Lincoln Financial Group®

Voluntary Life Insurance with Accidental Death and Dismemberment (AD&D)

SUMMARY OF BENEFITS

Sponsored by: Lincoln Public Schools

Life Benefit	Employee	Spouse	Dependent
Amount	Choice of $10,000 - $20,000 - $30,000 - $40,000 - $50,000 - $100,000 - $150,000 - $200,000 - $250,000 - $300,000	Choice of $10,000 - $20,000 -$30,000 - $40,000 - $50,000 - $100,000 - $150,000	$250 Child: 14 days to 6 months $10,000 Child: 6 months to age 26
	Employees age 70 and older, maximum benefit is $50,000. **Employee must elect coverage for spouse and dependents to be eligible.**	Not to exceed 100% of employee elected amount. **Employee must elect coverage for spouse and dependents to be eligible.**	Newborn children to age 14 days are not eligible for a benefit. **Employee must elect coverage for spouse and dependents to be eligible.**
Guarantee Issue	$100,000 under age 60 $10,000 age 60-69 No Guarantee Issue age 70 and older	$30,000 under Spouse's age 60 No Guarantee Issue Spouse's age 60 and older	$10,000
AD&D Benefit	**Employee**	**Spouse**	
Amount	The benefit amount is equal to the life amount elected by you. Cost included in the schedule.	Same as employee	
Benefit Reduction	**Employee**	**Spouse**	
Benefits will reduce:	35% at age 70 An additional 15% of original amount at age 75 Benefits terminate at age 80 or retirement, whichever is first	Benefits terminate at Spouse's age 70	
Additional Benefits			
See Definition:	Accelerated Death Benefit	See Definition:	Conversion
See Definition:	Portability		
Eligibility	**Employee**	**Spouse and Dependents**	
	All full-time active employees working 15 or more hours per week in an eligible class are eligible for coverage. A delayed effective date will apply if the employee is not actively at work.	Cannot be in a period of limited activity on the day coverage takes effect.	

Lincoln Public Schools

Employee Schedule of Monthly Life and Accidental Death and Dismemberment Premium

Employee and Spouse premiums are calculated separately.
Employee premiums are based on employee actual age.
Benefits and premium amounts reflect age reductions.

AGE	Monthly Rate per $1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$100,000	$150,000	$200,000	$250,000	$300,000
<70	0.190	$1.90	$3.80	$5.70	$7.60	$9.50	$19.00	$28.50	$38.00	$47.50	$57.00
		$6,500	**$13,000**	**$19,500**	**$26,000**	**$32,500**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
70-74	0.190	$1.24	$2.47	$3.71	$4.94	$6.18	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
		$4,000	**$8,000**	**$12,000**	**$16,000**	**$20,000**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
75-79	0.190	$0.76	$1.52	$2.28	$3.04	$3.80	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Spouse Schedule of Monthly Life and Accidental Death and Dismemberment Premium

Employee and Spouse premiums are calculated separately.
Spouse premiums are based on Employee's actual age.
Benefits and premium amounts reflect age reductions.

AGE	Monthly Rate per $1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$100,000	$150,000
<30	0.090	$0.90	$1.80	$2.70	$3.60	$4.50	$9.00	$13.50
30-34	0.090	$0.90	$1.80	$2.70	$3.60	$4.50	$9.00	$13.50
35-39	0.120	$1.20	$2.40	$3.60	$4.80	$6.00	$12.00	$18.00
40-44	0.180	$1.80	$3.60	$5.40	$7.20	$9.00	$18.00	$27.00
45-49	0.280	$2.80	$5.60	$8.40	$11.20	$14.00	$28.00	$42.00
50-54	0.400	$4.00	$8.00	$12.00	$16.00	$20.00	$40.00	$60.00
55-59	0.580	$5.80	$11.60	$17.40	$23.20	$29.00	$58.00	$87.00
60-64	0.940	$9.40	$18.80	$28.20	$37.60	$47.00	$94.00	$141.00
65-69	1.660	$16.60	$33.20	$49.80	$66.40	$83.00	$166.00	$249.00
70+	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Dependent Children Rate = $2.82 monthly

Premium covers all dependent children regardless of the number of children.

Definitions	
Accelerated Death Benefit	Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.
AD&D	Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable. This insurance is optional.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance and it will be provided at your own expense.
Portability	If coverage has been in force for at least 12 months, you may continue your coverage for a specified period of time after your employment by paying the required premium. Portability is available if you cease employment for a reason other than Total Disability or retirement. A written application must be made within 31 days of your termination.
Term Life	Coverage provided to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Exclusion: Suicide	Benefits will not be paid if the death results from suicide within two years after coverage is effective. May apply if employee contributes toward the premium.

Additional Benefits	
BeneficiaryConnect SM	Support services for beneficiaries who have experienced a loss.
TravelConnect SM	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information
Contact Lincoln Financial Group at (800) 423-2765 or log on to www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

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The Lincoln National Life Insurance Company
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Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: LINCOLNPU	GROUP POLICY #: 40-0001000-03157 VLife	Billing Division or Location: 112685

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) Lincoln Public Schools			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address	City	State	Zip		

Gender: ☐Male ☐Female	Marital Status: ☐Married ☐Single	Home Phone ( )	Occupation	Average Hours Worked Per Week:

Completed By Employer

Earnings: $______________ ☐ Hourly ☐Monthly ☐ Weekly ☐ Yearly	Date of Full-Time Employment:	Rehire Date:

Product Selection (Complete for ALL Enrollments)

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

TYPE OF COVERAGE			AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life/AD&D Insurance	☐Yes	☐No	☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $300,000	$
Voluntary Spouse Life/AD&D Insurance	☐Yes	☐No	☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ $100,000 ☐ $150,000	$
Voluntary Dependent Child Benefit	☐Yes	☐No	$ 10,000	$

Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number	
Street Address			City	State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number	
Street Address			City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

Request for Coverages
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:
❑ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
❑ **NOT ENROLL myself in the Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
❑ **NOT ENROLL my dependents in the Program.** I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTE: A PERSON COMMITS INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name:________________________ Employee Signature:_________________________ Date:___________