wish to CONFIRM the changes made in this enrollment session.
☐ I wish to WAIVE coverage (no previous election made), or I wish to CANCEL changes made in this session (to a previous election made)

[Back](#) [Next](#)

SPOUSE ENROLLMENT:

Answer the two required questions.

Your answers will cause the page to update with custom rates applicable to your situation.

Choose desired life insurance coverage amount. If you would like an amount that is not shown, enter that amount in the Benefit Amount box and click the calculator to view the premium.

Press NEXT on the bottom right-hand corner of the screen to continue.

Insurance for Spouse Test

Spouse Employment Status. To the best of your knowledge, does the employee's spouse work now, for wage or profit, and has he/she worked at least 20 hours each week performing all duties of his/her regular occupation at his/her regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?

Is there any other individual life insurance in force or applied for on the proposed insured?

Biweekly Deduction	Benefit Amount
<input type="radio"/> \$18.12	10,000
<input checked="" type="radio"/> \$36.25	50,000
<input type="radio"/> \$72.50	75,000
<input type="radio"/> \$109.25	100,000
<input type="radio"/> \$145.75	150,000
<input type="radio"/> \$182.25	200,000
<input type="radio"/> \$218.75	250,000

Biweekly Deduction: [Calculator](#)

Benefit Amount: [Calculator](#)

Base Policy \$95.57

Application riders

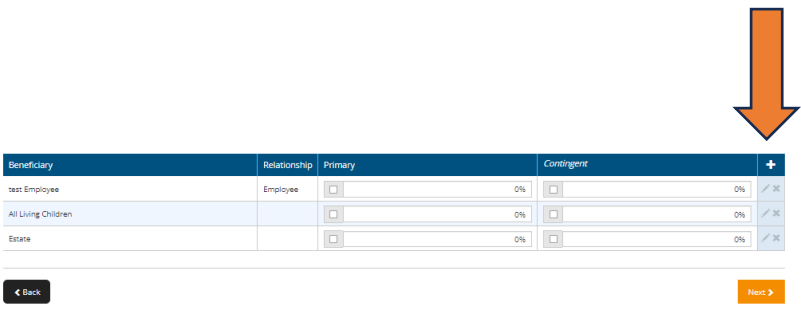
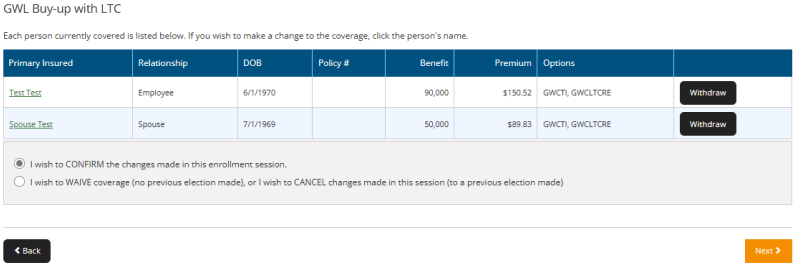
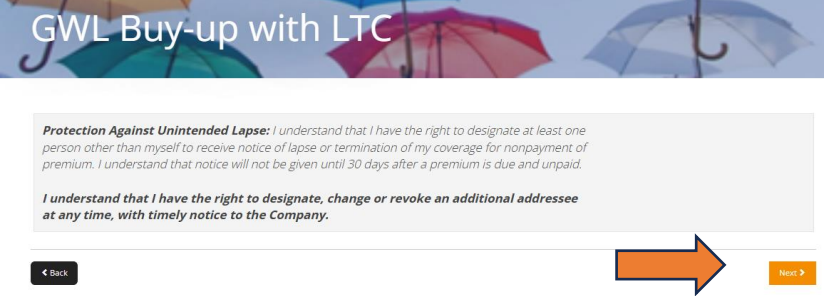
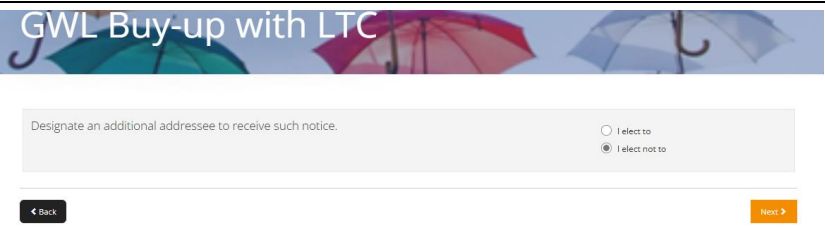
☒ Accelerated Death Benefit for Terminal Illness or Condition

☒ Accelerated Death Benefit for Long Term Care with Restoration and Extension of Benefits

Total Premium: **\$95.57**

☒ I wish to apply for this coverage
☐ I wish to DECLINE this coverage

[Back](#) [Next](#)

