Lincoln Financial Group
Employer Administration Guide
Welcome to Lincoln!

A solid partner

Lincoln Financial Group makes it easy to offer employee and employer-paid protection. Our flexible and quality lineup of products, our streamlined enrollment process, and our outstanding service and support have made us a leader in employee benefits for businesses just like yours. What’s more, the Lincoln history of dependability and integrity means our responsive, customized service is something you can count on.

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 acknowledgement of your responsibility under this admin guide.
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Contact Information

**General customer service**
Life/Disability/Dental/Vision Products: 1-800-423-2765  
Accident/Critical Illness Products: 1-877-815-9256  
Email: clientservices@lfg.com

**Online service**
www.LincolnFinancial.com

**Claims Questions**
Customer Care Center: 1-800-423-2765  
Email: claims@lfg.com

**Submitting a Claim**
Emails:  
Life claims: lifecareclaims@lfg.com  
Disability Claims: disabilityclaims@lfg.com  
Accident & Critical Illness claims: worksiteclaims@lfg.com

**Enrollments & adjustments**
Email: lfgenrollments@lfg.com  
Fax: 877-573-6177

**Important:** When you contact Lincoln, please have available the information specific to your group policy such as your Group ID, policy name or policy number. If you are calling in regard to an employee matter, be prepared to provide the employee’s Social Security and/or claim number. Having this information readily available will help us serve you better.
ENROLLMENT

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 evidence of insurability requirements established 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/or who 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 four different ways:

- Paper enrollment
- Web enrollment
- Electronic data interface (EDI) - EDI files take the place of member enrollment, adjustment, and termination forms or 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, etc.
- 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/or who elects coverage must complete a group Enrollment Form. A form will also need to be filled out when making a new election for a contributory coverage if elected after initial enrollment. There are a few things you should know about this:

- The employee’s signature serves as the payroll deduction authorization.
- Be sure to keep current beneficiary designation records (applicable to Life/AD&D 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 enrollment form been signed and dated by the employee?
- 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 Date
  - Salary and Hours Worked
  - Occupation
  - Class Code
o Gender
o Employee’s Full Address and Telephone Number

• If applicable, have all questions under the Statement of Health section on the evidence of insurability form been answered for the employee (and spouse, if applicable)?
  o Height
  o Weight
  o Yes or No to all health questions. If “Yes” to any health question, a detailed explanation is required. For Critical Illness, the coverage will be declined if any of the health questions are answered “Yes,” so a detailed explanation is not required.

• 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 names and dates of birth for each?
• Have the desired coverages been checked for contributory (employee-paid) plans?
• For voluntary life and critical illness coverage:
  o Is the tobacco question answered?
  o Has a beneficiary been designated?
  o Is the spouse date of birth included, if applicable?
  o Are the unit amounts indicated?
• For voluntary STD and voluntary LTD coverage:
  o Are the unit amounts indicated?
  o Is the elimination period and duration included?
• For voluntary dental, vision, and accident coverage:
  o Have all eligible dependents to be covered been listed?
  o 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 when employees 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.

NOTE 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 the waiting 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 form 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 Entrant**
An employee is considered a late applicant if applying for contributory coverage more than 31 days after the 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, they must also submit an evidence of insurability form. 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 form 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 only be elected at initial enrollment and the open enrollment time frame in your contract. DHMO is only available 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 (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 (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 will never require evidence of insurability.

For **disability coverage**, there are no approved qualifying events. All late applicants must complete 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.

**Cancelling Coverage**
At any time, a Group Insurance Change Request form may be faxed to (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 medical underwriting and a new pre-existing 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 which exceeds contract guidelines.

- An evidence of insurability form must be submitted and the additional benefit amount will be approved or denied through written notification.
- Do not report such amounts or an 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 (did not enroll initially and/or outside of an approved open enrollment and are now requesting coverage)
  - Note: Applicant will be responsible for any medical fees incurred if a late enrollee
- If spouse coverage is over the guaranteed Issue amount
- If the spouse is applying for coverage after initially declining and/or outside of an approved open enrollment
- If an employee wants to increase their or their spouse’s coverage outside of an approved open enrollment
- If an employee is age 60 or over
  - Please check your policy to confirm age that benefit reductions begin. Typically, the benefit reductions are triggered by age. 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 forms.

