Northwestern Mutual®

SAMPLE DOCUMENT

DISABILITY INCOME WAGE CONTINUATION PLAN

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SAMPLE DISABILITY INCOME WAGE CONTINUATION PLAN

The following Sample Disability Income Wage Continuation Plan, in combination with an adopting Corporate Resolution, has been drafted to reflect a "C" Corporation's intention to pay (out of its general assets) continued, full salary to any Corporate Officer who suffers a total disability, with long-term disability benefits to be provided, thereafter, under the terms of a Disability Income Insurance Policy. The envisioned Disability Income Insurance Policy would provide maximum disability income insurance benefits to age 65, after a 90-day waiting period, and would be owned by the insured Officer. The premiums required to maintain such Insurance in force would be paid by the Corporation, pursuant to the terms of the Plan. The contemplated Disability Income Insurance Policy would be integrated into the Plan, by listing the Policy on the Plan's "Schedule A".

DISABILITY INCOME WAGE CONTINUATION PLAN
— Sample for the use of legal counsel only —

The *(Insert Name of Corporation; e.g.,* "ABC Company, Inc."*)*, a *(Insert State of Incorporation; e.g.,* "Wisconsin"*)* Corporation (hereinafter referred to as the "Corporation"), has established, as of this *(Insert #)* day of *(Insert Month)*, *(Insert Year)*, by appropriate Resolution of its Board of Directors, a Disability Income Wage Continuation Plan, the terms and conditions of which are, as follows:

ARTICLE ONE
EMPLOYEES COVERED BY THE PLAN

1.01 This Disability Income Wage Continuation Plan (hereinafter referred to as the "Plan") has been established for the benefit of the select group of highly-paid management employees of the Corporation who are or hereafter become members of the class of employees serving as Officers of the Corporation (hereinafter referred to individually as a "Participant" or collectively

as the "Participants"). The Plan shall cover a Participant while he or she is employed as a Corporate Officer, on a full-time basis.

1.02 A Participant shall be considered employed on a full-time basis if he or she customarily works for the Corporation at least thirty-five (35) hours per week, and at least forty-six (46) weeks per year.

1.03 Any eligible employee shall have the right to elect not to participate in the Plan. Such an election shall be made by submitting a written statement to that effect to the Plan Administrator designated, below. Upon submission of such a statement, the electing employee shall be ineligible to receive any further benefits under the Plan.

ARTICLE TWO
OPERATION OF THE PLAN

2.01 The Corporation shall, upon receiving timely, written notice from an insured Participant that such payment is due, pay the premiums necessary to maintain, in force, the Participant's personally-owned Disability Income Insurance Policy or Policies set forth on the attached Schedule A (which policy or policies shall hereinafter be referred to as the "Disability Income Insurance").

2.02 In addition to the foregoing, if a Participant is totally disabled (as hereinafter defined), the Corporation shall pay to him or her, each month, for the first three (3) consecutive months immediately following the date of onset of such Participant's total disability, an amount which (in combination with any Disability Income Insurance benefits to which the totally disabled Participant is entitled during the relevant month) will provide the totally disabled Participant with a total amount equal to his or her regular gross monthly salary immediately prior to the date of onset of such total disability. Each such monthly payment shall be paid out of the general assets of the Corporation.

2.03 For the purposes of the Plan, a Participant shall be considered to be "totally disabled" when he or she is so defined under any Disability Income Insurance being maintained for the Participant under the terms of the Plan. Such determination shall be made solely and exclusively by the insurance company (hereinafter referred to as the "Insurance Company") which has issued the subject Disability Income Insurance, and such Participant shall continue to be considered so disabled, for the purposes of the Plan, until the Insurance Company ceases to recognize him or her as being entitled to receive disability income insurance benefits for total disability under the terms of the subject Disability Income Insurance. In the event no Disability Income Insurance is being maintained for the Participant under the terms of the Plan, the Corporation shall determine if and when such Participant is "totally disabled", for the purposes of the Plan, using the definition of that term as it is set forth under the then most recently issued long-term Disability Income Insurance Policy Series Contract being offered for sale to the general public by

the ***(****Insert Name of Insurance Company; e.g.,* "Northwestern Mutual Life Insurance Company"***)***, as of the Effective Date of the Plan.

ARTICLE THREE
FUNDING POLICY AND BASIS OF PAYMENTS TO AND FROM THE PLAN

3.01 In compliance with the Employee Retirement Income Security Act of 1974 (ERISA), the following procedures for establishing and carrying out a funding policy and providing for a basis of payments to and from the Plan are hereby established.

