Partnering to help you lead.

Lincoln Financial Group makes it easy for you. Easy to empower and educate your employees. Easy to make decisions—and move forward—confidently. Our knowledge and the breadth of our portfolio allows us to meet your needs today and adapt as they change for tomorrow. We’re driven to provide you competitive benefits through flexibility, constant innovation and timely insights. We never waver in our commitment to find the answers that are right for you.

Important Notice

This guide explains general principles in your Lincoln Financial Group certificate of insurance or group policy. Any information regarding a particular person’s eligibility, benefit level, or right to continuation or conversion is obtained from the certificate of insurance. If a conflict exists between this manual and the certificate of insurance or group policy, the certificate of insurance or group policy takes precedence. Lincoln Financial Group reserves the right to change or discontinue the procedures outlined herein at any time. Regarding sample forms used or described in this manual: Insurance forms are frequently revised. Please contact your Lincoln Financial Group benefits representative to be certain you are using the most current form available. This guide includes products offered by Lincoln Financial Group that may not be applicable to your organization. Your payment of premiums will be interpreted as acceptance and acknowledgment of your responsibility under this Administration Guide.
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Annual vs. Open Enrollment

Annual enrollment is the period that is approved by underwriting and recurs each year. During the Annual enrollment period, employees can sign up for initial coverage or change (increase/decrease) existing coverage, subject to the established evidence of insurability requirements and policy benefit maximums. Please refer to your group policy to determine your annual enrollment period.

Open enrollment is a singular period or event that is approved by underwriting for employees to sign up for initial benefits or increase benefits by a defined increment level or benefit option (as defined in your group policy) without providing evidence of insurability, subject to benefit maximums. You may work with your broker or sales representative to request an open enrollment.

Employees who elect to enroll after the approved enrollment period must complete the Evidence of Insurability form provided, which includes medical questions in the Statement of Health section.

Enrollment Options

Enrollment information must be submitted for each new employee hired who is eligible for benefits and elects coverage. For individual accident and critical illness, paper enrollment forms must be submitted. For group accident and critical illness and all other products, our customers have the option of sending enrollment information to Lincoln in any of four different ways:

- Paper enrollment
- Web enrollment
- Electronic data interface (EDI)—EDI files take the place of member enrollment, adjustment and termination forms, as well as maintenance of information on our website. With EDI, Lincoln accepts Excel files through our FTP server for an efficient and secure transaction.
  - If you used EDI with a prior carrier, Lincoln will review your existing file feed to determine whether it will work with our system. It will be reviewed to determine format, custom development, fees and so on.
- Eligibility file (for self-billed customers maintaining their own member records) provided to Lincoln to service claims and member inquiries

Please work with your sales representative or assigned case manager to determine the best enrollment option for you.

Instructions for completing and submitting paper enrollment forms can be found below. If you elect Web enrollment, eligibility file or EDI, your case manager will provide instructions for completing the enrollment process.
Paper Enrollment Process

Each new employee hired who is eligible for benefits and elects coverage must complete a group enrollment form. A form will also need to be completed when making a new election for a contributory coverage if elected after initial enrollment. There are a few things you should know about this process:

- The employee’s signature serves as the payroll deduction authorization.
- Be sure to keep current beneficiary designation records (applicable to life, accidental death & dismemberment, and critical illness only).
- When you need a new supply of certificates for new hires, please contact a client service representative at 1-800-423-2765 or email clientservices@LFG.com.

We offer multiple options for submitting enrollment forms:

**Fax:** 1-877-573-6177

**Email:** lfgenrollments@LFG.com

**Mail:** The Lincoln National Life Insurance Company
P. O. Box 2616
Omaha, NE 68103-2616

*For groups situated in New York, mail to:* Lincoln Life & Annuity Company of New York
P. O. Box 2616
Omaha, NE 68103-2616

File the completed enrollment form with your office records. When one of your employees applies for benefits, we will ask that you send us the enrollment form, along with several other items (such as payroll records, change forms, adjustment forms, beneficiary designations, etc.).

Confirm the following before submitting the enrollment form:

- Is the handwriting legible and the information accurate?
- Has the employee signed and dated the enrollment form?
- Has the section marked “Completed by the Employer” been completed?
- Has all critical information been provided, including but not limited to:
  - Policy number or group ID or group name
  - Company name, division, billing location, and sort group (whichever apply)
  - Social Security number
  - Date of birth
  - Date of full-time employment or rehire
  - Salary and hours worked
  - Occupation
  - Class code
- Gender
- Employee’s full address and telephone number
- If applicable, has the beneficiary information been filled out?
- If applicable, are all dependents to be enrolled in the dental and/or vision plan legibly listed, with full name and date of birth for each?
- Have the desired coverages been checked for contributory (employee-paid) plans?
- For voluntary life and critical illness coverage:
  - Is the tobacco question answered?
  - Has a beneficiary been designated?
  - Is the spouse date of birth included, if applicable?
  - Are the unit amounts indicated?
- For voluntary short-term disability (STD) and voluntary long-term disability (LTD) coverage:
  - Are the unit amounts indicated?
  - Are the elimination period and duration included?
- For voluntary dental, vision and accident coverage:
  - Have all eligible dependents to be covered been listed?
  - Has one of the coverage options been checked?

**Note for Self-Billed Groups**
Do not fax or mail the enrollment forms to our company, except for dental or vision coverage, late entrants or employees who are applying for a benefit above the guaranteed issue amount. Periodic EDI or eligibility files (monthly preferred) should be submitted to Lincoln to support claims processing and member eligibility verification.

**Notes for List-Billed Groups**
- Do not mail enrollment forms with your premium payment.
- Do not mail the originals if you have faxed in your enrollments.
- Do not write adjustments on your billing statement.

We do not typically allow employer-paid (non-contributory) coverages to be waived by individual employees. Dental coverage may be waived if proof of current dental insurance for the employee is submitted at time of enrollment. Sections D and F must be completed in full if dental coverage is being waived.
Employee Eligibility

Employees who have elected coverage will be eligible for benefits after completing the eligibility waiting period as defined in your policy. All new employees will be added to the bill effective the first of the month following completion of the waiting period, or upon signing the enrollment form, whichever is later. There will be no mid-month premium calculation.

Please note that contractually, employees have 31 days from their date of eligibility to enroll. If employees enroll for contributory coverage during this 31-day eligibility period, the effective date will be the first of the month following the date of signature (or upon approval of coverage if evidence of insurability is required). We strongly suggest that employees complete and submit applications during this 31-day eligibility period.

Refer to your policy to determine if employees may enroll throughout the year. Even if allowed under your contract, there is not a guaranteed issue amount and the Evidence of Insurability application must be completed within 31 days (unless there was a qualifying event). See below for additional information about qualifying events.

Refer to your policy for provisions regarding when employees and their dependents cease to be eligible (i.e., age limitations).
Late Entrants
Employees are considered late applicants if they apply for contributory (i.e., employee-paid) coverage more than 31 days after their date of eligibility.

Non-contributory coverage (employer paid):
- Non-contributory means the premium is fully paid by the employer.
- All eligible employees must be enrolled.
- The coverage for the late applicant will be made effective on the employee’s original effective date.
- Lincoln assumes liability on all eligible employees, whether or not an enrollment form has been submitted. Therefore, your company is responsible for paying back premium for employees whose enrollment forms were overlooked or sent in late.
- Eligible employees cannot waive non-contributory coverage.

Exception: Dental coverage may be waived only if the employee has coverage elsewhere. In this case, an enrollment form still must be submitted, and the name of the other dental carrier must be listed.

Contributory coverage (employee paid):
- Contributory means any portion of the premium is paid by the employee (i.e., the employee contributes to the cost of the insurance).
- The late applicant must submit a completed enrollment form, and for life, disability, and critical illness, he/she must also submit an Evidence of Insurability application. For accident coverage, the employee must wait for the annual enrollment period to apply.
- The employee will be added to the bill only after we review the Evidence of Insurability application and approve the coverage.
- Do not begin payroll deduction until written notice of approval is provided to you.
- For dental coverage only (excluding voluntary dental and DHMO), no evidence of insurability is required, but a late entrant to the plan will have limitations. Voluntary dental and DHMO coverages may be elected only at initial enrollment and the open enrollment time frame in your contract. DHMO is available only in California, Florida and Texas. See your policy for details.

Family Status Change / Qualifying Event
For dental coverage, a qualifying event is loss of previous coverage and/or acquiring a dependent (through marriage, birth, adoption, etc.). If an employee elects coverage within 31 days of an approved qualifying event, late entrant penalties are waived for the spouse for marriage. The employee would still be considered late.

For life coverage, a qualifying event is acquiring a dependent (through marriage, birth, adoption, etc.). If an employee enrolls dependents within 31 days of an approved qualifying event, the evidence of insurability requirement is waived. Voluntary child life coverage never requires evidence of insurability.

For disability coverage, there are no approved qualifying events. All late applicants must provide evidence of insurability.
Enrolling a Rehired Employee

Any employee who returns to work after temporary termination may request insurance coverage with the following stipulations:

- A new enrollment form with the rehire date and current information must be completed.
- The rehired employee is an addition on the statement of premium due.
- The rehire date will be used to determine eligibility, unless otherwise noted in the group insurance contract.
- The rehired employee may be considered a late applicant if applying for coverage more than 31 days after the date of eligibility.
- If the employee is a late applicant, do not begin payroll deductions until written notice of approval has been provided to you.

Canceling Coverage

At any time, a Group Insurance Change Request form may be faxed to 1-877-573-6177 or emailed to lfgenrollments@LFG.com. The employee must sign and date the Change Request form. Please note that if the employee wants to add coverage at a later date, he/she may be subject to evidence of insurability and a new preexisting condition limitation period.

Guaranteed Issue

The guaranteed issue amount is the maximum benefit Lincoln will underwrite without requiring evidence of insurability. Evidence of insurability is required whenever an employee requests a benefit amount that exceeds contract guidelines.

- An Evidence of Insurability application must be submitted, and the additional benefit amount will be approved or denied through written notification.
- Do not report such amounts or any increase on the statement of premium due until written notice of approval is provided to you.
Evidence of Insurability Requirements
For life, disability and critical illness coverage, evidence of insurability may be required for employees and/or spouses in the following scenarios:

- If the amount applied for is over the guaranteed issue amount
- If they are late enrollees (those who did not enroll initially or at an approved open enrollment, and are now requesting coverage)
- If spouse coverage is over the guaranteed issue amount
- If a spouse is applying for coverage after initially declining and/or outside of an approved open enrollment
- If an employee wants to increase employee or spouse coverage outside of an approved open enrollment period
- If an employee is age 60 or over
  - Typically, benefit reductions are triggered by age. Please check your policy to confirm the age at which benefit reductions begin. If the reductions start at age 65, then evidence of insurability would be required for an employee age 65 or older. The age 60 for evidence of insurability would apply to the spouse age for voluntary life coverage.