Evidence of Insurability Underwriting Requirements
During the underwriting process, Lincoln’s underwriters may request additional requirements based on the applicant’s age and amount of coverage applied for, or the medical history provided. These requirements include:

- Paramedical exam and/or laboratory testing
- Medical records
- Telephone Interview

There is no charge for medical requirements when an application is made at initial eligibility, within 31 days of the eligibility waiting period, or when applying to increase an existing life coverage.

Lincoln will send a notification to the applicant’s home address when a medical exam and/or lab testing is required. Our paramedical vendor will then initiate contact with the applicant to schedule an appointment at a mutually convenient time and location.
• Applicants responsible for medical requirement fees will receive a request for the amount to be remitted for the medical requirements.
  o The fee for medical and/or laboratory testing is $80.
  o The fee to obtain medical records is $40 per record.
  o The applicant has the option to obtain the records from their physician on their own and forward them to Lincoln. If this option is chosen, any fees charged by the physician are the responsibility of the applicant.
• If the medical requirements or requested fees are not received within 30 days, we will close our files and send two copies of the withdrawn letter to the Plan Administrator.

Notification of Underwriting Decisions
The following evidence of insurability decision correspondence is sent to the Plan Administrator for distribution to the employee(s):
• Approval: An approval letter or confirmation of coverage letters indicates the coverage(s) approved and the effective date. You may elect whether these letters are sent to the employer only, the employee only, or both employer and employee.
• Declination: A declination letter provides notification of the declination for requested coverage. Instructions are provided for the employee should they wish to request more detailed information. Two copies of the letter are provided.
• Withdrawn: A withdrawn letter is sent when medical requirements and/or missing information are not received within 30 days of our request. Two copies of the letter are provided.
• Denial and withdrawn decisions will not affect any coverage the employee currently has in force.

Evidence of Insurability Status Reports
The Evidence of Insurability Decision Code 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 through Lincoln’s online administration website at www.LincolnFinancial.com.

Electronic Submission of Administrative Changes & Adjustments
On-line 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 bill includes the ability to:
  • Enroll new members
• Change member information
• Terminate members and coverages
• Best of all, most changes are processed real time and reflected on your next bill
• With our Virtual Billing service, you can add or terminate members, then recalculate your bill to reflect the actual amount you owe, and pay your bill in real time
BILLING AND PREMIUM REMITTANCE

Billing for Life/Disability/Dental/Vision Products
Prior to each premium due date, you will receive a billing summary. Bills are generated on the 10th or 20th of each month and will be mailed in separate envelopes for each division/location/account of the group.

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

Billing for Accident and Critical Illness products
Accident and Critical Illness are billed separately from Life, Disability, Dental and Vison. 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 covered employee covered and premium due.
- If an employee terminates 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.
- List bill statement should match the amount of the check remitted.

Payroll file billing for Accident and Critical Illness:
We also offer payroll file billing for Accident and Critical Illness, which provides 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 Bill 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 on the payroll file.

Here is an example of the payroll deduction file you can send:
Premium Remittance Process

Premium is due on or before the due date listed on your billing summary. To ensure timely credit of 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 your Group ID and all Billing Locations associated with the payment in the comment section.

