Dear Policyholder:

It is a pleasure to welcome you as a new policyholder of the Life Insurance Company of North America (LINA), a New York Life Company. We are pleased to provide the coverage for your New Jersey Temporary Disability Benefit (TDB) program.

The Following Forms are enclosed for your records:

- The master policy and any modifying Endorsements (Endorsement #1)
- A copy of the signed New Jersey DP-1 Form for your records
- A Notice of Your Employer's New Jersey Temporary Disability Benefit Plan and any modifying Endorsements (Endorsement #2). These documents are to be posted conspicuously at the site of your place of business.

If you have any questions or if you need assistance, please contact your Account Manager or Account Service Representative.

Very truly yours,

Scott Berlin, President

PRIVATE PLAN NO.
199-76670

State of New Jersey
Department of Labor &
Workforce Development
Division of
Temporary Disability Insurance
Private Plan Operations

EMPLOYER IDENTIFICATION NO.
0824217215-000-00

CERTIFICATE OF MODIFICATION OF PRIVATE PLAN

This is to certify that Private Plan No. ***199-76670*** approved for:

THE KEY MANAGEMENT LLC
7777 Fay Ave
La Jolla, CA 92037

has, on the basis of a notification received November 22, 2024
been modified as to the:

[X] Contribution provisions

[X] Benefits provisions

[ ] Classes of workers covered

[X] Insurer

[ ] Other provisions of the plan ( )

effective January 1, 2025

THIS PRIVATE PLAN COVERS: All Employees

DIVISION OF TEMPORARY DISABILITY INSURANCE

Charyl Yarbrough

Charyl Yarbrough
Assistant Commissioner

Date: November 29, 2024

By: Griet Medrano

Griet Medrano, Examiner

cc: Life Insurance Company of North America- ATTN: Shawna Green

DP-5C

NOTICE OF YOUR EMPLOYER'S NEW JERSEY TEMPORARY DISABILITY BENEFITS PLAN

Insured By New Jersey Temporary Disability Benefits Policy issued to

Employer: TheKey Management, LLC

Employer Registration No.: 82-4217215 Private Plan No.: 199-76670

by the
LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PENNSYLVANIA

This plan provides the benefits described below, for each period that an insured employee is Disabled. The benefits payable to the insured employee are in the same amount and for the same duration as such insured employee would receive if covered by the State Plan established by the New Jersey Temporary Disability Benefits Law.

ELIGIBILITY

Effective January 1, 2025 you will not be eligible unless you have either:

a) earned at least $303 per week for 20 total weeks; or
b) earned at least $15,200

within the Base Year prior to the week you submit a claim for benefits. You will not be eligible if you have been unemployed for 2 weeks or more.

CONTRIBUTIONS

You will not be required to contribute more than **0**.23**%** of the first $165,400 of your wages during **2025**.

DISABILITY OPTIONS

If you become Disabled while you are covered, we will pay:

Effective January 1, 2025, 85% of your Average Weekly Wage to a maximum of $1,081 subject to a maximum of 70% of the statewide Average Weekly Wage.

We will pay 1/7 of this amount for each day of a partial week that you are Disabled, with the total rounded down to the nearest dollar.

You will be deemed "Disabled" if you cannot do all the duties of your job.

We will pay this benefit until the first of these things happens:

a) We have paid benefits for 26 weeks; or We have paid 1/3 of your total wages (rounded down to the nearest dollar) earned in the 52 weeks before you became Disabled; or
b) You are no longer Disabled.

We will treat several periods of disability as one period, if:

a) They are due to the same or related causes; and
b) They are separated by less than 14 days.

To figure your "Average Weekly Wage" divide your total wages earned from your most recent covered employer during the "Base Weeks" in the "Base Year" immediately prior to the calendar year in which the period of disability began, or in which you submit a claim for benefits.

Base Week means any calendar week (Sunday through Saturday) in which you earned at least $303.

Base Year is the first four of the last five completed Calendar Quarters immediately prior to the disability. Calendar Quarter means a period of three consecutive calendar months ending on March 31, June 30, September 30 or December 31.