3.02 The funding policy of the Plan shall be that all premiums required to maintain, in force, any Disability Income Insurance set forth on the attached Schedule A shall, upon receipt of timely, written notice from the covered Participant that payment is due, be paid when due.

3.03 The Named Fiduciary of the Plan shall be responsible for carrying out this funding policy by making timely delivery of any required premiums to the underlying Insurance Company. The required premiums shall be paid to said Insurance Company out of the general assets of the Corporation and shall constitute the Corporation's payments to the Plan.

3.04 The Corporation's payments from the Plan shall be provided out of the general assets of the Corporation at the time any such payments are to be made. No specific amounts therefor shall be set aside in advance or otherwise. In addition, any amounts received by a Participant directly from the Insurance Company under the terms of any Disability Income Insurance being maintained for the Participant by the Corporation under the terms of the Plan shall also constitute payments from the Plan.

3.05 Payments to Participants shall be made out of the general assets of the Corporation or from the Insurance Company under the terms of any Disability Income Insurance being maintained by the Corporation under the terms of the Plan, or both, upon the submission and approval of an insurance claim and/or a claim for benefits made pursuant to the Claims Procedure, established, as required by ERISA, and set forth, below.

ARTICLE FOUR
CLAIMS PROCEDURE

4.01 The following Claims Procedure shall control the determination of benefit payments under the Plan.

4.02 Filing of a Claim for Benefits. A Participant or beneficiary of the Plan shall make a claim for any benefit provided under the Plan in the following manner:

(1) If the benefit being claimed is provided under the Plan directly from the general assets of the Corporation, the claimant shall deliver a written request therefor (i.e., a claim for benefits) to the Plan Administrator (or such person or office as the Plan Administrator shall designate for the processing of claims). Upon receipt of such a claim for benefits, the Plan Administrator (or such person or office as the Plan Administrator has designated for the processing of claims) may require the claimant to complete such forms and provide such additional information as may be reasonably necessary to establish the claimant's right to the claimed benefit under the Plan.

(2) Any claim for a benefit being provided under the Plan by an Insurance Company shall be filed with the Insurance Company in accordance with the procedures established by it, and the Plan Administrator (or such person or office as the Plan Administrator has designated for the processing of claims) shall, upon written request of a claimant, make available copies of any claim forms or instructions provided by the Insurance Company or advise the claimant where such forms or instructions may be obtained.

4.03 Notification to Claimant of Decision. If there is an adverse benefit determination with respect to a claim for benefits provided directly from the general assets of the Corporation, the Plan Administrator (or the party to whom such authority has been delegated) shall furnish the claimant with a notice of such adverse benefit determination, meeting the requirements of paragraph 4.04, below, within a reasonable period of time, but not later than forty-five (45) days after the receipt of the claimant's claim by the Plan. If the Plan Administrator (or the party to whom such authority has been delegated) determines that matters beyond the control of the Plan require more than forty-five (45) days to process the claimant's claim for benefits, such period may be extended for up to an additional thirty (30) days, by furnishing written notice of the extension to the claimant prior to the end of the initial forty-five (45) day period, indicating the circumstances requiring the extension of time and the date by which the benefit determination is expected to be rendered. If, prior to the end of the first thirty (30) day extension period, the Plan Administrator (or the party to whom such authority has been delegated) determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within the extended period, the period for making the determination may be extended for up to an additional thirty (30) days by furnishing written notice of the extension to the claimant prior to the expiration of the first thirty (30) day extension period, indicating the circumstances requiring the extension of time and the date by which the benefit determination is expected to be rendered. Any notice of extension furnished hereunder shall include an explanation of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. Upon receipt of any notice of extension, the claimant shall be afforded forty-five (45) days within which to provide any specified information. Failure of the Plan Administrator (or such party to whom such authority has been delegated) to provide a notice of the Plan's adverse benefit determination in the specified time period shall constitute a denial of the claim

and the claimant shall be entitled to require a review of such claim and adverse benefit determination under the appeal and review procedures specified in paragraphs 4.05 and 4.06, below.