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

Following is the information needed to remit premium via US 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
PO Box 0821
Carol Stream, IL 60132-0821

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

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

**Wire Transfers**
Bank of America
100 West 33rd St. NE 100
New York, NY 10001
ABA #: 0260-0959-3
Acct #: 4426416656 (if sitused 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-Pay (Web payment)**
You can elect an online ePayment, which is a one-time withdrawal initiated by you.
Billing and Premium Remittance for Accident and Critical Illness Products:

**Checks – Standard Delivery**
Attn: 1H-20  
PO 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 auto 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**
Acct. Name: Lincoln National Life Ins. Co. Acct
Bank of America
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 will be due to consider reinstatement. The Request for Reinstatement form is sent 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: ifgenrollsments@lfg.com
Mail: The Lincoln National Life Insurance Company
PO Box 2616
Omaha, NE 68103-2616

If situated in New York use mailing address:
Lincoln Life & Annuity Company of New York
PO 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 type 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 found at LincolnFinancial.com to submit any type of the following changes as they occur:
  o Name changes
  o Beneficiary changes
Instructions for Completing Statement of Premium Due

New Employees Due to Mergers and Acquisitions
If you need to add employees due 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 group 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 generated.

**Line 2:** Report the number of new members and volume. (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 backside 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 (-) which 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**

<table>
<thead>
<tr>
<th>GR-AD</th>
<th>Account # AEKO-BL-26389</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC CORPORATION</td>
<td>Due Date: 1-01-99</td>
</tr>
<tr>
<td>ATTN - JANE DOE</td>
<td>Policy Number: 000010021269-00000</td>
</tr>
<tr>
<td>123 MAIN STREET</td>
<td></td>
</tr>
<tr>
<td>ANYTOWN, USA 11111</td>
<td></td>
</tr>
</tbody>
</table>

**Current Changes of Insurance in Force**

<table>
<thead>
<tr>
<th>LIFE</th>
<th>DEP LIFE</th>
<th>AD &amp; D</th>
<th>LTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In Force on Last Statement</td>
<td>25 625,000</td>
<td>21 126,000</td>
<td>25 625,000</td>
</tr>
<tr>
<td>2. Additions</td>
<td>1 25,000</td>
<td>1 5,000</td>
<td>1 25,000</td>
</tr>
<tr>
<td>3. Volume Increases</td>
<td>2,000</td>
<td></td>
<td>2,000</td>
</tr>
<tr>
<td>4. Terminations (include deaths and disabilities)</td>
<td>2 42,000</td>
<td>2 12,000</td>
<td>2 42,000</td>
</tr>
<tr>
<td>5. Volume Decreases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. In Force on Premium Due Date</td>
<td>24 610,000</td>
<td>20 120,000</td>
<td>24 610,000</td>
</tr>
<tr>
<td>7. Current Premium Rate</td>
<td>6%</td>
<td>1%</td>
<td>.95</td>
</tr>
<tr>
<td>8. Unadjusted Premium</td>
<td>$125.50</td>
<td>$24.00</td>
<td>$30.50</td>
</tr>
<tr>
<td>9. Back Premium Charges(+)</td>
<td>+ .10</td>
<td>—</td>
<td>+ .10</td>
</tr>
<tr>
<td>10. Back Premium Credits(–)</td>
<td>(.90)</td>
<td>(.12)</td>
<td>(.90)</td>
</tr>
<tr>
<td>11. Adjusted Premium TOTAL</td>
<td>$326.70</td>
<td>$22.80</td>
<td>$29.70</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL PREMIUM</th>
<th>$546.73</th>
</tr>
</thead>
<tbody>
<tr>
<td>(ADD LINE 11 ACROSS)</td>
<td></td>
</tr>
<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
To calculate the initial premium for age rated products, use the insured’s age on their eligibility date to calculate premium. For future years, refer to your contract to determine if 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 Premium

Life

<table>
<thead>
<tr>
<th>LIFE / AD&amp;D INSURANCE (BASIC AND OPTIONAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life and AD&amp;D rates are per $1,000 of coverage, so premium should be calculated based on the actual benefit amounts provided to each employee. Use the formula listed below to calculate the cost:</td>
</tr>
<tr>
<td>BENEFIT AMOUNT X RATE = PREMIUM</td>
</tr>
<tr>
<td>$1,000</td>
</tr>
</tbody>
</table>