Instructions	Screen Shot
<p>ASSIGN SPOUSE BENEFICIARIES:</p> <p>You can add additional people to be beneficiaries – just click the + icon.</p> <p>If primary and contingent beneficiaries are not alive at time of claim, payment will be made to the estate.</p> <p>Press NEXT on the bottom right-hand corner of the screen to continue.</p>	
<p>CONFIRM ELECTIONS:</p> <p>This screen shows you the coverage you selected for yourself and spouse that is EMPLOYE PAID. If you change your mind about any of them, click WITHDRAW. If correct, click NEXT.</p>	
<p>PROTECTION AGAINST UNINTENDED LAPSE:</p> <p>Read the section.</p> <p>Press NEXT on the bottom right-hand corner of the screen to continue.</p>	
<p>DESIGNATE ADDRESSEE TO RECEIVE UNINTENDED LAPSE NOTICE:</p> <p>Make your selection.</p> <p>Press NEXT on the bottom right-hand corner of the screen to continue.</p>	

Instructions

ADDITIONAL QUESTIONS:

Answer the additional questions.

Press NEXT on the bottom right-hand corner of the screen to continue.

Screen Shot

GWL Buy-up with LTC

Accelerated Death Benefit for Long Term Care

Is this rider to replace or change any existing long term care coverage or life insurance coverage including accelerated death benefits?

Test Text ☐ Yes ☐ No

Spouse Test ☐ Yes ☐ No

I understand that by electing this coverage, I have read and agree my answers to EACH of the below questions is "NO".

I understand that if my answer to ANY of the below questions is "YES", I will waive my Alistate Benefits coverage on this enrollment and proceed with my coverage election by calling Alistate Benefits at 866-991-0917.

I confirm my answer to EACH question below is "NO":

Do you have another long term care insurance policy, certificate or rider in force (including health care services contract or health maintenance organization contract)?

Did you have another long term care insurance policy, certificate or rider in force during the last 12 months?

Are you covered by Medicaid?

Accelerated Death Benefit for Long Term Care Rider Checklist. You will receive the following documents as part of this enrollment:

- Accelerated Death Benefit for Long Term Care Rider Outline of Coverage
- Accelerated Death Benefit for Long Term Care Rider Summary and Disclosure Statement
- Summary of Accelerated Death Benefit for Long Term Care Rider
- Important Notice to Applicant
- Notice to Applicant Regarding Replacement of Long-Term Care Insurance or Life Insurance Including Accelerated Death Benefits

This contract for long term care rider is not intended to be a federally qualified long term care insurance contract.

Test Text

Spouse Test

List all accident and health or sickness insurance policies which you have sold the applicant.

Test Text

Spouse Test

List all accident and health or sickness insurance policies you sold to this applicant which are still in force.

Test Text

REPRESENTATION & EMPLOYMENT STATUS:

If you agree, click "I Agree".

Press NEXT on the bottom right-hand corner of the screen to continue.

GWL Buy-up with LTC

REPRESENTATION. I have read or had read to me this completed form. I represent that statements and answers given on this form are representations, not warranties, and are true, complete, and correctly recorded to the best of my knowledge and belief.

☐ I Agree

EMPLOYEE EMPLOYMENT STATUS. I certify that I work now, for wage or profit, and I have worked at least 20 hours each week performing all duties of my regular occupation at my regular place of employment for at least the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy.

Fraud Warning Notice: 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.

Caution: If your answers on this application are misstated or untrue, AHL may have the right to deny benefits or rescind your Accelerated Death Benefit coverage, if applied for.

< Back

Next >

SIGN AND SUBMIT:

If you are satisfied with your choices, press NEXT on the bottom right-hand corner of the screen to electronically sign the forms.

If you wish to make any changes to your elections, click on the benefit plan name GWL BUY-up with LTC.

Sign and Submit

Here is a recap of your enrollment elections. The summary below shows your election for each benefit and includes your pre-tax and post-tax contributions **per pay period** for each plan.

- **Are You Satisfied With Your Elections?** If you are satisfied with your choices, click on the "NEXT" button at the bottom of this screen to sign your Enrollment Certification Form electronically using your PIN.
- **Need to Make Some Changes?** If you wish to make any changes to your elections, click on the benefit plan name in the menu on the left.

Your Benefits

Plan	Description	Employee Pre-tax	Employee Post-tax	Employer Paid
GWL BUY-up with LTC - Employee Only	AB Group Whole Life (GWL) - Option 1 (BE paid) EO	\$0.00	\$0.00	\$16.73
GWL BUY-up with LTC	AB Group Whole Life (GWL) - Option 2 (BE paid) EO	\$0.00	\$190.52	\$0.00
GWL BUY-up with LTC	AB Group Whole Life (GWL) - Option 2 (BE paid) SO	\$0.00	\$89.03	\$0.00
Total		\$0.00	\$240.25	\$16.73

Signatures Required

To complete your enrollment, you must sign the following forms. Press Next to begin signing forms.