4.04 Content of Notice. The notice to be provided to every claimant who receives an adverse benefit determination under paragraph 4.03, above, shall be in writing and shall set forth, in a manner calculated to be understood by the claimant:

(1) the specific reason or reasons for the adverse determination;

(2) reference to the specific Plan provisions on which the determination is based;

(3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(4) a description of the Plan's procedure for a review of an adverse benefit determination, describing the steps to be taken by a claimant who wishes to submit his or her claim for review; the time limits applicable to such procedures; and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA, following an adverse benefit determination on review; and

(5) the following:

(a) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and

(b) if the adverse benefit determination was based on a medical necessity or experimental treatment exclusion or limit (or similar exclusion or limit), either an explanation of the scientific or clinical judgment for the adverse benefit determination, applying the terms of the Plan to the claimant's medical circumstances; or a statement that such explanation will be provided free of charge to the claimant upon request.

4.05 Appeal of Adverse Benefit Determinations. The purpose of the appeal and review procedures set forth in this paragraph and in paragraph 4.06, below, is to provide a procedure by which a claimant (or the claimant's duly authorized representative) shall have a reasonable opportunity to appeal an adverse benefit determination to an "appropriate named fiduciary" of the Plan for a full and fair review of the claim and the adverse benefit determination. To accomplish that purpose, the claimant or the claimant's duly authorized representative:

(1) may submit written comments, documents, records, and other information relating to the claim for benefits;

(2) shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and

(3) may request that the review take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

A claimant (or the claimant's duly authorized representative) may appeal an adverse benefit determination by filing a written application therefor with the appropriate named fiduciary at any time within one hundred eighty (180) days following receipt by the claimant of written notice of the adverse benefit determination. As used herein, the term "appropriate named fiduciary" with respect to a claim for benefits provided directly from the general assets of the Corporation shall be the Plan Administrator. The requested review shall be conducted in a manner that does not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual. If the claimant (or the claimant's duly authorized representative) requests, in writing, the appropriate named fiduciary shall also furnish the claimant (or the claimant's duly authorized representative) with the identity of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

4.06 Decision on Review. The benefit determination on review of a claim and adverse benefit determination shall be made in the following manner:

(1) The decision on review shall be made by the appropriate named fiduciary, who may, in his, her or its discretion, hold a hearing on the adverse benefit determination. The appropriate named fiduciary shall make his, her or its decision within a reasonable period of time, but not later than forty-five (45) days after the Plan's receipt of the claimant's request for review

(i.e., the filing of the appeal) without regard to whether all the information necessary to make a benefit determination on review accompanies the filing.

(2) Notwithstanding the preceding paragraph, in the case of a Plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, the preceding paragraph shall not apply, and the appropriate named fiduciary shall, instead, make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the Plan's receipt of the claimant's request for review, unless the request for the review is filed within thirty (30) days preceding the date of such meeting (in which case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review). If special circumstances (such as the need to hold a hearing, as authorized, above) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator shall notify the claimant of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

(3) Notification of the decision on review shall be in written or electronic form and shall include specific reason or reasons for the decision, written in a manner calculated to be understood by the claimant, as well as references to the specific Plan provisions on which the decision is based. Such notice shall also include: (a) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (b) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about the applicable rules, the claimant's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and (c) a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notification of the decision on review shall also set forth, in a manner calculated to be understood by the claimant, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request; and if the adverse benefit determination is based on a medical necessity or experimental

treatment or similar exclusion or limit, the notification of the decision on review shall also set forth, in a manner calculated to be understood by the claimant, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. The notification of the decision on review shall also include the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(4) In the event the decision on review is not furnished to the claimant within the time required, the claim shall be deemed denied on review.

4.07 Claims Procedure for Benefits Provided through Insurance. When benefits of the Plan are provided in whole or in part under Disability Income Insurance issued by an Insurance Company, the initial decision and notice of decision on a claim for benefits under the insurance policy shall be made by the Insurance Company that issued the policy in the time and manner as specified in paragraphs 4.03 and 4.04, above. Said Insurance Company shall have sole responsibility for review of and the decision on any denied claims on appeal and is hereby designated as the "appropriate named fiduciary" of the Plan for which it is the insurer for purposes of such review and final decision. The time and manner of such review and final decision shall be as specified in paragraphs 4.05 and 4.06, above.

ARTICLE FIVE
NAMED FIDUCIARY AND PLAN ADMINISTRATOR

5.01 The ***(****Insert Named Fiduciary; e.g.,* "Corporation"***)*** is hereby designated as the Named Fiduciary of the Plan, in accordance with ERISA, and shall serve in such capacity until resignation or removal by the Corporation's Board of Directors and appointment of a successor by duly adopted Resolution of such Board.

5.02 The Named Fiduciary shall have the authority to control and manage the operation and administration of the Plan.

5.03 The Named Fiduciary designated or appointed under the terms of paragraph 5.01, above, is hereby designated as the Plan Administrator of the Plan.