**EXAMPLE:** (Life insurance for John Smith)  
25,000 = 25,000 X .55 = $13.75  
1,000

**EXAMPLE:** (Life insurance for all employees of ABC Corporation)  
610,000 = 610,000 X .55 = $335.50  
1,000

**EXAMPLE:** (AD&D insurance for John Smith)  
25,000 = 25,000 X .05 = $1.25  
1,000

**EXAMPLE:** (AD&D insurance for all employees of ABC Corporation)  
610,000 = 610,000 X .05 = $30.50  
1,000

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

Dependent Life

<table>
<thead>
<tr>
<th>FAMILY UNIT X RATE = PREMIUM</th>
</tr>
</thead>
</table>
| EXAMPLE: (Dependent life insurance for John and Sarah Smith and children)  
1 Family Unit X 1.20 = $1.20 |

**EXAMPLE:** Coverage for all employee families at ABC Corporation  
20 Family Units X 1.20 = $24.00
Short-term disability

- 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

<table>
<thead>
<tr>
<th>Basic Monthly Earnings*</th>
<th>X</th>
<th>Rate</th>
<th>=</th>
<th>Employee Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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 equals the maximum monthly benefit divided by the benefit percentage covered by the plan)

<table>
<thead>
<tr>
<th>LTD maximum covered monthly earnings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Percentage</td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>50%</td>
</tr>
<tr>
<td>60%</td>
</tr>
<tr>
<td>66 2/3%</td>
</tr>
</tbody>
</table>

Calculating for the entire group

<table>
<thead>
<tr>
<th>Employee Monthly Premium</th>
<th>Group Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,012 x .38 = $11.44</td>
<td>50,264 x .38 = $191.00</td>
</tr>
</tbody>
</table>

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
Conversion forms vary by state. You may request

Monthly earnings don’t exceed LTD maximum covered monthly earnings
LTD rate: $.38

Fees

For self-administered groups, these 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 (January premium due, need all premium associated with that January bill before premium can be posted)

CONVERSION

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 their 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; 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 which 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.
  - Conversion rate is based on age, gender and tobacco status.

Conversion Notification Requirements 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 their 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. Conversion forms vary by state. You may request your state specific Application for Conversion of
Group Life Insurance from a Client Service Representative at 1-800-423-2765 or email clientservices@lfg.com.

Late Notification of the Conversion Privilege
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 1-800-423-2765 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, and
- The last day in which insurance would otherwise terminate under the group policy
- Smoker status
- 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, 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 a conversion policy issued will be effective on the later of its date of issue, 31 days after the date on which the person’s 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 dies within the 31-day conversion period.

If situs 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 if Master Policy Terminates or Member Becomes Ineligible Due to Amendment of Master Contract
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 at least five years.

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 its amount may not exceed the lesser of:

- The amount specified in the contract (e.g. $10,000)
- The amount of life insurance which terminates 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.

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 of 60% 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 their 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 twelve consecutive months is eligible for conversion. The twelve months can be 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 only convert 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.
- Remains on a layoff or leave of absence beyond the continuation period provided in the Individual termination section of the group policy.

Insured employees whose insurance terminates for the following reasons may not convert if any of the following apply (this list is not limited to the below, but may include):

- 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 1-800-423-2765. The representative will need:

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

**Submitting An Application**

An Application for Conversion of Group Long-Term Disability can be obtained by contacting a Client Service Representative at 1-800-423-2765 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 both the completed application (including the Employer Questionnaire) to Lincoln.

- There is no “notification period” 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 of date of termination
of employment, the Conversion Privilege is no longer available.

The completed forms should be mailed to the following address:

   The Lincoln National Life Insurance Company
   Attn: Group LTD Conversions
   P. O. Box 2616
   Omaha, NE, 68103-2616

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 first quarter’s premium. Upon receipt of the first quarter’s 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 they are no longer eligible for coverage through their employer, and to take advantage of group rates that may be lower than individual policy premiums. The employee must send in a written Portability Application for the coverage, along with the first quarterly premium payment, within 31 days of the date insurance would otherwise end. The form is available on our website at www.LincolnFinancial.com (one form for life and/or disability, one form for accident and/or critical illness). 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 must have had coverage for at least 12 months before they are 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 1-800-423-2765.