If you do not have sufficient qualifying weeks or wages in your Base Year to qualify for benefits, then an Alternative Base Year may be used to determine your Average Weekly Wage. "Alternative Base Year" is defined as:

1) The last four completed Calendar Quarters immediately prior to the period of disability, except if you do not have sufficient qualifying weeks or wages in the last four completed quarters, or
2) The last three completed Calendar Quarters immediately prior to the period of disability."

Average Weekly Wage means, the amount derived by dividing your total wages earned from your most recent employer during the Base Weeks in the Base Year immediately preceding the calendar week in which the period of disability began, or in which you submit an advance claim, pursuant to R.S. 43-21-49(a)(3), for the benefits by the number of Base Weeks.

If the above computation is less than your average weekly earnings in employment with all covered employers during the 26 calendar weeks before you became Disabled, then the "Average Weekly Wage" will be based on earnings from all covered employers during those 26 calendar weeks.

Effective on and after June 17, 2020

Partial Return To Work

During a period of disability and at the option of your employer, you may return to work for your employer on a reduced basis while recovering from the disability. The Insurance Company will consider such disability to be part of the original disability for which Temporary Disability Benefits are paid and will apply the same terms, provisions and conditions that were used for the original disability, subject to the terms of the Partial Return To Work provision.

To be eligible for a Partial Return To Work Benefit, you must meet the following conditions:

a) Have been unable to perform the duties of your employment due to Disability and received full benefits under the policy for at least 7 consecutive days prior to returning to work on a reduced basis; and
b) The employer must grant permission for you to return to work on a reduced basis.

If these conditions are met, the benefit amount payable for Partial Return To Work will be equal to the wages you earned during the week subtracted from the Temporary Disability Benefit you would have received, if you had not returned to work, rounded down to the next multiple of $1.00.

The maximum duration of partial benefits paid during a period of disability when you return to work on a reduced basis will be 8 weeks, unless the Insurance Company, after a review of medical documentation from a Qualified Healthcare Provider, approves in writing an extension beyond 8 weeks. The duration will not be extended beyond a 12 week period.

In no event will weekly benefits for each period of disability exceed the maximum benefit duration of 26 weeks.

If you are able to return to work on a reduced basis, but the employer is unable or otherwise chooses not to permit you to do so, you will continue to be eligible for disability benefits until you are fully recovered from the disability and able to perform the duties of your employment.

For purposes of this provision, Qualified Healthcare Provider means:

a) a legally licensed physician;
b) dentist;
c) podiatrist;
d) chiropractor
e) certified nurse midwife;
f) advanced practice nurse; or
g) public health nurse designated by the division.

LIMITATION ON BENEFITS

Waiting Week - We will not pay benefits for the first 7 straight days that you are Disabled. This does not apply if you are Disabled:

a) for at least 3 straight weeks more; or
b) for at least 26 total weeks for that disability; or
c) due to donating an organ or bone marrow.

Other Compensation - If you receive any other money from your employer while you are Disabled, we will not pay more than your weekly wage right before you were Disabled, minus any such money paid by your employer.

EXCLUSIONS

We will not pay benefits:

a) While you are not under the care of a legally licensed physician, dentist, optometrist, podiatrist, practicing psychologist, advanced practice nurse, certified nurse midwife, or chiropractor, who, when requested by the division, shall certify within the scope of the practitioner's practice, your disability, the probable duration thereof, and, where applicable, the medical facts within the practitioner's knowledge; or
b) If you become Disabled as a result of injury to yourself done by you on purpose; or injury received while you were committing a crime of the first, second, third, or fourth degree; or for any period during which you would be disqualified for unemployment compensation benefits for gross misconduct under subsection (b) of R.S.43:21-5; or
c) While you are doing any work for wage or profit, except as provided in the "Partial Return To Work" provision; or
d) If you were disqualified for unemployment compensation (under Section 43:21 - 5(d), of the New Jersey Revised Statutes) before you became Disabled; or
e) If the weekly amount which together with any remuneration you continue to receive from the employer exceeds regular weekly wages immediately prior to disability.

NON-DUPLICATION OF BENEFITS

We will not pay benefits for any period for which you get or may claim benefits from any of the sources listed below.

a) Any unemployment compensation or similar law.
b) Any disability or cash sickness benefit or similar law.
c) Any Workers Compensation Law or occupational disease law, except for benefits for a permanent partial or total disability which you suffered previously. In case any such benefits are awarded for a period for which we paid you these benefits, then we shall receive your rights to such award, up to the amount that we paid.