Please note that children are not required to submit Evidence of Insurability applications.

Evidence of Insurability Process
After electing their benefits, employees will access the My Lincoln Portal link (MyLincolnPortal.com) and register for the site using the employer’s portal access code (typically the Group ID).

Once logged into the portal, the employee completes a dynamic questionnaire on the site by selecting “Complete Evidence of Insurability.” Upon submission, most applicants will benefit from a real-time decision, or they’ll be informed about next steps.

Evidence of Insurability Underwriting Requirements
During the underwriting process, Lincoln’s underwriters may request additional information based on the applicant’s medical history. These requirements may include:

- Medical records
- Medical forms completed by the applicant and/or the applicant’s doctor

The employee is responsible for fees from the medical provider associated with obtaining this information.

Lincoln will send a notification via mail to the applicant’s mailing address, or via email, depending on the applicants selected preference, when additional information is required.

- If the requested information is not received within 60 days, we will close our files and send two copies of the withdrawn letter to the plan administrator.
Notification of Underwriting Decisions

Applicants using the online EOI application on MyLincolnPortal.com who are immediately approved will be notified at that time. If email is the applicant’s selected communication preference, approval will be sent via email. In all other instances, Lincoln will reach out to the employee by email or mail with a notification of any decision(s) regarding the coverage(s) requested. Updated statuses will also be available on MyLincolnPortal.com.

Declination and withdrawn decisions will not affect any coverage the employee currently has in force.

Evidence of Insurability Status Reports

The Evidence of Insurability Summary Report provides status information and decision activity (not available for critical illness coverage). Please direct inquiries to a client service representative at 1-800-423-2765 or clientservices@LFG.com. A similar report is also available for list-billed groups through Lincoln’s online administration website at LincolnFinancial.com.

Electronic Submission of Administrative Changes and Adjustments

Lincoln’s online services allow administrators to perform many administrative functions via the Internet at LincolnFinancial.com. Online functionality includes the ability to:

- Submit life, life waiver, STD and LTD claims
- View life, life waiver, STD, LTD and dental claims status
- Review bills and payment status
- View and print group forms, administration guidelines, contracts and certificates

Additional functionality for list-billed groups includes the ability to:

- Enroll new members
- Change member information
- Terminate members and coverages
- Have most changes processed in real time and reflected on your next bill

Finally, with our Virtual Billing service, you can add or terminate members, recalculate your bill to reflect the actual amount you owe, and pay your bill—all in real time.
Billing for Life/Disability/Dental/Vision Products

Prior to each premium due date, you will receive an email detailing your billing summary for the following month. Bills are generated on the 10th or 20th of each month and are to be completed online via Lincoln4Benefits.com. You will not receive a paper statement.

- For list-billed groups, the online billing summary will list each employee covered under the plan and the premium payment due. You will be required to pay as billed. Any adjustments will be reflected on the next month’s bill.
  Please check your billing summary carefully to ensure that all eligible employees are included on the statement and premiums are accurate by matching payroll deductions if applicable.
- For self-billed groups, you will complete a statement of premium for each billing period to complete with lives, volume and premium totals by line of coverage.
  Please include the completed statement and remit with your premium payment.

Note: If you want to receive a paper bill, please contact Customer Service at 800-423-2765.

- Two additional billing options are available for the Dental Self-Funded Administrative Services Only (DSFO) product:
  - Weekly – claim charges will be billed every week for the previous week.
    o Claim charge days will begin on Thursdays and end on Wednesdays of the week prior to billing.
    o The ACH withdrawal day will be every Tuesday.
  - Biweekly – claim charges will be billed every other week for the previous two weeks.
    o Claim charge days will begin every other Thursday and end on Wednesdays of the week prior to billing.
    o The ACH withdrawal day will be every other Tuesday.

Here are some examples of the DSFO claim charges billing schedule:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Claim Charge Beginning Day</th>
<th>Claim Charge End Day</th>
<th>ACH Withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>07/04/2019</td>
<td>07/10/2019</td>
<td>07/16/2019</td>
</tr>
<tr>
<td></td>
<td>07/11/2019</td>
<td>07/17/2019</td>
<td>07/23/2019</td>
</tr>
<tr>
<td>Biweekly</td>
<td>07/04/2019</td>
<td>07/17/2019</td>
<td>07/23/2019</td>
</tr>
<tr>
<td></td>
<td>07/18/2019</td>
<td>07/31/2019</td>
<td>08/06/2019</td>
</tr>
</tbody>
</table>
Billing for Worksite Accident and Critical Illness Products

Accident and critical illness products are billed separately from life, disability, dental and vision. Bills are generated on the 1st or 20th of each month, depending on your billing frequency.

- Bills will be mailed in separate envelopes for each division/location/account.
- A billing statement will list each employee covered and the premium due.
- If an employee terminates coverage after the premium due date, premiums are due through the payroll cycle in which premiums have been deducted.
- Please mark off policies on the billing statement for which remittance is not sent. Please indicate the reason for the deletion.
- The list bill statement should match the amount of the check remitted.

Payroll File Billing for Accident and Critical Illness Products

We also offer payroll file billing for accident and critical illness products, providing a timely and efficient way for you to submit payroll deductions for your employees’ premiums. All information is sent electronically—no bills are printed or mailed.

Payroll File Billing Instructions

- A payroll deduction file should accompany each check. The payroll deduction file must include employee name, Social Security number, premium amount deducted, and line of coverage.
- The check amount must match the total in the payroll file.

Here is an example of a payroll deduction file:

```
<table>
<thead>
<tr>
<th>Group Name:</th>
<th>LFG Group ID:</th>
<th>Payroll Frequency:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Check Date</th>
<th>Deduction</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith, John</td>
<td>10/12/2012</td>
<td>Lincoln Accident</td>
<td>11.21</td>
</tr>
<tr>
<td>Smith, John</td>
<td>10/26/2012</td>
<td>Lincoln Accident</td>
<td>11.21</td>
</tr>
<tr>
<td>Doe, Jane</td>
<td>10/12/2012</td>
<td>Lincoln Crit Illness</td>
<td>30.50</td>
</tr>
<tr>
<td>Doe, Jane</td>
<td>10/26/2012</td>
<td>Lincoln Crit Illness</td>
<td>30.50</td>
</tr>
</tbody>
</table>
```
**Premium Remittance Process**

Premium is due on or before the due date listed on your billing summary. To ensure timely credit to your account, please remit your premium promptly. If remitting payment by mail, please enclose payment coupon or summary page from the bill to ensure proper credit. Complete “Amount Enclosed” and mail to address shown on the bill.

If you are paying for more than one division/location/account, please send all completed coupons or summary pages with your payment.

If remitting payment by wire or ACH, please be sure to indicate in the comment section your group ID and all billing locations associated with the payment.

Do not mail any other items with premium payment. Any new applications or changes to covered employees should be sent separately to lffenrollments@LFG.com.

Following is the information needed to remit premium via U.S. mail, overnight mail, wire and ACH.

**Billing and Premium Remittance for Life/Disability/Dental/Vision Products**

**Checks – Standard Delivery**
The Lincoln National Life Insurance Company  
P.O. Box 0821  
Carol Stream, IL 60132-0821

**Checks – Overnight Lockbox Address**  
8430 W. Bryn Mawr  
3rd Floor Lockbox  
Chicago, IL 60631

*If group is situated in New York, please mail to:*  
Lincoln Life & Annuity Company of New York  
P.O. Box 7247-0347  
Philadelphia, PA 19170-0347

**Checks - Overnight Lockbox Address**  
**First Data / Remitco**  
Attn: Lincoln Life & Annuity Company of New York / Lockbox #  
400 White Clay Center Drive  
Newark, DE 19711

**Wire Transfers**
Bank of America  
100 West 33rd St. NE 100  
New York, NY 10001  
ABA #: 0260-0959-3  
Acct #: 4426416656 (if situated in New York,  
Acct #: 375076053)  
Acct Name: Lincoln Financial  
Comment section: Group ID and all billing location numbers associated with payment

**ACH Transfers**
Bank of America  
100 West 33rd St. NE  
New York, NY 10001  
ABA #: 111000012  
Acct #: 4426416656  
Acct Name: Lincoln Financial  
Comment section: Group ID and all billing location numbers associated with payment  
Note: Withdrawals for automated ACH by LFG occur on the 1st or the 15th of each month

**E-Payment (Web Payment)**
You can elect an online e-payment, which is a one-time withdrawal initiated by you.
Billing and Premium Remittance for Worksite Accident and Critical Illness Products

Checks – Standard Delivery
Attn: 1H-20
P.O. Box 7894
Ft. Wayne, IN 46801-7800

Checks – Overnight Lockbox Address
Attn: Cash Receipts 1H-20
1300 South Clinton St.
Ft. Wayne, IN 46802

Wire Transfers
Wells Fargo Bank
1248 O St.
Lincoln, NE 68508
Routing #: 121000248
Acct #: 4122053218
Comment section: Group ID and all billing location numbers associated with payment

ACH Transfers
Wells Fargo Bank
1248 O St.
Lincoln, NE 68508
Routing #: 074900275
Acct #: 4122053218
Comment section: Group ID and all billing location numbers associated with payment
Note: All ACH payments must be client initiated. LFG will not automatically pull money from accounts.

Billing and Premium Remittance for Universal Life Product

Checks – Standard Delivery
75 Remittance Drive Ste 1920
Chicago, IL 60875-1920
Note: Please include comment to state WUSL

Checks – Overnight Lockbox Address
100 North Green St.
Greensboro, NC 27401
Attn: Catherine Gourley
Note: Please include comment to state WUSL

Wire Transfers
100 W. 33rd St.
New York, NY 10001
Number: 009402857788
ABA Number: 026009593
Reference: Billing location number / policy number and name

Reinstatement Process
If premiums are not paid within the grace period, your policy may lapse in accordance with your contract. Should your policy lapse, a $100 reinstatement fee and a Request for Reinstatement form, along with any unpaid premiums, must be provided before we will consider reinstatement. The Request for Reinstatement form is sent to you with the lapse notification. These items should be sent to the address that you use to remit your premium.
Adjustments to List Bill
List-billed groups should pay as billed. Lincoln does not prorate premium. If an employee terminates after the premium due date, premiums are due for the entire month. If an employee is effective after the premium due date, premium will not be charged until the next premium due date. We offer multiple options for submitting adjustments and changes:

Online: LincolnFinancial.com (enter changes under the Member tab)
Fax: 1-877-573-6177
Email: lfgenrollments@LFG.com
Mail: The Lincoln National Life Insurance Company
P.O. Box 2616
Omaha, NE 68103-2616

If situated in New York, use the following mailing address:
Lincoln Life & Annuity Company of New York
P.O. Box 2616
Omaha, NE 68103-2616

To help us serve you better, please:
• Do not mail changes and adjustments with your premium payment.
• Do not mail the originals if you have faxed in your changes and adjustments.
• Keep a copy for your records.
• Use the Adjustment Report found on LincolnFinancial.com to submit any of the following changes as they occur:
  – Terminations
  – Class changes
  – Billing location changes
  – Salary changes (if benefit is salary based)
• Use the Group Insurance Change Request form found at LincolnFinancial.com to submit any of the following changes as they occur:
  – Name changes
  – Beneficiary changes
  – Marital status changes
  – Dependent coverage changes
  – Salary changes
    o Salary changes must be reported as they occur for all employees whose coverage is determined according to their earnings. Please email these changes in an Excel file to lfgenrollments@LFG.com for prompt processing. The Excel file must contain the group name, employee name and Social Security number, new salary amount and effective date of salary change.
    o Claims are paid according to the most current salary information we have on record.
    o For definition of earnings, please refer to your contract.
New Employees Due to Mergers and Acquisitions
If you need to add employees to your plan due to a merger or acquisition, notify your broker and regional sales office, and provide the following information:
- A complete census or enrollment forms
- Date of acquisition, name of acquired company, and effective date of coverage

Responsibilities of Self-Billed Groups
Self-billed groups are responsible to report the number of covered lives, volume of insurance and premium for each line of coverage, and to remit the correct amount of premium each month. It is the group’s responsibility to accurately apply coverage restrictions, reductions and terminations as required by the policy. For example, dependent spouses must not be insured if they are over the maximum eligible age (usually 70). Premium deductions and remittances must be reduced or ended as age-based coverage amount reductions or terminations apply.