Insured employees may not be eligible for portability of life or disability coverage if any of the following apply (this list is not limited to the below, but may include):

- 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
CLAIMS

Life Claims

Eligibility/benefit verification
The following information is required to determine eligibility and verify benefits:

- Eligibility file/billing employee list or benefit screen prints showing the amount of life insurance coverage in force at the time of death (actual benefit amount)
- 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 enrollment date and benefit amount along with any increases or Human Resource verification of initial and current coverage to confirm compliance of eligibility guidelines.
- Payroll Records verifying premium deductions for optional or voluntary life coverage
- If the insured was on leave due to disability and dies at a later date, verification is needed that premium was continued through the month of death. A current eligibility file/billing report, human resource record or an adjustment report of some kind showing the termination date of life insurance would suffice.

Filing a Life claim
For your convenience, claims may be filed telephonically by calling 1-866-783-2255.

To file a paper claim, complete the employer or plan administrator portion of the state specific Life Claim Form, which can be found on our website at www.LincolnFinancial.com. We offer multiple options for submitting paper claims:

- Email: lifeclaims@lfg.com
- Web: www.LincolnFinancial.com
- Fax: 1-800-462-4660
- Mail: Lincoln National Life Insurance Company
  PO Box 2609
  Omaha, NE 68103

If group is situated in New York please mail to:
  Lincoln Life & Annuity Company of New York
  PO Box 2609
  Omaha, NE 68103-2609
In order to complete our claim review, we will need the following information/documentation:

- Insured's Name (and dependent name, if dependent claim)
- Date of Hire
- Date of Birth
- Claim Type (Life/Accidental Death, Dismemberment or Accelerated Death benefit request)
- Insurance class (found in the policy schedule of insurance)
- Effective Date (for the employee and/or dependent)
- Policy Information (Policy #, Group ID) Plan/Class
- Billing/Claim Location
- Claimed benefit and amount
- Hourly or annual salary
- Date of Last Salary Increase
- Average Hours Worked Per Week
- Last date worked
- Reason for Ceasing Work
- Relationship to Insured
- Insured persons social security and dependent social security numbers for dependent claim
- Date of Death
- Copy of Certified Death Certificate stating the manner & cause of death (original document not required unless death occurred in foreign country)
- Most current beneficiary designation showing whom the insured elected as the beneficiary
- Funeral assignment stating our company name or policy number signed by the designated beneficiaries of legal age
- Date of Dismemberment if Living Benefit or AD&D
- Attending Physician Statement for Living Benefit or Dismemberment

Payment of Benefits
At time of claim, the beneficiary may elect from the following payment options:

- Check mailed to the beneficiary
- Direct deposit
- Secure Line/Retained Asset (may not be available for all coverages)
  - if claim 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. (Not available in all states)

Accidental Death & Dismemberment
If an accidental bodily injury results in death or dismemberment, then the following documentation is required (if applicable):

- 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
• If policy contains Accident plus – will need individual claim forms for these benefits (ex. Seat belt, airbag benefit, child care payment, etc.)

Beneficiary Designation
Prior to paying any claim where the beneficiary designation was obtained by the employer, a call needs to be made to the group to confirm beneficiary of the policy unless the designation is sent in with the claim form.

What if...

The primary beneficiary has died?
If the primary beneficiary is no longer living, a certified death certificate must accompany the claim before payment can be made to the contingent (secondary) beneficiary. If the contingent (secondary) beneficiary is also deceased, a certified death certificate will also be required in order to pay certain relatives or the Estate.

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.

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.

Beneficiary is a minor child?
According to state law, a minor lacks capacity to sign a binding release of an insurance contract. Only the lawfully appointed representative of a minor may give release for the 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/Transfer to Minors Act) in the appropriate jurisdiction allow for other payment provisions to be used.