Exceptions to the provision above: We will reduce the amount paid or payable under the Temporary Disability Benefits Law by the benefits payable by these programs if a claimant is eligible for or receiving benefits under:

a) a disability benefit law of another state; or
b) a disability or cash sickness program known as maintenance and cure as provided under the federal maritime law commonly referred to as the Jones Act.

Any benefits that we pay will be reduced by amounts paid at the same time by any retirement, pension or permanent disability benefit plan or allowance program to which your employer contributed on your behalf. This applies to both government and private plans.

PAYMENT OF CLAIMS

Notice of Claim - If you become Disabled, you (or someone on your behalf) must send us written notice within 30 days, or as soon after that as is reasonably possible. This notice should include your name, your employer's name and policy number. Send this notice to us at our home office in Philadelphia, Pa., or to an agent authorized by us. We will then send you claim forms.

Proof of Loss – When we receive notice of claim, the Insurance Company will send claim forms for filing proof of loss. Proof of loss must be sent back to us not more than 90 days after the end of a covered period of disability, or as soon after that as is reasonably possible. We will send claim forms to you upon receipt of your notice of claim. If you do not receive the claim forms within 15 days of our receipt of your notice of claim, you can meet the proof requirements by submitting, within the time required, written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of the nature and extent of the loss. This proof must include written proof of the occurrence, type and amount of the loss.

Payment of Claims - We will pay benefits when we receive due proof of loss. Benefits will be paid every week, every 2 weeks, or as often as you are usually paid by your employer. Any amount due at the end of the covered period will be paid as soon as we receive due proof of loss.

We will pay you if you are living. Otherwise, we will pay your spouse or civil union partner (including a civil union partner in a same-sex relationship from another jurisdiction that provides substantially all of the rights and benefits of marriage), if living. Otherwise, we will pay your estate.

Physical Examinations - We may have you examined as often as reasonably necessary while a claim is pending, but not more than once a week.

Legal Actions - You may not sue for benefits less than 60 days nor more than 3years after the date claim forms are due. This does not affect in any way your right of appeal under the New Jersey Temporary Disability Benefits Law. If you can't agree with your employer or us as to the benefits we will pay, you may file a complaint in writing within 1 year after the start of the period for which you are claiming benefits. Complaints must be sent to:

NJ Department of Labor and Workforce Development, Division of Unemployment and Temporary Disability Insurance, Disability Insurance Services
P.O. Box 957
Trenton, New Jersey 08625-0957

ADVANCE CLAIM SUBMISSION

If you know of an anticipated period of disability, in advance, you may provide proof of loss prior to, but not more than 60 days before, the date the period of disability begins. If you provide satisfactory proof of loss, the Insurance Company will start the benefit payment as of the date the benefit begins.

If the Insurance Company is unable to make a determination of your claim, you will be advised prior to the first date of disability as to what additional information is needed. In this instance, you will be given the opportunity to resubmit your claim. If you provide proof of loss less than 30 days before the period of disability begins, the Insurance Company will begin your benefit payments within 30 days of receipt of satisfactory proof of loss.

OVERPAYMENT/REFUNDS

An overpayment occurs when the Insurance Company determines that the total amount paid in benefits is more than the amount that was due to you under the policy.

According to New Jersey Disability Law, if the overpayment results because of an error made by the employer, physician, or the Insurance Company and you did not knowingly misrepresent or withhold any material fact to obtain the benefits, the following limits apply:

1) the amount withheld from any subsequent benefit check shall be an amount not greater than 50% of the amount of the check; and
2) any refunds of overpayments will be waived in cases where you are permanently Disabled or deceased.

JOB PROTECTION

Your employer shall not discharge, harass, threaten or otherwise discriminate or retaliate against you, with respect to your compensation, terms, conditions, or privileges of employment, on the basis you requested or took any temporary disability benefits, including retaliation by refusing to restore your employment following a period of leave.

Upon a violation of this paragraph, you or a former employee may institute a civil action in the Superior Court for relief.