Form Name	Status	Date Signed/Revised	Electronic Date Signed/Revised
ABCT-BENCA	Unsigned		
ABCT-BENCA	Not Reviewed	N/A	N/A
ABCT-BENCA	Not Reviewed	N/A	N/A
ABCT-BENCA	Unsigned		
ABCT-BENCA	Not Reviewed	N/A	N/A
ABCT-BENCA	Not Reviewed	N/A	N/A
ABCT-BENCA	Unsigned		
ABCT-BENCA	Not Reviewed	N/A	N/A
ABCT-BENCA	Not Reviewed	N/A	N/A
ABCT-BENCA	Not Reviewed	N/A	N/A
ABCT-BENCA	Not Reviewed	N/A	N/A
ABCT-BENCA	Unsigned		

Instructions

REVIEW AND SIGN FORMS

After reviewing each form, click on the box to place a checkmark next to each.

Click SIGN FORM

Screen Shot

Review / Sign Forms

Your enrollment will not be complete until you review and sign the forms listed below. By entering your electronic signature below, you are giving your consent to the electronic signature (e-signature) process and authorization to use electronic records and electronic signatures connected with your enrollment. If you decline the e-signature process, you will not be able to complete your enrollment electronically.

Please review each document carefully and place a checkmark next to each before signing.

Form Name
<input checked="" type="checkbox"/> AB21526-1 SUMMARY AND DISCLOSURE STATEMENT
<input checked="" type="checkbox"/> AB21526-1 SUMMARY AND DISCLOSURE STATEMENT
<input checked="" type="checkbox"/> AB21526 SUMMARY AND DISCLOSURE STATEMENT
<input checked="" type="checkbox"/> AB21526 SUMMARY AND DISCLOSURE STATEMENT
<input checked="" type="checkbox"/> PLMS&S

Employee: By clicking the Sign Form button, I am electronically signing the form listed above.

Sign Form

Next >

SIGNATURE REQUIREMENTS:

This is your Benefit Confirmation. You may click DOWNLOAD FORM to keep a copy.

To sign, click enter your login PIN in the box.

Benefit Verification / Deduction Confirmation

Name	SSN	Employee ID	Date of Hire	Reason for Completing Form
Test Test	XXX-XX-8465	0	01/01/2024	Open Enrollment

Location	Department	Job Class	Pay Mode
Headquarters	Default	FT	24

Work Phone	Home Phone	E-mail

Address	
1234 Street	San Francisco, CA 664464546

Benefit Deduction Summary

Plan	Product	Cvg	Benefit Amount	Ded. Cycle	Employer Cost	Employee Pre-tax Cost	Employee Post-tax Cost
GWL with LTC - Employer	AB Group Whole Life (GWL) -	EO	10,000	24	16.73	0.00	16.73
GWL Buy-up with LTC	AB Group Whole Life (GWL) -	EO	90,000	24	0.00	0.00	0.00
GWL Buy-up with LTC	AB Group Whole Life (GWL) -	SO	50,000	24	0.00	0.00	0.00

Download Form

Please enter your PIN/Password below and click on "SIGN FORM" to complete your enrollment and submit your elections. By entering your PIN/Password, you are electronically signing the Benefit Verification/Payment Confirmation Form above. Please review it carefully before entering your PIN/Password.

PIN:

Sign Form

FINAL SCREEN:

This is the final screen. You can always log back in during enrollment to make changes.

Congratulations!

Your enrollment is now complete. You may log-in to the system at any time during the year to review your benefit elections.

Recap of Your Elections

Listed below is a recap of your elections including who is covered under each benefit plan and your named beneficiaries. Scroll down to the bottom of this screen to view a list of your completed enrollment forms.

GWL with LTC - Employer Paid

Enrollment Details

Person Name	Relationship	Description	Policy #	Cost
Test Test	Employee	AB Group Whole Life (GWL) - Option 1 (ER paid); EO		\$0.00

Beneficiary Information

Name	Relationship	Address	Phone	Percent	Type
Spouse Test	Spouse	1234 Street, San Francisco, CA 664464546		100.00	Primary

GWL Buy-up with LTC

Enrollment Details

Person Name	Relationship	Description	Policy #	Cost
Test Test	Employee	AB Group Whole Life (GWL) - Option 2 (EE paid); EO		\$150.52
Spouse Test	Spouse	AB Group Whole Life (GWL) - Option 2 (EE paid); SO		\$89.83

Beneficiary Information

Name	Relationship	Address	Phone	Percent	Type
Spouse Test	Spouse	1234 Street, San Francisco, CA 664464546		100.00	Primary

Name	Relationship	Address	Phone	Percent	Type
Test Test	Employee	1234 Street, San Francisco, CA 664464546		100.00	Primary