Funeral Home Assignment
The beneficiary can assign the proceeds to a funeral home-in order to cover funeral expenses (not available for accident coverage death benefit). 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, proceeds will be deducted from the portion allotted for that beneficiary only.
- The form must indicate the policy holder 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 called the Living Benefit. This benefit allows advance payment of part (based on policy language) of the Insured Person’s personal life insurance. It may be paid to a terminally ill insured person in a lump sum, once during his or her lifetime. Terminally ill means the Insured person has a medical condition which is expected to result in death within 12 months, despite appropriate medical treatment (some states vary - check the policy to verify timeline). 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 your specific policy to verify the amount).
- be insured under the policy on the date the living benefit is to be paid. (Certain state requirements may vary. See your specific policy for details.)

The insured person (or his or her legal representative) must apply for the benefit by calling our telephonic intake line at 1-866-783-2255 or by completing a Request for Living Benefit claim form.

Lincoln requires satisfactory proof that the Insured Person is terminally ill, including a Physician’s written statement indicating the approximate life expectancy.

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

The Extension of Death Benefit is commonly referred to as Waiver of Premium. This is a benefit allowing the employee/employer to forego premium payment on life insurance during a qualifying period of Total Disability.

Our standard policy provides Waiver of Premium for life and optional life. AD&D policy premium cannot be waived. For voluntary plans, usually only the life premium may be waived. Please refer to your policy for verification.

Not every life contract includes the Extension of Death Benefit. Refer to your policy to determine if the Extension of Death Benefit is included.
The employee is required to provide proof of continued total disability under the terms of the policy. Please refer to your policy for the specific reason Waiver of Premium would terminate.

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

**Premium Adjustments for Waiver of Premium**
For employees who have filed for the Extension of Death Benefit, continue to pay the premium for the employee during the waiting period. Adjustments to premium will occur after the claim has been approved for waiver of premium.

For list billed groups, our administration area will be notified of the waiver and will 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 and use the effective date indicated on the correspondence. The employer should not make the adjustment until notified that the claim has been approved for waiver of premium.

**1099-INT for Beneficiary**
Any interest received from a life claim that is over $600.00 will be considered income and the insured will receive a 1099-INT.

**Accident/Critical Illness Claims**

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

- **Fax:** (877) 668-5331
- **Mail:** The Lincoln National Life Insurance Company  
  PO Box 2609  
  Omaha, NE 68103

  **If used in New York mail the completed form to:**  
  Lincoln Life & Annuity Company of New York  
  PO Box 2609  
  Omaha, NE 68103

**Payment of Benefits**
For Accident and Critical Illness claims, checks are mailed to the insured.
For Accident and CI 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 reconsider a denied claim. 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:** (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 enrollment form or copies of payroll deductions.

**Short-term Disability (STD) Claims**

**Filing a Claim for Short-term Disability (STD)**

Claim forms are available on our website at www.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 (866-783-2255)  
- Telephonic intake is the preferred method for submitting a STD claim, as it allows for 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
Once the initial intake process is completed, we proceed with the following steps:

- We will assign the employee’s leave to a short-term disability 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 long-term disability.

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, all claim checks are mailed directly to the employee’s home. Our standard procedure is to issue short-term disability checks every other week.

**Updated Salary Not Reflected in Benefit Checks**

If the claim was incurred prior to the date of 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 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 employees.

**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 bi-weekly basis using your own form or providing in 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.

**Return to Work Notification**
Providing us with return to work information over the phone at 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 the information is being given over the phone, the following information is required regarding the return to work:
- Date the employee returned to work
- Whether the employee returned to the same occupation
- Whether the employee returned to work full or part time?