Following are instructions to complete each section of the statement of premium due.

Instructions for Completing Statement of Premium Due

Line 1: Information listed here is from the last paid bill in our system at the time the current statement of premium due is generated.

Line 2: Report the number of new members and volume of insurance. (Use the reverse side of the statement of premium due to list adjustments being taken.)

Line 3: Report the total increase in volume for in-force members due to salary changes and/or class changes. (Use the back side of the statement of premium due to list adjustments being taken.)

Line 4: Report the number of terminations and volume for in-force members. (Use the reverse side of the statement of premium due to list adjustments being taken.)

Line 5: Report the total decrease in volume due to salary, class and/or age reduction changes for in-force members. (Use the reverse side of the statement of premium due to list adjustments being taken.)

Line 6: For each coverage, calculate the total lives and volume by adding items 1, 2 and 3, and subtracting items 4 and 5.

Line 7: This is the current premium rate for each coverage.

Line 8: Calculate the unadjusted premium due for each coverage by multiplying each volume recorded on Line 6 by each appropriate rate.

Line 9: Report any back charges (+) that have not been reported on a previous statement of premium due.

Line 10: Report any premium credits due (-) that have not been reported on a previous statement of premium due.

Line 11: For each coverage, calculate the adjusted premium totals by adding items 8 and 9, and subtracting item 10.

Total premium: Add line 11 across and list the total premium due for all coverages in the box provided at the bottom of page 1.
Example of Statement of Premium Due

STATEMENT OF PREMIUM DUE

GR-AD
ABC CORPORATION
ATTN - JANE DOE
123 MAIN STREET
ANYTOWN, USA 11111

Account # AEKO-BL-26389
Due Date: 1-01-99
Policy Number: 000010021269-00000

<table>
<thead>
<tr>
<th>Current Changes of Insurance In Force</th>
<th>LIFE</th>
<th>DEP LIFE</th>
<th>AD &amp; D</th>
<th>LTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Force on Last Statement</td>
<td>25,625,000</td>
<td>21,126,000</td>
<td>25,625,000</td>
<td>25,51,658</td>
</tr>
<tr>
<td>Additions</td>
<td>1,25,000</td>
<td>1,5,000</td>
<td>1,25,000</td>
<td>1,2,058</td>
</tr>
<tr>
<td>Volume Increases</td>
<td>2,000</td>
<td>—</td>
<td>2,000</td>
<td>95</td>
</tr>
<tr>
<td>Terminations (include deaths and disabilities)</td>
<td>2,42,000</td>
<td>2,12,000</td>
<td>2,42,000</td>
<td>2,3,550</td>
</tr>
<tr>
<td>Volume Decreases</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>In Force on Premium Due Date</td>
<td>24,610,000</td>
<td>20,120,000</td>
<td>24,610,000</td>
<td>24,50,264</td>
</tr>
<tr>
<td>Current Premium Rate</td>
<td>35%</td>
<td>1.20</td>
<td>0.5</td>
<td>0.38</td>
</tr>
<tr>
<td>Unadjusted Premium</td>
<td>$3,356.50</td>
<td>$24.00</td>
<td>$3,0.50</td>
<td>$191.00</td>
</tr>
<tr>
<td>Back Premium Charges (+)</td>
<td>+ 1.10</td>
<td>—</td>
<td>+ 1.0</td>
<td>(5.83)</td>
</tr>
<tr>
<td>Total Premium (ADD LINE 11 ACROSS)</td>
<td>$3,392.70</td>
<td>$22.80</td>
<td>$29.70</td>
<td>$185.83</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL PREMIUM</th>
<th>$546.73</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Amount Due</td>
<td>$546.73</td>
</tr>
</tbody>
</table>

Jane Doe (402) 123 4567
POLICYHOLDER’S SIGNATURE
Calculating an Insured’s Age for Premium Purposes
To calculate the initial premium for age-rated products, use the insured’s age on his or her eligibility date. For future years, refer to your contract to determine whether premium will increase immediately upon entering a new age band, or on the employer’s next policy anniversary date.

Establishing Initial Payroll Deductions
You should initially deduct only the premiums needed to cover the guaranteed issue amount. Upon approval of additional coverage (above guaranteed issue), begin deductions for the full amount of premium. For accurate administration, all deductions should begin on the first of the month only.

Calculating Premiums
Life

![Life insurance calculation table]

- If benefit is salary based, ensure that rounding is conducted according to policy and be aware of any maximum and/or minimum benefit.
- Life and accidental death & dismemberment (AD&D) are two separate benefits and need to be reported separately.

Dependent Life

![Family unit premium calculation]

- If benefit is salary based, ensure that rounding is conducted according to policy and be aware of any maximum and/or minimum benefit.
- Life and accidental death & dismemberment (AD&D) are two separate benefits and need to be reported separately.
Short-Term Disability (STD)
- Premium is calculated one of two ways: Per $10 of weekly benefit - OR - per $100 of monthly covered payroll
- The Schedule of Insurance page in your policy specifically states which method should be used when calculating the premium for your group.

Below is an example of how to calculate each:

<table>
<thead>
<tr>
<th>Per $10 of Weekly Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee’s Weekly Benefit is $500</td>
</tr>
<tr>
<td>Rate is $.64 per $10 of Weekly Benefit</td>
</tr>
<tr>
<td>500 divided by 10 = 50</td>
</tr>
<tr>
<td>50 x $.64 = $32.00 per month</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Per $100 of Monthly Covered Payroll</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee’s Monthly Covered Payroll is $1,200</td>
</tr>
<tr>
<td>Rate is $.64 per $100 of Monthly covered payroll</td>
</tr>
<tr>
<td>$1,200 divided by 100 = 12</td>
</tr>
<tr>
<td>12 x $.64 = $7.68 per month</td>
</tr>
</tbody>
</table>

Long-Term Disability (LTD)
- Rates are per $100 of basic monthly earnings by employee.
- Basic monthly earnings cannot exceed the LTD maximum covered monthly earnings (LTD maximum covered monthly earnings equal the maximum monthly benefit divided by the benefit percentage covered by the plan).

<table>
<thead>
<tr>
<th>Benefit Percentage</th>
<th>Maximum Monthly Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>5,000</td>
</tr>
<tr>
<td>60%</td>
<td>6,000</td>
</tr>
<tr>
<td>66 2/3%</td>
<td>7,500</td>
</tr>
</tbody>
</table>

LTD Maximum Covered Monthly Earnings

<table>
<thead>
<tr>
<th>Employee Monthly Premium</th>
<th>Group Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3.012</td>
<td>50.264</td>
</tr>
</tbody>
</table>

Calculating for the Entire Group
Assumptions used in calculation:
- Maximum monthly benefit: $5,000
- Benefit percentage: 60%
- Basic monthly earnings for sample employee: $3,012
- Total covered payroll for sample group: $50,264
- Monthly earnings don’t exceed LTD maximum covered monthly earnings
- LTD rate: $0.38
Fees

- For self-administered groups, fees are either placed on their own bill, or will appear on separate pages at the end of bills that have other lines of coverage.
- All premium must be available to post to an account before a premium billing period can be paid (e.g., when the January premium comes due, you will need to have all premium associated with that January bill before you can post the premium).
Conversion of Group Life Insurance

Conversion of life insurance allows a covered person to purchase an individual life policy from Lincoln Financial Group without evidence of insurability, when all or part of his/her coverage under the group policy ends. The insured has 31 days from the date coverage terminates to apply for conversion.

All employees and covered dependents are eligible if all or part of the life insurance provided to them by their group policy terminates for any reason except:

- Termination or amendment of the group policy (groups sitused in NY excluded), or
- The insured person’s request for
  - termination of insurance or
  - cancellation of payroll deduction

Any individual policy issued under the General Conversion Benefit will

- be for an amount not to exceed the amount of life insurance that was terminated (the insured person may request a lower amount of coverage);
- be issued at the insured person’s age at his/her nearest birthday;
- be issued without disability or other supplemental benefits; and
- require premiums based on the class of risk to which the person belongs, based on age, gender and tobacco status.

A conversion policy also may be purchased if

- all or a part of anyone’s insurance terminates due to amendment or termination of the group policy, and
- that person has been covered continuously under the group policy for the time period specified in the contract.

Refer to your specific group policy coverage for provision details.

Any conversion policy issued due to group policy termination or amendment will be subject to the same conditions as a policy issued under the General Conversion Benefit, except that its amount may not exceed the lesser of

- the amount specified in the contract (e.g., $10,000) or
- the amount of life insurance that is terminated less the amount of any group life insurance for which the insured person becomes eligible within 31 days after the termination.

Refer to your specific group policy coverage for provision details and notice time periods.

Requirements for Conversion Notification to the Insured

When an insured person’s personal insurance terminates under the group policy, your company must provide the insured person with written notice of the right to convert. Lincoln typically will not have individuals’ contact information and may not learn of their termination in a timely manner. Therefore, the group policyholder must assure that a timely conversion notice is given, either directly or by sending a termination file to Lincoln, which will then notify impacted employees. Conversion forms
vary by state. You may request your state-specific Application for Conversion of Group Life Insurance from a client service representative at 1-877-321-1015 or by email at clientservices@LFG.com.

Privilege of Late Notification of the Conversion
An additional period in which to convert will be granted if written notice is not given to the insured person at least 15 days before the 31-day conversion period ends. The extension of the conversion period will expire on the earlier of

- 15 days after the insured person is given written notice, or
- 60 days after the 31-day conversion period ends, even if the insured person is never given the notice.