5.04 The Named Fiduciary, Plan Administrator, Corporation and any other named fiduciary or other persons (not named fiduciaries) who are designated to carry out fiduciary responsibilities under the Plan shall each have the discretionary authority to interpret Plan provisions and make determinations regarding Plan Participants', and beneficiaries' eligibility for and entitlement to

Plan benefits, and the Corporation intends that any such decisions be given deference by a Court.

ARTICLE SIX
ALLOCATION OF FIDUCIARY RESPONSIBILITIES

6.01 The Named Fiduciary may allocate his, her or its responsibilities for the operation and administration of the Plan, including the designation of persons who are not named fiduciaries to carry out fiduciary responsibilities under the Plan. The Named Fiduciary shall effect such allocation of his, her or its responsibilities by delivering to the Corporation a written statement, signed by the Named Fiduciary, that specifies the nature and extent of the responsibilities allocated, including, if appropriate, the persons, not named fiduciaries, who are designated to carry out fiduciary responsibilities under the Plan.

6.02 The Plan Administrator may allocate his, her or its responsibilities for the operation and administration of the Plan, including the designation of persons who are not named fiduciaries to carry out fiduciary responsibilities under the Plan. The Plan Administrator shall effect such allocation of his, her or its responsibilities by delivering to the Corporation a written statement, signed by the Plan Administrator, that specifies the nature and extent of the responsibilities allocated, including, if appropriate, the persons, not named fiduciaries, who are designated to carry out fiduciary responsibilities under the Plan.

6.03 The Corporation may allocate its responsibilities for the operation and administration of the Plan, including the designation of persons who are not named fiduciaries to carry out fiduciary responsibilities under the Plan. The Corporation shall effect such allocation of its responsibilities, through action of its Board of Directors, by adopting Resolutions specifying the nature and extent of the responsibilities allocated, including, if appropriate, the persons, not named fiduciaries, who are designated to carry out fiduciary responsibilities under the Plan.

ARTICLE SEVEN
TERMINATION OF EMPLOYMENT

7.01 In the event the employment of a Participant as a full-time Officer of the Corporation terminates, for any reason [other than as a result of his or her total disability (as previously herein defined)], the Corporation's obligations and the Participant's rights to participate and receive benefits under the Plan shall thereupon cease; provided, however, that such termination of employment shall not affect the rights of a Participant to receive benefits hereunder for any covered disability which arose prior to such termination.

ARTICLE EIGHT
EFFECTIVE DATE AND PLAN YEAR

8.01 The effective date of the Plan shall be: ***(Insert Date)***. The Plan Year shall be the calendar year (i.e., January 1 – December 31).

ARTICLE NINE
PURPOSE

9.01 It is the intention of the Corporation that the benefit payments and insurance premium contributions under the Plan shall be eligible for the income tax treatment afforded under Section 22, Section 106 and/or Section 104 of the Internal Revenue Code, as amended, or as hereafter amended.

ARTICLE TEN
NONASSIGNABILITY

10.01 The Plan, and the rights, interest and benefits receivable hereunder from the general assets of the Corporation or otherwise, shall not be assigned, transferred, pledged, sold, conveyed, or encumbered in any way by the Participant and shall not be subject to execution, attachment or similar process. Any attempted sale, conveyance, transfer, assignment, pledge or encumbrance of the Plan or of any such rights, interest and/or benefits, contrary to the foregoing provisions, or the levy of any attachment of similar process thereupon, shall be null, void and without effect.

ARTICLE ELEVEN
AMENDMENT AND TERMINATION PROCEDURE

11.01 It is the intention of the Corporation that the Plan shall continue, in effect, indefinitely. Nonetheless, the Corporation reserves the unilateral right to amend or terminate the Plan at any time or times, in whole or in part, by duly adopted Resolution of the Corporation's Board of Directors, notice of which would be promptly given to the Participants. No such amendment or termination, however, shall affect the rights of a Participant to receive benefits hereunder for any total disability (as previously defined) which arose after the Effective Date hereof, but prior to such amendment or termination.

ARTICLE TWELVE
COMMUNICATION

12.01 A copy of the Plan shall be given to each Participant by the Plan Administrator.

SCHEDULE A
LIST OF DISABILITY INCOME INSURANCE POLICIES

(Insert specific details of each Disability Income Insurance Policy being maintained under the terms of the Plan for each Participant.)