**Preexisting Condition Clause**
This provision stipulates that disabilities caused or contributed to by a pre-existing condition are excluded from coverage under the contract unless certain conditions have been met. A pre-existing 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 pre-existing provision is included in your policy, an investigation based on the pre-existing language will be conducted, if applicable.
- Example: A 3/12 pre-existing clause means that any disabling condition for which the Insured received treatment during the 3 months immediately prior to the effective date of coverage is excluded. Once the Insured has been covered for 12 months the pre-existing 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. These 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 reconsider a denied claim. 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:** (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 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 employee position such as enrollment form or copies of payroll deductions. The employee should also provide any additional information to support the appeal. Such information could include:

- Medical records
- Test results
- Payroll records

New Jersey/New York disability claims information

If your employee is unable to work due to illness or injury, have the employee complete a New York DBL or New Jersey TDB STD claim form. If they have both statutory and STD coverage 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 claims forms:

Email: NYNJClaims@lfg.com

Fax: (855) 398-7387

Mail: Lincoln Life & Annuity Company of New York  
PO Box 2609  
Omaha, NE 68103-2609

If situated in New Jersey send to:  
The Lincoln National Life Insurance Company  
PO Box 2609  
Omaha, NE 68103-2609

New York Disability Benefits Law (DBL) Claim Features
- Payments are issued on a bi-weekly basis
• Payments will be sent via check 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 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 Temporary Disability Insurance (TDI) Claim Features
• Payments are issued on a bi-weekly 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 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 the LTD Claim form.

Email: DisabilityClaims@lfg.com
Web: www.LincolnFinancial.com
Fax: 877-843-3950
Mail: The Lincoln National Life Insurance Company
PO Box 2609
Omaha, NE 68103

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

We suggest that the claim be submitted at least 45-60 days prior to the end of the elimination period to ensure 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.

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 meeting 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 7 days prior to November 1. If the payment is sent out via direct deposit it will usually be sent approximately 3 days prior to November 1.

Payment will not be made beyond the date the physician has released 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 beyond that date.

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 is indicated in the Schedule of Benefits page in the contract. The benefit is calculated by multiplying the pre-disability income of the employee times this percentage. Some contracts provide for a flatbenefit amount which the employee is entitled to receive. The policy also contains a minimum and maximum amount available under the contract.

Some common reasons for differences in amount paid versus amount expected on disability claims are:

- Unreported salary increases
- Confusion regarding payment period or elimination period
- Taxes were withheld
- Integration of other income

**Preexisting Condition Clause**

This provision stipulates that disabilities caused or contributed to by a pre-existing condition are excluded from coverage under the contract unless certain conditions have been met. A pre-existing 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 pre-existing provision is included in your policy, an investigation based on the pre-existing language will be conducted, if applicable.

**Example:** A 3/12 pre-existing clause means that any disabling condition which the Insured received treatment during the 3 months immediately prior to the effective date of coverage is excluded. Once the Insured has been covered for 12 months the pre-existing 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 income received up to the minimum benefit (refer to your specific policy coverage for provision details). Some examples of other income are:
- Social Security (both employee and family)
- Short-term disability benefits
- Workers’ compensation
- State disability benefits
- 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 elimination period wording allows for the temporary recovery during the elimination period and 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. The days an employee is not disabled 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 as a result of sickness or injury which 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 lessor of:

1. The scheduled benefit percentage multiplied by the insured employee’s Pre-disability earnings less other income benefits (excluding partial earnings).
2. One hundred percent of the insured employee’s pre-disability earnings less other income benefits, including earnings from partial employment.
3. 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 death; or until recovery.

**Example:**

Assumptions:

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-disability earnings</td>
<td>$5,000</td>
</tr>
<tr>
<td>Benefit percentage</td>
<td>60%</td>
</tr>
<tr>
<td>Maximum monthly benefit</td>
<td>$5,000</td>
</tr>
<tr>
<td>Partial employment earnings</td>
<td>$2,200</td>
</tr>
<tr>
<td>Income from other sources</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Progressive:**

The partial disability benefit payable is the lesser of:

A) 60% of pre-disability earnings less other income benefits
   \[ \text{pre-disability earnings} \times 60\% \]
   \[ \text{$3,000} \]

B) Pre-disability earnings
   Less partial employment earnings and other income benefits
   \[ \text{$5,000} - \text{$2,200} \]
   \[ \text{$2,800} \]

C) Maximum monthly benefit
   \[ \text{$5,000} \]

**Partial disability benefit payable** \[ \text{$2,800} \]

*** Please refer to your specific policy coverage for provision details

**Work-related Disabilities**

Our standard contract integrates with Workers’ Compensation benefits. An example of integration: 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 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 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 employees.