THIS NOTICE MUST BE POSTED CONSPICUOUSLY AND CONTINUOUSLY AT THE EMPLOYER'S PLACE OF BUSINESS

LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA.
A NEW YORK LIFE INSURANCE COMPANY,
herein called the Company

IN CONSIDERATION of the payment of the premium and in reliance upon the statements contained in the application, a copy of which forms a part hereof, the Company agrees with the employer named in the application, subject to the terms of this policy, as follows:

PART I. Benefits. The Company will afford the coverage and pay the disability benefits to which any employee would be entitled because of employment within any insured class as stated in item 2 of the application while this policy applies to such class, if he were covered under the State Plan, as defined in Article III and limited in Section 6 of the Temporary Disability Benefits Law of the State of New Jersey, hereinafter called "said law". Said law shall include any laws amendatory thereof or supplementary thereto which are or may become effective during the policy term.

This policy provides benefits in accordance with a private plan established by the employer pursuant to said law. If because of a period of disability an employee becomes entitled to benefits hereunder, the employee shall not be paid less per week, nor for fewer weeks, than he would be entitled to be paid under said law for said disability were the employee not covered under any private plan; provided, the maximum amount payable hereunder in any twelve month period shall not be more than the employee would have been entitled to receive had such employee been covered by the State Plan during said twelve month period and, if an employee is in concurrent employment with two or more employers having private plans, the Company will pay to the employee its pro rate share of benefits in accordance with regulations applicable to concurrent coverage. The maximum total benefits payable to the employee in any 12 month period under said law shall be applicable separately to each period of disability.

PART ll. PAYMENT OF ASSESSMENTS. The Company agrees to pay all assessments which may be levied against the employer in accordance with the provisions of said law, but only to the extent that such assessments are based upon wages paid by the employer to employees insured under this policy while this policy is in full force.

PART lll. EMPLOYEE CONTRIBUTIONS. No greater contribution shall be required of any employee toward the premium for this insurance than the amount he would have to contribute to the New Jersey State Disability Benefits Fund were he insured thereunder.

PART lV. PREMIUM. The premium for this policy shall be computed on the basis stated in item 5 of the application. On the first day of each calendar quarter after the effective date of this policy, premium shall become due for the insurance provided during the previous calendar quarter. The amount of premium due on each such premium due date shall be determined by applying the premium rate then in effect to the total wages subject to unemployment insurance taxes for the previous calendar quarter (excluding wages over $156,800 per calendar year) as reported to the Division of Employment Security of the Department of Labor and Industry of New Jersey, hereinafter called "the Division." If this policy was not in effect for the full calendar quarter, the premium computed in accordance with the foregoing shall be prorated for the period this policy was in effect. The employer shall determine the amount of each premium due and shall remit such amount in full to the Company or to its authorized agent, together with a complete copy of each quarterly report made to the Division. A period of grace of thirty days following the premium due date shall be allowed the employer for the payment of any premium. The Company reserves the right to establish new premium rates at the end of any policy year or whenever the terms of this policy are changed or whenever the Company's obligations under this policy are increased by reason of any amendment to said law or authorized regulations thereunder.

PART V. POLICY TERM. This policy is effective on the effective date stated in item 4 of the application and shall continue until terminated in accordance with the terms hereof. This policy applies only to disability commencing while this policy is in force, except as provided in section 8 (e) of said law.

PART VI. TERMINATION. This policy shall automatically terminate when the employer terminates the private plan covered hereunder or when the Division withdraws approval of said plan.

If during any 12 months period ending not less than 3 months or more than 12 months prior to any renewal date the sum of all benefits paid or payable under Part 1 of this policy exceeds 60% of the premium earned by the Company during such period or if the Company's obligations under this policy are increased by reason of any amendment to said law or authorized regulations thereunder, the Company may terminate this Policy as of the next renewal date by giving 60 days written notice to the employer at the address stated in this policy and to the Division.

If any premium remains unpaid at the expiration of the grace period, the Company may terminate this Policy by written notice to the employer at the address stated in this policy and to the Division. Such termination shall be effective on the fifteenth day after such notice is received by the Division or on the date of termination stated in such notice, whichever is the later. The employer shall be liable to the Company for the premium for the period this policy is in force after the due date of any such defaulted premium.