If sitused in New York, please check your group policy for period durations.

No death benefits will be payable under the policy after the 31-day conversion period expires.

Requesting a Quote
To request a quote, the insured person can contact one of our client service representatives at 1-877-321-1015 or clientservices@LFG.com. We will need the following details to provide a quote:

- The group policy number
- The insured person’s date of birth and sex
- The benefit amount requested
- The day on which insurance would otherwise terminate under the group policy
- The insured person’s smoking status
- The insured person’s state of residence

The Application for Conversion of Group Life Insurance also includes a section to request a quote via mail or email. However, we recommend the insured contact a client service representative, who can model various quotes based on the insured’s budget.

Submitting an Application
After receiving a quote from a client service representative, the insured will receive a quote package, which contains an illustration, an instruction letter and the Application for Conversion of Group Life Insurance. Upon completion of the form by the insured person, it can be mailed, along with the premium payment, to:

The Lincoln National Life Insurance Company
P.O. Box 0821
Carol Stream, IL 60132-0821

The coverage provided by any conversion policy issued will typically be effective on the first of the month after the date on which the person’s previous life insurance terminated.
**Death During the Conversion Period**

Lincoln will pay a death benefit under the policy equal to the amount of the life insurance that could have been converted, provided

- the person was entitled to purchase a conversion policy and
- the person died within the 31-day conversion period.

If sitused in New York, please check your policy for period duration.

The death benefit will be paid even if no one applied for the conversion policy. If the first premium was paid for the conversion policy, then the amount of that premium will be refunded, and the conversion policy will be void.

**Conversion of Long-Term Disability (LTD) Insurance**

LTD conversion allows a terminated employee to convert group LTD coverage. Eligible employees who convert will receive a benefit amount (typically 60% of salary) or the benefit percentage under the group policy on their termination date (whichever is less).

- The maximum monthly benefit is the lesser of $3,000, or the maximum monthly benefit under the group policy on the termination date.
- The elimination period under the converted policy will be 180 days.
- The converted premium amount will differ substantially from the group premium amount.

If your policy contains the conversion privilege, any employee who has been insured under the group LTD plan for at least 12 consecutive months may be eligible for conversion. The 12 months can be under a combination of coverages under our Company’s LTD plan and any prior group LTD plan that has been replaced with our policy. An employee may convert only if he or she

- resigns from employment with the employer;
- is terminated from employment with the employer, with or without cause;
- goes on a layoff or leave of absence; or
- remains on a layoff or leave of absence beyond the continuation period provided in the Individual Termination section of the group policy.

Employees may not convert in certain circumstances, including but not limited to the following:

- The group’s LTD policy is terminated by the group or by our Company
- The group’s policy is amended to exclude the class to which the employee belonged
- The employee no longer belongs to a class eligible for coverage under the group policy
- The employee retires or dies
- The employee fails to pay the required premium
- The employee is disabled under the terms of the group policy
**Requesting a Quote**

To receive a quote for LTD conversion, please contact a client service representative at 1-877-321-1015. The representative will need the following information:

- Group policy number or ID
- Date of birth
- Sex
- Last date worked
- Last regular monthly salary amount

**Submitting an Application**

An Application for Conversion of Group Long-Term Disability can be obtained by contacting a client service representative at 1-877-321-1015 or emailing clientservices@LFG.com. The group policyholder (the employer) must complete the Employer Questionnaire portion of the application in full and give the application to the terminating employee. The employee then has 31 days from date of termination to submit the completed application (including the Employer Questionnaire) to Lincoln.

- No “notification period” is allowed in the LTD conversion privilege. It is extremely important that eligible employees be provided the correct paperwork immediately upon termination.
- If the employee does not submit the correct paperwork within 31 days after the date of termination of employment, the conversion privilege is no longer available.

**Mail the completed forms to the following address:**

The Lincoln National Life Insurance Company  
P.O. Box 0821  
Carol Stream, IL 60132-0821

Upon our receipt of the completed forms, we will determine eligibility. An eligible employee will receive notification, and we will request a check for the initial premium. Upon receipt of the initial premium, processing will continue, and the LTD conversion policy will be issued.

**Portability**

Portability is a feature that allows an employee’s group life, disability, accident, or critical illness coverage to continue on a direct-billed basis after the employee is no longer eligible for coverage through the employer, while taking advantage of group rates that may be lower than individual policy premiums. The employee must send in a completed Application for Portability for the coverage, along with the initial premium payment, within 31 days of the date insurance would otherwise end. The form is available on our website at [https://www.lincoln4benefits.com/jpfebill/forms/gfrmsel2.asp](https://www.lincoln4benefits.com/jpfebill/forms/gfrmsel2.asp).

There is one form for life and/or disability, and separate forms for accident and/or critical illness (use the form for the situs state of the group). The mailing address is listed on the applicable form.
Accident and critical illness may be ported at any time. For life or disability, the employee typically must have had coverage for at least 12 months to be eligible for portability. Also, for life and disability, the length of time that coverage under the portability provision will continue is limited. Please refer to your group policy for specific details. For assistance, please call one of our client service representatives at 1-877-321-1015.

Insured employees may not be eligible for portability of life or disability coverage in certain circumstances, including but not limited to the following:

- Total disability (from their own occupation)
- Termination from an eligible class
- Fewer than 12 months of in-force coverage
- Termination of the employer’s group policy
- Work hours reduced below contract requirements
- Active military leave
Continuation

Continuation is a feature that allows an employee’s group life coverage to continue on a direct-billed basis after the employee is no longer eligible for coverage through the employer, while taking advantage of rates that may be lower than individual policy premiums. The employee must send in a completed Application for Life Continuation for the coverage, along with the initial premium payment, within 31 days of the date insurance would otherwise end. The form is available on our website at https://www.lincoln4benefits.com/jpfebill/forms/gfrmsel2.asp. The mailing address is listed on the applicable form.

The employee typically must have had coverage for at least 12 months to be eligible for continuation. The length of time that coverage under the continuation provision will continue is limited. Any active Continuations will terminate if the group policy terminates with LFG. In that case, the employee could apply for conversion. Please refer to your group policy for specific details. For assistance, please call one of our client service representatives at 1-877-321-1015.

Insured employees may not be eligible for continuation of life coverage in certain circumstances, including but not limited to the following:

- Total disability (from their own occupation)
- Termination from an eligible class
- Fewer than 12 months of in-force coverage
- Termination of the employer’s group policy
- Work hours reduced below contract requirements
- Active military leave
Life Claims
At Lincoln Financial Group, we take a stream-lined, coordinated approach to claims management to ensure the process from intake to benefit decisions are coordinated and clearly communicated, with compassionate claims specialists supporting the process every step of the way.

How do I contact Lincoln?
Claimant Service Excellence Center (800) 423-2765
General Claims questions: Claims@LFG.com

How do I start a Life Claim?
We offer flexibility in the way you choose to have the claim submitted by providing multiple intake options. We will accept a claim started by the group Policyholder, Insured or Beneficiary.

- **Claimant Excellence Initiation Center for telephonic claims**: 866-783-2255
- **Email**: LifeClaims@LFG.com (only for submitting documentation or claims)
- **Mail**: The Lincoln National Life Insurance Company, PO Box 2649, Omaha, NE 68103
- **If group is in New York send to**: Lincoln Life & Annuity Company of New York, PO Box 2649, Omaha, NE 68103
- **Fax**: 1-800-462-4660
- **Web**: LincolnFinancial.com
- **Lincoln Financial Group’s Links process**: Our LINKS process allows for automatic transfer of information from a Life waiver claimant who has passed to start a Life claim; no separate claim form needs to be submitted for the life insurance.

Express Life Claims Service
Lincoln strives to provide compassionate service through the difficult time associated with a death. To help ease the claim process, Lincoln offers the Express Life Claims Service for employer paid life coverages. This service allows for the processing of a life claim without the death certificate when the following criteria are met:

- Benefit amount is $300,000 or less.
- Claim must be reported by the employer or information from the beneficiary must be validated with the employer.
- Death must have occurred in the United States.
- Coverage is not contestable.
- Death must be due to natural causes.
- Beneficiary of the coverage is confirmed and undisputed.
- For benefits not meeting the above requirements, Lincoln will require a copy of the death certificate be provided as part of that coverage review.

What is the basic claim information needed to start a claim review?
A complete claim includes the employer's portion of the claim form, complete beneficiary information and a copy of the death certificate (if required). In most cases we will only need a copy of the certified death certificate (if required). Some exceptions would be foreign deaths or potential fraud situations. If
a claim is initially received without this basic information, then it will go into the Life Incomplete claim process below as we try to gather this information.

**Turn-Around Times for Claims**
- Initial claim — within 5 business days Lincoln will review to determine if we can pay, pend or deny the claim.
- Correspondence—within 3 business days of receiving correspondence we will review to see if can now make the claim decision.
- Email/Phone — we will respond within 24 business hours to any inquiries.

**What happens if the basic information is not provided?**
If the basic claim information is not provided when the claim is entered, then we will take the following steps to try to obtain that information as quickly as possible.
- The intake team will enter the claim within 24 hours (real time if submitted telephonically). If claim does not have the minimal information to make it complete (allowing for the full claim review) then the claim goes into an incomplete claim queue.
- A life claims examiner reviewing the incomplete claim queue will make a call within 1 business day to the appropriate party to request the missing minimal information needed to make the claim complete.
- If the missing information is not received within 3 business days of the claim receipt a missing information letter is sent to the appropriate parties.
- If the missing information is not received within 10 business days of the claim receipt a closure letter is sent.
- Once this basic information is received, then the claim is updated and moves into the complete life claims queue. Within 5 business days of it becoming complete, a separate life claims examiner will pull the claim. At this point, the claim will go through a thorough review to determine if the claim decision can be made to pay, pend for additional information, or deny the claim.

**What other information may be required to complete the claim review?**

**Eligibility/Benefit Verification**
We will need confirmation of coverage (below are some examples):
- Documentation of who the insured named as the beneficiary(ies)
- Enrollment form from group confirming coverage
- Census/Billing (employee list for self-billed groups)
- Benefit screen print showing the amount of life insurance coverage in force at the time of death (for self-billed groups)
- If the insured is on leave due to disability and dies at a later date, verification that premium was continued through the month of death. A current eligibility file / billing report, a human resources record or an adjustment report of some kind showing the termination date of life insurance will suffice.

If benefit is salary-based, verification of salary as of last day worked is required along with verification of the current salary-based benefit amount (Human Resource compensation screen print or payroll record)
If benefit is Optional or Voluntary (contributory), include verification of the initial coverage election date and benefit amount along with any increases or Human Resource verification of initial and current coverage to confirm compliance of eligibility guidelines.