RECEIPT

Receipt of a copy of the ***(****Insert Name of Corporation; e.g.,* "ABC Company, Inc."***)*** Disability Income Wage Continuation Plan is hereby acknowledged this: ***(****Insert Date of Receipt***)*** .

Signed:

_____, Participant
(Print Name: _____)

NOTES TO DRAFTSMEN

Note #1

The Sample Disability Income Wage Continuation Plan, as presented, above, is not an "elective" plan. In order to be an "elective" plan, each covered employee would have to be given the opportunity to elect to pay income taxes on the disability income insurance premiums being paid by the employer for the insurance coverage provided during a given plan year, with the intended result that those employees who elected to be so taxed would (if they became disabled during such plan year) receive their disability income insurance benefits income tax-free

While Rev. Rul. 2004-55 describes a number of ways in which elective rights could be incorporated into a disability income wage continuation plan, one of the approaches described would be to grant each covered employee the right to make such an election, prior to the beginning of a given plan year (or at the time of entry into the plan), and then treat such an election as being applicable to all future plan years, unless and until such election is subsequently withdrawn. Using such an approach, the preceding Sample Disability Income Wage Continuation Plan could be made an "elective plan" by inserting therein (between paragraphs 3.03 and 3.04 in Article III), the following provision:

3.035 A Participant may elect to be taxed on all (but not less than all) of the Corporation's payments made under the Plan to maintain, in force, the Disability Income Insurance coverage being provided such Participant under the terms of this Plan during a given Plan Year. In order to be effective, any such election must be received by the Plan Administrator (or the party to whom such authority has been delegated), in writing, prior to the beginning of the subject Plan Year (and, in any event, prior to the onset of any sickness or accident which gives rise to said Participant's right to receive any disability income benefits under the terms of the subject Disability Income Insurance). Any such timely received election which has not been withdrawn (in the same manner as required hereunder to be advanced) prior to the beginning of said Plan Year, shall become irrevocable once the subject Plan Year begins. Once a Participant's election has become irrevocable, it shall remain, in force, from one Plan Year to the next, unless and until affirmatively withdrawn (in the same manner as required hereunder to be advanced). Any such withdrawal shall become effective as of the beginning of the next Plan Year that begins after the date the Plan Administrator (or the party to whom such authority has been delegated) receives the notice of such withdrawal. Any Participant who becomes eligible for coverage under the Plan during a given Plan Year may make such an irrevocable election, effective as of such Participant's Plan entry date, provided that the Plan Administrator (or the party to whom such authority has been delegated) receives such Participant's election within thirty (30) days of the date of such Participant's entry into the Plan (and, in any event, prior to the onset of any sickness or accident which gives rise to said Participant's eligibility for disability income benefits under the terms of the underlying Disability Income Insurance). For a Plan Year during which an election made in accordance with this paragraph becomes irrevocably effective, the

> Corporation shall include in the electing Participant's gross income the full amount of the premium(s) it pays to provide the subject Disability Income Insurance coverage during such Plan Year (which amount shall be reported, as income, on the Participant's Form W-2 for the subject Plan Year).

Two further comments regarding this optional "elective plan" provision bear mentioning: First, you will notice that the provision, as presented, would require any valid election to be made prior to the onset of any sickness or accident that gives rise to the electing employee's right to receive benefits under the disability income insurance coverage being provided under the Plan. While not addressed in Rev. Rul. 2004-55, we believe that such a prerequisite is consistent with the underlying intent of the Ruling. Secondly, the language set forth in Rev. Rul. 2004-55 is not exactly clear as to how the specific amount to be included in an electing employee's income should be calculated, or in what tax year or years such amount should be included in the electing employee's income. Under the FACTS set forth in said Ruling, it is indicated that "If an employee elects after-tax treatment, the Employer allocates the appropriate proportion of the [in this case, 'group'] premium to that employee and includes that amount in the employee's gross income for the year in which the payments are made (i.e., the premiums are reported on the employee's Form W-2 for that year)." Under the HOLDING set forth in the Ruling, it is stated that ". . . disability benefits received by an employee who has irrevocably elected, prior to the beginning of the plan year, to have the coverage paid by the Employer on an after-tax basis for the plan year in which the employee becomes disabled are excludable from the employee's gross income under § 104(a)(3)." Since a policy year will rarely dovetail with a plan year, and since premium payment arrangements will vary from policy to policy (i.e., annual, quarterly, monthly), varying answers to the questions raised will result, depending upon how you interpret the language in the Ruling. One approach to this issue has been to make the plan year the calendar year, and then calculate the amount to include in an electing employee's income for the plan/calendar year by looking at each underlying policy year, and prorating the premiums paid for the portion of each policy year that falls within the plan/calendar year.