The insurance of an employee insured hereunder shall terminate automatically immediately upon the earliest of the following dates: (a) the date this Policy terminates provided the employee is in employment with the Employer on the date of termination of the policy; if an employee has terminated his employment with the Employer prior to the termination of this policy his insurance under this Policy shall terminate at the expiration of a period of two weeks immediately following the date of termination of his employment with the employer; (d) the date following termination of his employment with the Employer on which he becomes employed by another covered employer.

PROVISIONS

1. No statement made by the applicant for insurance shall avoid the insurance or reduce benefits hereunder, unless contained in the written application signed by the applicant. No agent has authority to change this policy or to waive any of its provisions. No change in this policy shall be valid unless approved by an officer of the Company and such approval be endorsed hereon.

2. This policy, the Application of the employer, copy of which forms a part hereof, and the individual applications, if any, of the employees constitute the entire contract between the parties. No provision of the charter constitution or by-laws of the Company shall avoid this policy or be used in defense of any claim hereunder unless such provision is incorporated in full in this policy.

3. All Statements of the employer and employees contained in any such application for insurance shall be deemed representations and not warranties.

4. All new employees, in the groups or classes insured under this policy, shall be added to such groups or classes.

5. The Company shall furnish the insured employees with reasonable notice of the benefits provided by this policy either by direct notification or by conspicuous posting at the place of their employment.

6. Written notice of injuries, sickness or disease shall be given to the Company within thirty days after the commencement of disability from such injuries, sickness or disease.

Such notice given by or in behalf of the employee to the Company, or to any authorized agent of the Company, with particulars sufficient to identify the employee shall be deemed sufficient notice to the Company. Failure to give such notice within such time shall not invalidate nor reduce any claim if it be-shown not to have been reasonably possible to give such notice and that such notice was given as soon as was reasonably possible.

7. The Company upon receipt of such notice, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not so furnished within fifteen days after the receipt of such notice, the person making such claim shall be deemed to have compiled with the requirement of this policy as to proof of loss upon submitting within the time fixed in this policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim it made.

8. Written proof of such loss shall be furnished to the Company at its said office, within ninety days after the termination of the period of disability for which the Company is liable. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

9. The Company shall have the right and opportunity to examine the person of the insured employee when and so often, but not more than once a week, as it may reasonably require during the pendency of claim under this policy.

10. Subject to due proof of loss, all accrued benefits payable under this policy will be paid weekly, bi-weekly or as often as the employee is customarily paid his wages or salary during the continuance of the period for which the Company is liable, and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

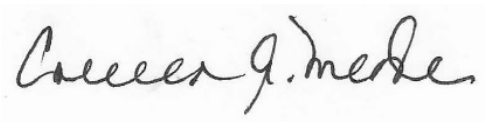
11. All indemnities under this policy are payable to the employee, provided, if at his death any indemnities are due as unpaid, such indemnities are payable to the surviving spouse or, it there be no surviving spouse, to the estate of the employee.

12. No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of this policy, and no such action shall be brought at all unless brought within two years after the expiration of the time within which proof of loss is required by this policy. This provision does not affect in any way an employee's right of appeal under the New Jersey Temporary Disability Benefits Law.

13. All books and records of the employer containing information pertinent to this insurance shall be open to examination by the Company during the policy term and within one year after the termination of this policy.

IN WITNESS WHEREOF, The LIFE INSURANCE COMPANY OF NORTH AMERICA has caused this policy to be signed by its President and Secretary at Philadelphia, Pennsylvania, and countersigned by a licensed resident agent of the Company.

Secretary,



Colleen J. Meade, Corporate Secretary

President,

Scott Berlin, President

Countersigned.....

Licensed Resident Agent

LIFE INSURANCE COMPANY OF NORTH AMERICA
ENDORSEMENT #1

Part I. Benefits is amended as follows:

1. The maximum duration of benefits for any individual shall be 26 weeks for each period of disability.

2. Employee contributions are not required.

Effective Date: January 1, 2025 Policy No: SDJ980172
Issued to: TheKey Management, LLC

President

LG-5134a

LIFE INSURANCE COMPANY OF NORTH AMERICA
ENDORSEMENT #2

It is hereby understood and agreed that the Poster Notice for this Private Plan is amended as follows:

1. You are not required to contribute toward the cost of your insurance.

2. The following statement replaces the "number of weeks payable" clause under the section entitled, "Disability Benefits":
   We will pay this benefit until the first of these things happens:
   a) We have paid benefits for 26 weeks; or
   b) You are no longer disabled.