**Payment Options**
- Direct deposit
- Check
- SecureLine Interest Bearing Checking Account: If a benefit payment is over $5,000, the beneficiary may elect to receive a secure line account. These accounts earn interest and the beneficiary receives a check book to access the account. The account is completely free for the beneficiary. Please note: SecureLine Accounts are not available for New York sitused groups or beneficiaries. The accounts also require a street address (no PO Box).

*Our claim form contains the options for the beneficiary to select the payment method. All payments should be mailed or deposited to the beneficiary directly.*

**Accidental Death & Dismemberment (AD&D)**
If an accidental bodily injury results in death or dismemberment, then the following documentation may be required (if applicable):
- Life or Dismemberment Claim form
- A copy of the police accident/incident report
- Toxicology report to determine if alcohol/drug policy exclusions apply
- Pharmacy records to determine if drug exclusion applies
- Autopsy report (in the event of death) to determine if medical exclusion applies

**Beneficiary Designation**
If the beneficiary designation was obtained by the employer, please send in the designation with the claim form. If the claim is sent without a beneficiary designation, a Lincoln Financial representative will call the group to confirm the beneficiary of the policy before payment is made.

**What If …**

There is no beneficiary?
Payment may be made to certain relatives or the insured person’s estate, as provided in the policy.

Payment is to be made to an estate?
Court documents of appointment must be forwarded to our Company before payment can be made to the estate. The documents of appointment must name the personal representative of the estate (also called the executor, executrix, administrator or other similar title) to whom benefits can be paid. A W-9 form verifying the tax identification number must also be provided.

Payment is to be made to a trust?
A copy of the trust document must be provided with the claim. Such documents must designate the trustee to whom proceeds will be paid. A W-9 form verifying the tax identification number must also be provided.
**Beneficiary is a minor child?**

A minor, defined by age according to state law, lacks capacity to sign a binding release of an insurance contract. Only the lawfully appointed representative of a minor may give release for payment to a minor. Life insurance benefits, therefore, cannot be paid to anyone who has not reached the age of majority. If guardianship documents are not secured, the proceeds will be held until the beneficiary reaches the age of majority, unless state statutes (e.g., the Uniform Gifts/Transfers to Minors Acts) in the appropriate jurisdiction allow for other payment provisions to be used.

**Funeral Home Assignment**

The beneficiary(ies) can assign the proceeds to a funeral home in order to cover funeral expenses. The required form can be obtained from the funeral home.

- This form must be signed by all named beneficiaries. If only one beneficiary signs the form, funeral expenses will be deducted from the portion allotted for that beneficiary only.
- The form must indicate the policyholder and policy number, and the amount of the benefit being assigned.
- The funeral home assignment cannot be signed by a minor (to assign benefits, the beneficiary must be of legal age).
- We do not accept collateral assignments (i.e., use of life insurance as collateral).

**Accelerated Death Benefit**

The Accelerated Death Benefit is also referred to as a Living Benefit. This benefit allows advance payment of part of the Insured Person’s personal life insurance. It may be paid to a terminally ill Insured Person in a lump sum, once during the Insured's lifetime. To qualify, in most states the Insured Person must:

- satisfy the actively at work requirement under the policy.
- be insured under the policy for at least 12 months (some states may vary - check the policy to verify timeline).
- have a minimum amount of personal life insurance under the policy on the date the living benefit is paid (2,000 is standard – check the specific policy to verify the amount).
- be insured under the policy on the date the form is completed.

The Insured Person (or his or her legal representative) must apply for the benefit by:

- completing a Request for Living Benefit claim form.
- providing satisfactory proof that the Insured Person is terminally ill, including a physician’s written statement indicating the approximate life expectancy.

Terminally ill means the Insured Person has a medical condition that is expected to result in death within 12 months, despite appropriate medical treatment. (Certain state requirements may vary. Please see your specific policy for details.)

**Extension of Death Benefit (Life Waiver of Premium)**

The Extension of Death Benefit provision is commonly referred to as a Life Waiver of Premium. This is a benefit allowing the employee/employer to waive premium payment on life insurance during a qualifying period of total disability.

An Extension of Death Benefit application must be completed to apply for the Life Waiver of Premium
benefit. The employee must be totally disabled, as defined by the policy, from any occupation for at least six months and be under the age of 60 at the time of disability (see the policy for plan details, as age and elimination period may vary). Refer to the section on filing a life claim for fax, mail and email information.

The standard policy provides Life Waiver of Premium for basic life and optional life. The AD&D policy premium cannot be waived. For voluntary plans, typically only the voluntary life premium may be waived. Please refer to your policy for verification, as this may vary.

In addition, not every life contract includes the Extension of Death benefit/Life Waiver provision. Refer to your policy to determine if this benefit is included.

If approved, the employee is required to provide proof of continued total disability under the terms of the policy. Please refer to the termination language in your policy for the specific reasons a Life Waiver of Premium claim would terminate.

**Premium Adjustments for Waiver of Premium**

Employees who have applied for the Extension of Death Benefit/Life Waiver of Premium continue to pay the premium during the elimination period. If the claim is approved, adjustments to premium will occur.

For list-billed groups, our administration area will be notified of the approval determination and will automatically make the adjustment to the bill. For self-billed groups, the plan administrator/employer must make the adjustment upon receipt of the copy of the approval letter, using the effective date indicated on the correspondence. The employer should not make the adjustment until notified that the claim has been approved for the Life Waiver of Premium.

**Taxability**

We issue 1099INT for any interest payment made over $10 paid to each beneficiary. Lincoln will require a W-8BEN Form if:

- The payee is a non-US citizen living in a foreign country
- The payee is a non-US citizen living within the United States (*)

Lincoln will require a W-9 Form if:

- The payee is a US citizen living in a foreign country
- The payee is a non-US citizen living within the United States (*)
- The payee is trust, estate, or other entity.

*W-8BEN and W-9 Forms can be found at the IRS website.
**Accident / Critical Illness Claims**

**Filing an Accident or Critical Illness Claim**
Claim forms can be found on our website at [LincolnFinancial.com](http://LincolnFinancial.com). We offer multiple options for submitting claim forms:

- **Fax:** 1-877-668-5331
- **Mail:** The Lincoln National Life Insurance Company  
  P.O. Box 2609  
  Omaha, NE 68103

**If situated in New York, mail the completed form to:**
Lincoln Life & Annuity Company of New York  
P.O. Box 2609  
Omaha, NE 68103

**Payment of Benefits**
For accident and critical illness claims, checks are mailed to the insured. For accident and critical illness that is pre-tax or employer paid, a 1099 will be issued if the combined benefits exceed $600.

**Appealing a Denied Claim**
In most instances, a written appeal must be received within 60 days from the date of denial to be considered. A written response will be completed within 45 days advising the claimant if additional information is needed or if a decision has been reached. We offer multiple options for submitting appeals:

- **Fax:** 1-402-361-1460
- **Email:** worksiteclaims@LFG.com
- **Mail:** Claims Shared Services  
The Lincoln National Life Insurance Company  
P.O. Box 2337  
Omaha, NE 68103

**If situated in New York, mail the completed form to:**
Claims Shared Services  
Lincoln Life & Annuity Company of New York  
P.O. Box 2337  
Omaha, NE 68103

The appeal letter should indicate the reason the claim should be reconsidered. If the denial was due to a waiting period or effective date issue, proof will be required to support insured’s position, such as an enrollment form or copies of payroll deductions.
Short-Term Disability (STD) Claims

Filing a Claim for Short-Term Disability
Claim forms are available on our website at LincolnFinancial.com. To avoid a delay in the processing of a claim, all questions on the claim form should be fully answered. A signed authorization is also needed and will help expedite the claim processing. We offer multiple options for submitting an STD claim:

**Telephonic intake: 1-866-STD-CALL (1-866-783-2255)**
- Telephonic intake is the preferred method for submitting an STD claim, as it allows an immediate opportunity to have a dialogue with our intake representatives, who can help explain the process and answer your employee’s questions.
- Our telephonic service hours are 7 a.m. to 7 p.m. CST Monday–Thursday and 7 a.m. to 5 p.m. CST on Fridays.

**Email:** DisabilityClaims@LFG.com

**Web:** LincolnFinancial.com (available only for fully insured STD products)

**Fax:** 1-877-843-3950

**Mail:**
Lincoln National Life Insurance Company
P.O. Box 2609
Omaha, NE 68103

If group is situated in New York, please send to:
Lincoln Life & Annuity Company of New York
P.O. Box 2609
Omaha, NE 68103-2609

Once the initial intake process is completed, we proceed with the following steps:
- We will assign the employee’s leave to an STD claims examiner.
- The STD claims examiner will reach out to the employee, employer and physician’s office to gather any additional information needed to make the STD benefits determination.
- The STD claims examiner will continue the claim management process, reviewing for the likelihood of a transition to LTD.

Due to applicable privacy laws and regulations, employers will not receive copies of letters that include private health or financial information.

Payment of Benefits
Unless otherwise indicated, claim checks are either mailed directly to the employee’s home or sent by direct deposit. Our standard procedure is to issue STD checks every other week.
Updated Salary Not Reflected in Benefit Checks
If the claim was incurred prior to the date of a salary increase, the increase would not be reflected in the benefit. If the increase was effective prior to the date of disability and meets contract requirements for reporting salary increases, you must audit all of your insured employee’s salary information, provide the amount and date of the increase and pay back premium on any increased amounts. Submit all salary changes to clientservices@LFG.com so Lincoln can update our records.

After we receive the premium for the increased amounts, we will make the adjustment to the benefits, and any retroactive benefits due would be paid to the employee.

Reporting Part-Time Earnings for an Employee Who Is Receiving Disability Benefits
You must provide the number of hours the employee works each day and the rate of pay, along with copies of payroll records. This may be provided on a weekly or biweekly basis using your own form or a letter. The information can be faxed or emailed, or you may contact your claims examiner directly. The partial benefit cannot be calculated or paid until you submit this information.

Lincoln Financial Group’s LINKS Process
Lincoln Financial Group offers a variety of programs and services to assist disabled employees and help them return to full productivity. One such program is LINKS — a highly efficient claims process for those covered by Lincoln short-term disability (STD) and long-term disability (LTD) plans. LINKS goes beyond usual expectations to provide a smooth transition from STD to LTD without claim filing. It is a proactive, integrated claims management system that provides early intervention with the insured to identify potential LTD claims.

How the LINKS Process Works
When an STD claim is received, the claims department determines whether the claimant is also covered under a Lincoln LTD plan. If so, the integration process begins. A team approach is used and, when deemed appropriate, a nurse and a vocational counselor are consulted for claim guidance. The LINKS program was designed by Lincoln to blend technology with the personal touch of our disability claims examiners. All claims information resides together in our system for more efficient access and coordination. Claims examiners work closely together to manage claims and monitor the progress of the disability.