Note #2

The Sample Disability Income Wage Continuation Plan, as presented, obligates the Corporation to pay premiums for the individually-owned, disability income insurance policies that become incorporated into the Plan by being listed by the Corporation on the Plan's Schedule A. In addition, the Sample Plan calls for the Corporation to pay full salary to a Plan Participant for the first three (3) months in the event of a total disability [which period of time was chosen to dovetail with the contemplated ninety (90) day waiting period under each of the envisioned disability income insurance policies].

As drafted, the Sample Plan also obligates the insurance company to pay the Plan's disability income insurance benefits, in accordance with the terms and conditions of the underlying policy. Such benefits may vary from policy to policy, depending upon the issuing insurance company, policy series, policy

options and underwriting limitations. For example, a given policy might pay benefits for total disability, as defined in the policy, for a fixed number of years; another policy might pay benefits, under a different definition of total disability, for as long as the insured is so disabled; a third policy might provide for both total and partial disability benefit payments; and, because of differences in age and health, covered employees may not all qualify for a desired level or type of insurance coverage. Whatever benefits a given, underlying insurance contract provides, however, such benefits are incorporated in the Sample Disability Income Wage Continuation Plan via reference to the terms of the underlying insurance contract. Those terms need not be elaborated upon in a disability income wage continuation plan drafted along the lines of the Sample Plan. However, if additional benefits to be paid from the general assets of the Corporation are desired (for example, to bring all covered individuals up to a minimum, total disability payment expectation level), then the provisions of **Article Two**, entitled "**Operation of the Plan**", would have to be modified, accordingly.

As an example, assume that a company desires to maintain a plan for its officers which would provide disability benefits of 50% of salary, up to a maximum of $5,000 per month, for as long as a participant is totally disabled. In order to help provide this benefit, each participating officer is directed to apply for a maximum benefit, long term, individually-owned disability income insurance policy from an insurance company of the officer's choice and/or is asked to allow an existing, personally-owned disability income insurance policy or policies to be incorporated into the plan. The premiums for such policies would, thereafter, be paid by the Corporation, pursuant to the plan. Assume that the end result of these efforts is that some officers are denied insurance coverage, and others successfully obtain varied types and amounts of coverage.

Under such circumstances, **Article Two**, entitled "**Operation of the Plan**", might be modified, as follows:

ARTICLE TWO
OPERATION OF THE PLAN

2.01 The Corporation shall, upon receiving timely, written notice from the insured, covered Participant that payment is due, pay the premium necessary to maintain in force the Participant's personally-owned Disability Income Insurance Policy or Policies set forth on the attached Schedule A (which policy or policies shall hereinafter be referred to as the "Disability Income Insurance").

2.02 In addition to the foregoing, if a Participant is totally disabled (as hereinafter defined), the Corporation shall pay to him or her, each month, commencing as of the date of onset of such disability, an amount, if any, which (in combination with any Disability Income Insurance benefits to which the totally disabled Participant is entitled during the relevant month) will provide the totally disabled Participant with a total amount equal to the lesser of:

(1) Fifty (50%) percent of his or her regular gross monthly salary immediately prior to the date of onset of such total disability, or

(2) Five thousand ($5,000) dollars.

Each such monthly payment shall be paid out of the general assets of the Corporation.

2.03 For the purposes of the Plan, a Participant shall be considered to be "totally disabled" when he or she is so defined under any Disability Income Insurance being maintained for the Participant under the terms of the Plan. Such determination shall be made solely and exclusively by the insurance company (hereinafter referred to as the "Insurance Company") which has issued the subject Disability Income Insurance, and such Participant shall continue to be considered so disabled, for the purposes of the Plan, until the Insurance Company ceases to recognize him or her as being entitled to receive disability income insurance benefits for total disability under the terms of the subject Disability Income Insurance. In the event no Disability Income Insurance is being maintained for the Participant under the terms of the Plan, the Corporation shall determine if and when such Participant is "totally disabled", for the purposes of the Plan, using the definition of that term as it is set forth under the then most recently issued long-term Disability Income Insurance Policy Series Contract being offered for sale to the general public by the ***(****Insert Name of Insurance Company; e.g.,* "Northwestern Mutual Life Insurance Company"***)*** , as of the Effective Date of the Plan.

— For the Use of Legal Counsel Only. Not for use by Financial Representatives with the public.—