Effective Date of Coverage: January 1, 2025 Policy No: **SDJ980172**

Issued to: TheKey Management, LLC

President

LG-5134a

ORIGINAL
TO BE SUBMITTED TO THE
DIVISION OF
TEMPORARY DISABILITY INSURANCE
PO BOX 957
TRENTON, NEW JERSEY 08625-0957

DP-1 (R-01-23)
STATE OF NEW JERSEY
DEPARTMENT OF LABOR
DIVISION OF TEMPORARY DISABILITY INSURANCE
APPLICATION FOR
APPROVAL OR MODIFICATION OF INSURED PRIVATE PLAN

82-4217215
New Jersey Employer Identification Number

SDJ980172
Private Plan Number

1. **CHECK ONE :** ☐ **Approval** is requested for an insured Private Plan

☒ **Modification** is requested for the insured Private Plan indicated above

to provide New Jersey Temporary Disability Benefits effective 1/1/25,
(Date Effective)

as described below and in accordance with the details attached for the employees of:

TheKey Management, LLC
(Name of Employer - exactly as registered with the NJ Department of Labor)

7777 Faye Ave Suite 210 La Jolla, CA 92037
(Employer's Address - Street, City, State, ZIP Code)

(760) 690 7380
(Employer's Phone Number)

2. The policyholder, if other than employer named in Item 1 above, will be:

(Policyholder's Name)

(Policyholder's Address - Street, City, State, ZIP Code)

3. Any and all notices or communications ***to the employer*** may be served by mail, addressed to the following designated person as the duly authorized representative of the above-named employer:

Representative's Name: Maria Cobb Representative's email: maria.cobb@thekey.com

Representative's Title: Senior Manager, Benefits Department email: n/a

7777 Faye Ave Suite 210 La Jolla, CA 92037
(Authorized Mailing Address - Street, City, State, ZIP Code)

(760) 690 7380
(Representative's Phone Number)

4. The Plan will cover:

(a) ☒ All covered employees of the employer. Number of New Jersey employees: 432

(b) ☐ Other (describe classes covered) _____
If more space is required, attach a separate sheet.

If option (b) is selected above, Form DP-1A must be attached to show excluded classes of employees.

5. The contributions required of employees covered by the Private Plan will be:

CHECK ONE:
(a) ☐ Statutory percentage of taxable wages, *(amount set annually by Law)*
(b) ☐ Other ____**%** of statutory taxable wage base *(must be less than statutory)*
(c) ☒ None. Employees were informed on 10/25/24 that no deductions would be taken for New Jersey Temporary Disability Benefits.

Method used: 1. ☒ Written Notice 2. ☐ Verbal Notice 3. ☐ Bulletin Board Notice
4. ☐ Other _____

Complete this section ONLY if the plan is contributory and covers members of a Collective Bargaining Agreement.

6. Employees' election: Employees' agreement to establishment or modification of the Plan (**Required** if employees contribute to the cost of the Plan, unless, in the case of a modification, such modification does not include either a reduction in the amount or duration of benefits or an increase in the rate of employee contributions.)

(a) Date election was held: ____
(b) Total number of employees required to contribute to the Private Plan: _____
(c) Number of employees in Line (b) agreeing to the Private Plan: _____

The original records of the election are submitted with this application.

(After being recorded by the Division of Temporary Disability Insurance, they will be returned to the employer, who shall retain them during the existence of the Plan and make them available for inspection by any authorized representative of the Division.)

If more space is required to complete any section, attach a separate sheet.