Return-to-Work Notification
Providing us with return-to-work information over the phone at 1-800-423-2765 will allow us to expedite the final payment. The group may also provide a return-to-work notification, or the employee may provide a doctor’s release form. If return-to-work information is being given over the phone, the following is required:
- Date the employee returned to work
- Whether the employee returned to the same occupation
- Whether the employee returned to work full or part time

Return to work date can also be reported through www.lincoln4benefits.com or emailed to disabilityclaims@LFG.com.

Preexisting Condition Clause
This provision stipulates that disabilities caused or contributed to by a preexisting condition are excluded from coverage under the contract unless certain conditions have been met. A preexisting condition is a sickness or injury for which the employee received medical treatment, consultation, care
or services including diagnostic measures or prescribed drugs or medicines during a specific period of
time prior to the employee’s effective date. If a preexisting condition provision is included in your
policy, an investigation based on the policy’s language will be conducted, if applicable.

Example: A 3/12 preexisting condition clause means that any disabling condition for which the insured person received
treatment during the 3 months immediately prior to the effective date of coverage is excluded. Once the insured person
has been covered for 12 months, the preexisting condition clause no longer applies.

**Social Security Assistance**

We employ former Social Security Administration experts to assist claimants throughout the initial
application and the appeal process. We will pay the cost of attorney fees for appeal representation.
Additionally, claimants who sign our indemnity agreement and show evidence that they’ve applied for
Social Security Disability Income will receive full benefit until an award is received. Claimants not
expected to qualify for Social Security are not required to go through the application process.
Employees with such claims are often recommended as return-to-work or case management
candidates.

**Appealing a Denied Claim**

In most instances, a written appeal must be received within 180 days from the date of denial to be
considered. A written response will be completed within 45 days, advising the employee if additional
information is needed or if a decision has been reached. We offer multiple options for submitting
appeals:

- **Fax:** 1-402-361-1460
- **Email:** DisabilityClaims@LFG.com
Mail: Claims Shared Services
The Lincoln National Life Insurance Company
P.O. Box 2337
Omaha, NE 68103

If sitused in New York, mail the completed form to:
Claims Shared Services
Lincoln Life & Annuity Company of New York
P.O. Box 2337
Omaha, NE 68103

The appeal letter should indicate the reason the claim should be reconsidered. If the denial was due to a waiting period or effective date issue, proof will be required to support the employee’s position, such as an enrollment form or copies of payroll deductions. The employee should also provide any additional information to support the appeal, such as:

- Medical records
- Test results
- Payroll records

New Jersey / New York Disability Claims Information

If an employee is unable to work due to illness or injury, have the employee complete a New York Disability Benefit Law (DBL) or New Jersey Temporary Disability Benefits (TDB) STD claim form. If the employee has both statutory coverage and STD through Lincoln, this form will initiate both claims. Completed claims should be submitted within 30 days after the individual becomes sick or disabled. We offer multiple options for submitting claim forms:

Email: NYNJClaims@LFG.com
Fax: 1-855-398-7387

Mail: If sitused in New York, send to:
Lincoln Life & Annuity Company of New York
P.O. Box 2609
Omaha, NE 68103-2609

If sitused in New Jersey, send to:
The Lincoln National Life Insurance Company
P.O. Box 2609
Omaha, NE 68103-2609

New York DBL Claim Features

- Payments are issued on a biweekly basis.
- Payments will be sent via check or direct deposit to the claimant.
- If the group offers a salary continuation or sick leave plan, reimbursement of the statutory disability benefit to the employer is an option.
• The employee must have a certified disability precluding work in full-time capacity.
• The employer will also receive a copy of the check and an explanation of benefits.

**New Jersey TDB Claim Features**
• Payments are issued on a biweekly basis.
• Payments will be sent via check to the claimant.
• If the claimant is out on a certified disability longer than 21 days, the claimant will be reimbursed for the elimination period.
• You will also receive a copy of the check and an explanation of benefits.

**Long-Term Disability (LTD) Claims**

**Filing a Claim for Long-Term Disability (LTD)**
We suggest that the claim be submitted at least 45–60 days prior to the end of the elimination period to ensure that a decision is made before the first payment is due (if the claim is payable). The elimination period is the time during which the employee is disabled before benefits become payable. We offer several methods for submitting an [LTD claim form](#).

- **Email:** [DisabilityClaims@LFG.com](mailto:DisabilityClaims@LFG.com)
- **Web:** [LincolnFinancial.com](http://LincolnFinancial.com)
- **Fax:** 1-877-843-3950
- **Mail:**
  The Lincoln National Life Insurance Company  
P.O. Box 2609  
Omaha, NE 68103
  
  If group is sitused in New York, please send to:  
Lincoln Life & Annuity Company of New York  
P.O. Box 2609  
Omaha, NE 68103-2609

**Payment of Benefits**
The initial payment is usually made when a decision is rendered on a claim, when appropriate. If the period for payment has passed, retroactive payments will be released. After the insured person meets the elimination period, LTD payments are made in arrears, which means they are paid at the end of the period for which they are due.

Example: If the elimination period is from September 1 to October 1, payment is made for the period from October 1 to November 1 and will usually be sent out by mail approximately seven days prior to November 1. If the payment is sent out via direct deposit, it will usually be sent approximately three days prior to November 1.

Payment will not be made beyond the date the physician releases the employee, without supporting documentation. Therefore, if a claim is submitted indicating a release date prior to the current date, payment will not be made.

Normally, payments are sent directly to the employee, unless otherwise requested in writing by the
group policyholder.

**Calculating LTD Benefits**
The contract dictates the percentage of benefit. The benefit amount or percentage of salary is indicated in the Schedule of Benefits page in the contract. The benefit is calculated by multiplying the pre-disability income of the employee by this percentage. Some contracts provide for a flat benefit amount the employee is entitled to receive. The policy also contains a minimum and maximum amount available under the contract.

Common reasons for differences in amount paid versus amount expected on disability claims:
- Unreported salary increases
- Confusion regarding payment period or elimination period
- Taxes withheld
- Integration of other income

**Preexisting Condition Clause**
This provision stipulates that disabilities caused or contributed to by a preexisting condition are excluded from coverage under the contract unless certain conditions have been met. A preexisting condition is a sickness or injury for which the employee received medical treatment, consultation, care or services including diagnostic measures or prescribed drugs or medicines during a specific period of time prior to the employee’s effective date.

If a preexisting condition provision is included in your policy, an investigation based on the policy language will be conducted, if applicable.

Example: A 3/12 preexisting condition clause means that any disabling condition for which the insured person received treatment during the 3 months immediately prior to the effective date of coverage is excluded. Once the insured person has been covered for 12 months, the preexisting condition clause no longer applies.

**Integration of Other Income**
Our contracts allow for integration of other income the employee receives due to the disability. This means that the benefit amount will be reduced by the other income received, up to the minimum benefit (refer to your specific policy coverage for provision details). Some examples of other income:
- Social Security (both employee and family)
- STD benefits
- Workers’ compensation
- State disability benefits
- A qualified employer retirement plan
Accumulation of the Elimination Period
The elimination period is the time during which the employee is disabled before benefits become payable. Accumulation of the elimination period allows the elimination period to be broken into nonconsecutive days. It is designed to reward an insured employee’s attempt to return to work.

The standard accumulation of elimination period wording under your contract is two times the elimination period. It ensures that disabled employees are not penalized for trying to go back to work during the elimination period. The days the employee is not disabled will not count toward satisfying the elimination period, but they may be consecutive or intermittent. All or part of the elimination period can be completed while working if the insured employee is considered disabled under the terms of our contract during the period of work activity.

Recurrent Disability
The claim of an employee who has attempted to return to work (full time) for six months or less, but then has gone back out on disability will be considered as the same claim, provided it is for the same disabling condition as the first period of disability. An employee who has returned to work for more than six months must file a new claim and meet another elimination period. If the employee returns to work and becomes disabled with a new disabling condition, this will be handled as a new claim.

Partial Disability Provision
Partial disability or partially disabled means that, as a result of sickness or injury that caused disability, the insured employee is
- able to perform one or more, but not all, of the main duties of his or her own occupation or any occupation on a full-time or a part-time basis; or
- able to perform all of the main duties of his or her own occupation or any other occupation, but only on a part-time basis.

After 24 months of partial disability benefit payments (the return-to-work incentive period), an earnings test is applied. Our partial disability benefit will cease if the employee is earning over 85% of pre-disability earnings (or over 60%, depending on the coverage purchased).

Our standard method of calculating partial disability benefits is the progressive method. Under this method of calculating partial disability benefits, the benefit payable will be the lesser of
- the scheduled benefit percentage multiplied by the insured employee’s pre-disability earnings less other income benefits, excluding earnings from partial employment; or
- 100% of the insured employee’s pre-disability earnings less other income benefits, including earnings from partial employment; or
- the scheduled benefit maximum.

Partial disability benefits are payable to the end of the benefit duration: until the disabled employee’s current earnings exceed 85% (or 60%) of pre-disability earnings, until the employee’s death or until the employee’s recovery from the disability.
Example:
Assumptions:
- Pre-disability earnings: $5,000
- Benefit percentage: 60%
- Maximum monthly benefit: $5,000
- Partial employment earnings: $2,200
- Income from other sources: $0

Progressive Calculation: *
The partial disability benefit payable is the lesser of:

- 60% of pre-disability earnings: $5,000
- less other income benefits: x 60%
- $3,000

- Pre-disability earnings: $5,000
- less partial employment earnings: -$2,200
- and other income benefits: $2,800

Maximum monthly benefit: $5,000

Partial Disability Benefit Payable $2,800
* Please refer to your specific policy coverage for provision details.

Work-Related Disabilities
Our standard contract integrates with workers’ compensation benefits. For example, if the employee’s benefit is $1,000 per month and he/she receives $300 per month from workers’ compensation, we will deduct the $300 from the $1,000, for a net benefit of $700.

Court-Ordered Garnishment of Benefits
We will accept a written request from you, the employer, with a copy of the court order for garnishment of disability benefits. We will also accept a copy of the court order if it is sent directly from the court or from any other entity. The request must be made in writing and submitted to the claims examiner handling the claim.

Death of an Employee Who Was Receiving Disability Benefits
Upon notification of a death, the survivor benefit will typically be paid to the surviving spouse or child/children less than 25 years of age when benefits have been paid and the disability has lasted more than 180 days.
Updated Salary Not Reflected in Benefit Checks
If the claim was incurred prior to the date of salary increase, the increase would not be reflected in the benefit. If the increase became effective prior to the date of disability and meets contract requirements for reporting a salary increase, you must audit all of your insured employee’s salary information, provide the amount and date of the increase and pay back premium on any increased amounts. Submit all salary changes to clientservices@LFG.com so Lincoln can update our records.

After we receive the premium for the increased amounts, we will make the adjustment to the benefits, and any retroactive benefits due would be paid to the employee.

Reporting Part-Time Earnings for an Employee Who Is Receiving Disability Benefits
You must submit information indicating the number of hours the employee works each day and the rate of pay. This may be provided on a weekly or monthly basis. You may also provide this information on your own form or as a letter, along with copies of payroll records. The partial benefit cannot be calculated or paid until this information is submitted.

Waiver of Premium for Disability
Waiver of premium is automatic when a long-term disability claim is approved, provided the disability extends beyond the period required to qualify. The employee and employer will receive a notification from the claims area indicating the date the waiver becomes effective. This automatic process is available for all groups except for those that have self-billed, employee-paid life coverage with no employer-paid life coverage.

Premium Adjustments for Waiver of Premium
For list-billed groups, the waiver will automatically be adjusted on the bill. For self-billed groups, the plan administrator must make the adjustment upon receipt of the copy of the approval letter and use the effective date indicated on the correspondence. The employer should not make the adjustment until after being notified that the claim has been approved for waiver of premium.

LTD Life Waiver Links Process
For claimants with Lincoln Financial Group life insurance coverage, and who meet all of the policy provisions, are eligible for the life waiver benefit. Through the LINKS process, a claim for waiver of life insurance premiums is automatically set up and coordinated with the Life Insurance department. This extra step in our integrated process means the employee will not have to submit a separate claim.

Return to Work Assistance
All of Lincoln’s disability plans are designed and managed to encourage and facilitate a timely return to work. Most claimants can be expected to fully recover or retain transferrable skills that can enable them to regain productivity in the workplace, and most people who have been ill or injured want to return to work when able.

Because the highest probability of a successful return to work is returning to the same employer, we strive to form partnerships with our customers that can result in a win-win outcome for the employer, employee, and Lincoln. And even if you find you do not have a role for your employee to return to, our Vocational Rehabilitation Consultants can work with your claimants to find alternative employment by leveraging transferable skills or helping to build new skills that lead to gainful employment.
Notification of Return to Work

Providing this information over the phone at 1-800-423-2765 will allow us to expedite the final payment. The group may also provide a Return to Work Notification form (available on the web at LincolnFinancial.com), or the employee may provide a doctor’s release form. If return-to-work information is being given over the phone, the following is required:

- Date the employee returned to work
- Whether the employee returned to the same occupation
- Whether the employee returned to work full or part time

Appealing a Denied Claim

In most instances, a written appeal must be received within 180 days from the date of denial to be considered. A written response will be completed within 45 days, advising the employee if additional information is needed or if a decision has been reached.

The appeal should indicate the reason the claim should be reconsidered. If the denial was due to a waiting period or effective date issue, proof will be required to support the employee’s position, such as the enrollment form or copies of payroll deductions.

Employees should also provide any additional information to support the appeal, such as:

- Medical records
- Test results
- Payroll records

We offer multiple options for submitting appeals:

Fax: 1-402-361-1460

Email: DisabilityBenefits@LFG.com

Mail: Claims Shared Services
The Lincoln National Life Insurance Company
P.O. Box 2337 Omaha, NE 68103

If situated in New York, mail the completed form to:
Claims Shared Services
Lincoln Life & Annuity Company of New York
P.O. Box 2337 Omaha, NE 68103

Tax Information Pertaining to Disability Benefits

Please be aware that Lincoln Financial Group is not a tax advisor and the following information is only to assist you with some general tax questions. Any specific or detailed questions should be addressed to your own tax consultant.
Taxability of Disability Benefits (i.e., Third-Party Sick Pay)

Short-term disability (STD) and long-term disability (LTD) benefits may or may not be considered taxable income. The taxability of these benefits is generally determined by who pays the premium and how the premium is paid. Federal law requires withholding of Social Security and Medicare taxes from third-party sick pay on the percentage of benefit attributed to the premium paid for by the employer or with pre-tax employee dollars. Following are a few examples of when a disability benefit may or may not be considered as taxable income:

<table>
<thead>
<tr>
<th>Premium Payment</th>
<th>Taxability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer pays 100% of the cost of the premium</td>
<td>100% Taxable Benefit</td>
</tr>
<tr>
<td>Employer pays 50% of the cost of the premium and the Employee pays the remainder of the premium on a post-tax basis</td>
<td>50% Taxable Benefit</td>
</tr>
<tr>
<td>Employer pays 50% of the cost of the premium and the Employee pays the remainder of the premium on a pre-tax basis</td>
<td>100% Taxable Benefit</td>
</tr>
<tr>
<td>Employee pays the entire cost of the premium on a pre-tax basis</td>
<td>100% Taxable Benefit</td>
</tr>
<tr>
<td>Employee pays the entire cost of the premium on a post-tax basis</td>
<td>0% Taxable Benefit</td>
</tr>
</tbody>
</table>

You will notice that if the employee pays any portion of the premium on a post-tax basis, this portion of the benefit is not taxable, and if any portion of the premium is paid on a pre-tax basis, this portion of the benefit is taxable. Pre-tax contributions are deemed “employer contributions” and, therefore, result in taxable benefits.

All disability payments, regardless of their taxability, must be reported to the government on a W-2. If the disability benefit is taxable, this amount should be recorded in Box 1 under wages, tips, and other compensation. If the disability benefit is nontaxable, this amount should be recorded on the W-2 in Box 12A, with code J. Box 13 should have “third-party sick pay” checked.

When a disability benefit is considered taxable, it may become subject to additional withholdings. These withholdings include the required withholding under the Federal Insurance Contributions Act (FICA), otherwise known as Social Security and Medicare taxes, and federal income tax (FIT). FICA and FIT are based upon the amount of the disability benefit that is actually taxable. For example, if only 50% of the disability payment is taxable, then FICA and FIT apply only to that portion of the benefit. FIT is withheld from disability payments only upon election by the employee.

Example:
The employer pays 50% of the premium and the employee pays the remainder of the premium on a post-tax basis = 50% taxable benefit.

- If the disability benefit is $250: $250 @ 50% = $125
  - $125 should be reported as taxable income, and FICA and FIT apply only to this portion of the payment.
    - FICA amount = $9.56 ($125 x 7.65% = $9.56).
    - The FIT amount will vary depending upon the employee’s whole-dollar election, but only $125 is taxable.
Lincoln is required by law to withhold FICA on “taxable” amounts for the first six months of any applicable disability period. FICA tax is required to be withheld until the first of the month following six full calendar months of disability, provided that our payment is made within the six-month period.

Example:
Disability date is 1/15
- 1st of the month following is 2/1
- (+) 6 months = 8/1
- For any payments made before 8/1, FICA applies. For any payments made on or after 8/1, FICA does not apply.
- The current FICA rate is 7.65%.
  - 6.20% = Social Security tax
  - 1.45% = Medicare tax
  - The FICA rate is subject to change annually.

Federal income tax withholding is voluntary rather than mandated by federal law. The LTD claim form allows the employee to elect the amount to be withheld when the claim is initially filed. However, if an employee elects to change his/her FIT withholding at a later date, a form W-4S should be provided. This form can be obtained from IRS website. The STD claim form does not allow an option for FIT withholding; therefore, the employee must provide the request in writing.

FICA Match
For LTD coverage, Lincoln Financial Group automatically includes our FICA match service.

For STD coverage, you have the option to retain responsibility for matching FICA or you may request that Lincoln Financial Group match FICA. The FICA match service for STD will result in an additional cost and must be part of or added to the policy.
STD Plan without FICA Match Service

<table>
<thead>
<tr>
<th>Tax reporting activity</th>
<th>Lincoln responsibility</th>
<th>Employer responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee FICA withholding and remittance (if applicable)</td>
<td>Yes*</td>
<td>No</td>
</tr>
<tr>
<td>Employer FICA remittance (if applicable)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>941 reporting</td>
<td>Yes* (employee FICA withholding)</td>
<td>Yes (employer FICA)</td>
</tr>
<tr>
<td>W-2 reporting and distribution</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>W-2 preparing and mailing</td>
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<td>Yes</td>
</tr>
<tr>
<td>W-2 corrections</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>FUTA/SUTA</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* Reporting done under Lincoln company name and Employer Identification Number.
Not available if group has Advice to Pay.

STD Plan with FICA Match Service

<table>
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<th>Tax reporting activity</th>
<th>Lincoln responsibility</th>
<th>Employer responsibility</th>
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<td>Employee FICA withholding and remittance (if applicable)</td>
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<td>941 reporting</td>
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<td>No</td>
</tr>
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<tr>
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</tr>
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</tr>
</tbody>
</table>

* Reporting done under Lincoln company name and Employer Identification Number.
Not available if group has Advice to Pay.

Reporting of Withholdings (FICA and FIT)
All FICA and FIT withheld from disability payments is sent through the Federal Reserve System. This is sent in one lump sum, at least twice weekly, under Lincoln’s applicable Employer Identification Number.

FICA Reports
Monthly or annual LTD and STD FICA reports may be obtained online at [LincolnFinancial.com](http://LincolnFinancial.com) or by calling a client service representative at 1-800-423-2765.
Only groups that had employees on disability in the reporting month and STD groups that do not have the FICA match service will receive the monthly report. Every group will receive a report at the end of the year if disability benefits have been paid.

While LTD groups do not receive a monthly FICA report, Lincoln will provide a yearly report of all claims paid.

**W-2s**
Lincoln will generate and report W-2s for all LTD groups that have claims. If Lincoln is providing the FICA match service, we will use Lincoln’s tax ID number for all the LTD and STD W-2s we generate. If you have requested that Lincoln print your W-2s without the FICA match service, your company’s tax ID will be used.

For all STD groups that have opted for the FICA match service, W-2s will be provided and reported. For STD groups that have elected to retain responsibility for matching FICA, a W-2 printing service may be requested from Lincoln. With the printing service, your W-2s are printed under your company’s name and tax ID number.

If the employer group is terminated with Lincoln, the W-2 and FICA reporting obligations remain the same.

A W-2 is required for nontaxable benefits, which should be reported as third-party sick pay (1099s are not issued for third-party sick pay). The employer can choose to include the third-party sick pay with the taxable wages the employee received during active employment, or to issue a separate W-2.

**Federal Income Tax Withholdings Made by Lincoln**
No amount other than the FIT amount should be included on any applicable W-2 prepared by the employer for an STD without FICA match. Lincoln will report the FIT amount on its own 941, and no further reporting is required by you.

**Withholding of Federal and State Income Taxes**
Lincoln will withhold federal taxes per the claimant’s request. A minimum of $88 per month in FIT must be withheld if the employee is requesting FIT withholding. Under most state income tax regulations regarding third-party sick pay, we do not have an obligation or the capability to withhold state income taxes at this time.
Dental Insurance

Filing a Claim
Have the dentist submit the dental claim form to the following address:
- Dental Claims Processing Center
- P.O. Box 3464
- Omaha, NE 68103-0464
- Fax: (877) 843-3945

If payments are assigned, then Lincoln can pay the dentist directly. Otherwise, payment will be made directly to the insured.