7. In each category, select the option *(check only one in each category)* that best describes the Plan you choose.

The benefits provided by the Plan, payable in accordance with the details attached, will be as follows:

CATEGORY A – Weekly Benefit Amount

- [x] Statutory – 85% of employee's average weekly wages, up to the maximum set for that calendar year
- [ ] Other (explain) _____

CATEGORY B – Limitations

- [x] Statutory - All provided by NJSA 43:21-39 of the NJ Temporary Disability Benefits Law
- [ ] Other (explain) _____

CATEGORY C - Eligibility Requirement

- [x] Statutory - 20 base weeks or 1,000 times the State minimum wage
- [ ] Other (explain) _____

CATEGORY D – Maximum Duration of Benefits for Each Period of Disability

- [ ] Statutory - The lesser of 26 times the weekly benefit amount or 1/3 total wages in base year *(the lesser)*
- [x] Enhanced - 26 weeks for each period of disability
- [ ] Other (explain) _____

CATEGORY E – Benefit Commencement for Each Period of Disability

- [x] Statutory – The first seven days of payment is held until the employee's unpaid leave continues for a total of 22 days or more. Upon that condition, the first seven days become payable retroactively
- [ ] Enhanced - On the first day with respect to any period of disability
- [ ] Other (explain) _____

GUARANTEED MINIMUM BENEFITS: Anything in this Plan to the contrary notwithstanding, the benefits payable to any employee for any period of disability commencing while insured hereunder, shall not be less than the employee would have been entitled to receive for such period under Article III of the NJ Temporary Disability Benefits Law, but for the employee's coverage under this Plan.

8. The undersigned employer agrees to the establishment of the above Private Plan in accordance with the New Jersey Temporary Disability Benefits Law.

(Note: Pursuant to the NJAC 12:18-2.9(b), if an employer provides disability benefits through a multi-benefit plan that does not comply with the New Jersey Temporary Disability Benefits Law, the employer shall establish a separate plan, maintained solely for the purpose of complying with the provisions of the Law.)

Employer's Signature: Signed by: Elizabeth Haight 74A3011A4063400... **Date:** 11/13/2024

Title: VP, Total Rewards *(Owner, Partner, or Corporate Officer; Pres., V.P., Secy., Treas.)* Printed Name: Elizabeth Haight

FOR INSURANCE COMPANY USE

9. Insurer's Agreement: The undersigned insurer **agrees**, upon approval by the Division of Temporary Disability Insurance of the New Jersey Department of Labor and Workforce Development, to insure the Private Plan described in this application and accompanying details, to pay the benefits referred to in Item 7 of this application, to furnish any required documentation to the Division, and to furnish a policy of insurance consistent with the provisions of the approved Private Plan. A copy of the completed policy will be submitted to the Division of Temporary Disability Insurance within **forty-five (45)** days of the date of approval of this application.

Should all notice of assessments made against the employer, be mailed to the insurer?

- [x] Yes
- [ ] No

All notices, orders, or communications to the insurer will be mailed to:

Shawna Olson *(Name)* Contracts Assoc. *(Title of Insurer Representative)*

12431 W Dreyfus Dr El Mirage AZ 85335 *(Address)*

NYL-Line *(Name of Insurer)*

Signature: Robert D. Potts *(insurer's authorized representative)* **Date:** 11.14.2024

Title: Director

No. SDJ. 980172

CLEAR FORM

APPLICATION TO
Life Insurance Company of North America

For

Group Disability Policy Insuring Under New Jersey Temporary Disability Law

To the Life Insurance Company of North America, Two Liberty Place, 1601 Chestnut Street, Philadelphia, Pennsylvania 19192: Based on the statement set forth below, the undersigned hereby applies for a group disability policy to include benefits in accordance with the private plan established by the undersigned pursuant to the New Jersey Temporary Disability Benefits Law.

Item 1. Name of Employer: TheKey Management, LLC

Address: 7777 Faye Ave Suite 210 La Jolla, CA 92037

Business: Services

Item 2. All classes of employees subject to the New Jersey Temporary Disability Benefits Law are to be insured under this policy, except the following:

Item 3. The total number of employees to be eligible for this insurance is 432 of which 383 are women.

Item 4. The effective date of this policy shall be 01/01/2025 , 12 midnight Eastern Time.

Item 5. Premium for this policy shall be computed at the rate of:
$24.75 per employee per month basis

Item 6. Previous group disability insurance carrier:
Unum

When and why terminated?
Moving insurance to New York Life

Caution: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Dated at Escondido, CA 92027 the 5.00 day of November , 2,024.00

Signed by:
Employer Signature: Elizabeth Haight
74A3011A4085400...

Title: VP, Total Rewards

CLICK TO PRINT