Preauthorization for Dental Work
Preauthorization is not required but is strongly advised for any claim expected to be over $300 of covered services. Preauthorization requests should be sent to the address listed above.

Dental ID Cards
Employees who are enrolled in dental coverage have access to a dental identification card available on the mobile app and www.lincolnfinancial.com that includes the policy number and dependent coverage. A certificate of coverage outlining the covered services, as well as the terms of coverage under the plan, will also be provided to the employer. The employer can provide a copy to employees, or employees can obtain a copy through our website at LincolnFinancial.com. If an employee needs a replacement or duplicate copy, contact a client service representative at 1-800-423-2765.

Prior Insurance Credit
Prior insurance credit is given at the time of the group’s implementation with Lincoln Financial. All employees who were covered with the group’s prior carrier will be included.

Accessing Dental Health Information
To access the Lincoln DentalConnect® health center website, go to LincolnFinancial.com:
- If you’re a new user, click “Register” on the Log In / Register drop-down menu; then select “Employee Benefits” and follow the prompts. Once you are registered, you’ll be directed to the Lincoln Financial Group homepage.
- Log in by selecting “My Benefit” from the Employee Benefits drop-down menu and filling in your username. On the next screen, you will be asked to enter your username again.
- Next, enter your password. You will then be asked to answer your security questions.
- You are now on the Overview page. Click “My Benefits” on the Employee Benefits drop-down.
- Under the “Coverages” section, click the “Lincoln DentalConnect” link to be connected to the site.
Locating a Participating Dentist (Dental PPO)

- Scroll to the bottom of the page.
- Under Employer Benefits, click “Find a Dentist.”
- A separate tab will appear. Enter your zip code to find dentists located in your area.

To Search for a Dentist
The Participating Dentist function allows you to search for a dentist by:
- Dentist name
- Specialty
- Proximity (to your home or office)

To Use the Participating Dentist Function:
- Enter your five-digit zip code.
- Select the distance you are willing to travel (up to 60 miles).

The site will automatically provide you with up to 100 dentists that most closely match your criteria. If your search does not locate the dentist you prefer, you can nominate a dentist.

To Nominate a Dentist
On the Find a Network Dentist results page, click the “Nominate a Dentist” link located at the top right-hand corner, and complete the form online.

For additional assistance, please contact Lincoln Financial Group customer service at 1-800-423-2765.
**COBRA**

Eligible employees and their covered dependents may have COBRA continuation rights when they are no longer eligible for coverage under an employer’s group health plan. Employers are responsible for administering COBRA. The Department of Labor publication “An Employer’s Guide to Group Health Continuation Under COBRA” provides information for employers on how to comply with COBRA’s requirements.

Please contact your employee benefits consultant or attorney if you have questions relating to COBRA.

To enroll in COBRA coverage, the employee or covered dependent needs to complete the COBRA election form, found on our website at LincolnFinancial.com, within 60 days from the date that the COBRA election form was mailed to the employee. The form must be completed, signed, dated and submitted to Lincoln Financial Group by the employer. We offer multiple options for submitting COBRA forms:

**Fax:** 1-877-573-6177

**Mail:** The Lincoln National Life Insurance Company Service Office
P.O. Box 2616
Omaha, NE 68103-2616

*If situated in New York, mail the completed form to:*
Lincoln Life & Annuity Company of New York Service Office
P.O. Box 2616
Omaha, NE 68103-2616

Please do not mail COBRA forms with your premium payment. Please do not mail the originals if you have faxed in COBRA forms.
Vision Insurance

Locating a Provider
To locate a convenient provider, employees can follow these steps:

• Visit lincolnfinancial.yourvisionplan.com
• In the Provider Quick Search box, enter a zip code or street address.
• Click the Search button to display a list of providers close to you.

For questions about vision benefits or help with online tools, call 1-800-440-8453.

Vision ID Card
Employees may follow these steps to print an ID card:

• Log in to lincolnfinancial.yourvisionplan.com using your user name and password. New users click the Register Now button to establish your username and password.
• Select “Print ID Card” on the Member Web Portal screen. You can generate an ID card by selecting a member from the drop-down menu and clicking the Get ID Card button.

Filing Out-of-Network Claims
Out-of-network claims may be submitted to the following address:

Claims Department – Lincoln VisionConnect
P.O. Box 30978
Salt Lake City, UT 84130-0978
Fax: 1-248-733-6060
Benefit Administration Overview

The registration and delegation process for Lincoln includes many controls designed to ensure the security of a company’s data.

The cornerstone of Lincoln’s security is that the group is responsible for who has access to their company’s data. This user is designated the super user. The super user has the ability to delegate access to other users for the purpose of administering or managing the company’s benefits on behalf of the super user. Delegated users have access to the company’s account that should be limited based upon need to protect the privacy of the data. Delegated access can range from viewing claims only to full account access with the exception of delegation authority.

Once you select your super user(s), Lincoln provides both the super user and their delegates with instructions and updates about registration, re-registration and delegation to ensure users maintain access to their data.

This Q&A answers common questions about registering and delegating account access. For more information, please call 1-866-360-0683.

Super Users and Delegates

What do super users do, and what information can they access?
Super users can see all the information regarding the company’s plan. This information includes coverage and plan details, contracts and certificates, enrolled employees’ salaries, and billing and claims information. They can modify coverage and add or remove employees from coverage. They can choose delegates and appoint as many (or as few) as they want. They can decide on how much access to information each delegate has.

Who can be a super user?
A super user must be an employee of the Lincoln client—usually someone in the human resources department. Another name for a super user is the primary group administrator (PBA).

Can brokers be named as super users?
Yes, only with written confirmation from the group. Brokers can also be appointed as delegates. It is the company's responsibility in granting this access.

Each company controls who has access to its employees’ personal information, including claims and salary information.

Who can be a delegate?
Anyone can be assigned as a delegate—either someone from the employer (an HR payroll employee, for example), or a broker, or someone from a third-party billing firm the client may work with. It’s up to the super user to choose and appoint the delegate(s). Please see the different levels of delegate access below to help guide the super user in assigning the right access to each delegate.
What do delegates do, and what information can they access?
Delegates can administer aspects of the company’s Lincoln benefits, depending on the level of access they are given by the super user. A super user can give a delegate full access to all plan information, or perhaps partial access—for example, giving a payroll employee access to only the billing or claims information. When super users choose their delegates online, they can view all levels of access and choose the one appropriate for each delegate.

What is the difference between a super user and a delegate?
A delegate cannot appoint other delegates. And their level of access to plan information will depend on what the super user’s preference.

What are the different levels of access for a delegate?
A super user can give a delegate full access to all plan information, or partial access—for example, giving a payroll employee access to only the billing information. The levels of delegate access are:

- **GA2 Basic** – Highest delegation level; same as super user’s access. This includes access to coverage and plan details, contracts and certificates, enrolled employees’ salaries, and billing and claims information. The only difference between a GA2 Basic delegate and a super user is that the GA2 Basic delegate cannot delegate to anyone else.
- **GA3 Basic No Salary** – Can view the same information as GA2, except for enrolled employees’ salary information.
- **GA4 Adjustments Only** – Can make any member changes and add new members but cannot view bills or claims. Can view enrolled employees’ salary information.
- **GA5 Billing** – Can only view billing information.
- **GA7 Claims** – Can only view claims information.

Why do super users and some delegates have access to salary information?
Salary information is often used to determine the level of coverage (a percentage of salary determines short-term and long-term disability and life insurance payouts) and coverage rates, so it’s important to be able to verify for accuracy.

If several people from within a client’s organization require online access, would they all use the same sign-on?
No. Each person needs to have a separate sign-on with its own level of access.
System Access for Super Users and Delegates

How is the super user selected and given access to the company’s Lincoln benefit information?
During implementation and onboarding, the client selects the super user and lets the Lincoln case manager who this is. The case manager then makes sure the new super user’s name is entered in the Lincoln Group Protection administrative system. The new super user then receives a registration email from Lincoln. This email provides links and instructions on how the super user can register an account in order to have access to the company’s Lincoln benefit information.

How does the super user choose delegates?
Once the super user has registered, he or she can select delegates, including any broker delegates. The super user registration email provides links to and instructions about this process. This is also when the super user assigns the appropriate level of access for each delegate.

Once a super user chooses delegates online, how do the delegates complete their registrations?
The new delegates will receive a registration email from Lincoln, with instructions on how to complete their registration online.

What is the maximum time for which a super user can appoint a delegate?
A super user can initially appoint a delegate for up to two years. During that time, they can extend the delegate’s access if they want, with the extension date determining the new expiration date. For example:

- A super user initially gives access to a delegate for two years— from January 1, 2021, to January 1, 2023.
- On September 1, 2022, the super user decides to extend the delegate’s access for two years. The delegate’s access now does not expire until September 1, 2024.

The super user should let delegates know when their access is being extended, and what their new expiration date is.

Does a super user’s access have an expiration date?
As long as a super user’s account has some activity (logging in, for example), their access will not automatically expire after a certain period of time. However, if there is no activity on the super user’s account for two years, the account will be disabled for inactivity and they would need to have their account enabled again by a customer service representative. Any users the super user has delegated would also lose their access when the super user is disabled for inactivity.

What if a company’s super user leaves the position or the company? What happens to the delegates the super user has chosen?
When a super user’s access is terminated as a result of change of position or change in employment status, delegated access to the employer’s information will be terminated for all delegates. This assures that the new super user will have control of who the delegates are and who has access to confidential benefit information.

Delegates will be notified of the termination. Once a new super user is selected and registered, they can select their delegates. Whether the delegates are new or existing, they need to complete the online
registration process.

When a super user leaves, how can a company avoid disruption and ensure that its benefits can be administered?

If a super user knows ahead of time that they will be leaving their position or company, they should inform their company as soon as possible so a new super user can be chosen and has time to reassign delegates. The outgoing super user should contact their Lincoln account manager or customer service representative, who will guide them through the process of registering a new super user so there is no interruption to the company’s access.

If a super user leaves with insufficient or no notice or does not inform Lincoln of their departure, the company needs to inform Lincoln of the change and their choice of new super user, via a company email address or if mailed, a company letterhead.

In an effort to help with this transition, Lincoln’s customer service team is prepared to help the new super user identify all the delegates who had been assigned by the previous super user.

How are super users and delegates informed when a delegate’s access is about to expire?

Lincoln will send emails to both super users and delegates one month before a delegate’s access is set to expire, and then weekly until the expiration date arrives. Both the super user’s and the delegate’s emails note the expiration date, and the super user’s email includes instructions on how to extend delegate access. If access is not extended, and a delegate’s expiration date arrives, another email is sent to both the super user and the delegate to inform them of the expiration.
The availability of a plan or program may vary by geographic service area and by plan design. Lincoln Financial Group assumes no responsibility for any circumstances arising out of the misuse, interpretation or application of any information supplied by Lincoln Financial Group as part of the Administration Guide.

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