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 on your own form or in the form of 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, “Your Waiver of Premium is effective ____(date)____.” 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 they are notified that the claim has been approved for waiver of premium.

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

- Date the employee returned to work
- Whether the employee return to the same occupation
- Whether the employee return 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 reconsider a denied claim. 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 employee position such as enrollment form or copies of payroll deductions.

Employees should also provide any additional information to support the appeal. Such information could include:

- Medical records
- Test results
- Payroll records

We offer multiple options for submitting appeals:

- **Fax:** (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 with your own tax consultant.
**Taxability of Disability Benefits (or) Third Party Sick Pay**

Federal law requires withholding of FICA from Third Party Sick Pay on the percentage of benefit attributed to the premium paid for by the employer or with pretax employee dollars.

Short-term and long-term disability 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. Following are a few examples of when a disability benefit may or may not be considered as taxable income:

<table>
<thead>
<tr>
<th>Description</th>
<th>Taxability</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Employer pays 100% of the cost of the Premium</td>
<td>100% Taxable</td>
</tr>
<tr>
<td>The 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>The 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>The Employee pays the entire cost of the premium on a pre-tax basis.</td>
<td>100% Taxable Benefit</td>
</tr>
<tr>
<td>The 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 pretax basis, this portion of the benefit is taxable. Pretax contributions are deemed “employercontributions” 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 a code J. Box 13 should be checked as Third Party Sick Pay.

When a disability benefit is considered taxable, these benefits may become subject to additional withholdings. These withholdings include the required withholds 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 only apply to that portion of the benefit. FIT is only withheld 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 $250.00: $250.00 @ 50% = $125.00*
$125.00 should be reported as taxable income and FICA & FIT only apply to this portion of the payment.

- **FICA amount** = $9.56 ($125.00 x 7.65% = $9.56).
- The FIT amount will vary dependent upon the employee’s whole dollar election, but only $125.00 is taxable.

Lincoln is required by law to withhold FICA for the first six months of any applicable disability period on “taxable” amounts. FICA tax is required to be withheld until the first of the month following six (6) 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 long-term disability claim form allows the employee to elect the amount to be withheld when they initially file the claim. However, if they elect to change their FIT withholding at a later date, a form W4-S should be provided. This form can be obtained from their local post office. The short-term disability claim form does not allow an option for FIT withholding; therefore, the employee must provide their request in writing.

**FICA Match**
For **long-term disability (LTD)** coverage, Lincoln Financial Group automatically includes our FICA match service.

For **short-term disability (STD)** coverage, you have the option to retain responsibility for matching FICA or you may request that Lincoln Financial Group match FICA. 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>
<td>No</td>
<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>

Monthly FICA reports will be sent to the employer. After year-end, an annual FICA report will also be printed and mailed to the employer in January.

- Reporting done under Lincoln company name and EIN
- Not available if group has Advice to Pay (ATP)

STD Plan with FICA match service

<table>
<thead>
<tr>
<th>Tax reporting activity</th>
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</tr>
<tr>
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<td>No</td>
</tr>
<tr>
<td>941 reporting</td>
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<td>No</td>
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<td>W-2 preparing and mailing</td>
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<td>No</td>
</tr>
<tr>
<td>W-2 corrections</td>
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<td>No</td>
</tr>
<tr>
<td>FUTA/SUTA</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

After year-end, annual FICA reports will be printed and mailed to the employer in January.

- Reporting done under Lincoln company name and EIN
- Not available if group has Advice to Pay (ATP)

Reporting of Withholdings (i.e. FICA & FIT)

All FICA & 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 & STD FICA reports may be obtained online at LincolnFinancial.com or by calling a Client Services 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-2’s for all LTD groups who have claims. If Lincoln is providing the FICA match service, we will use Lincoln’s Tax ID number for all generated LTD claims W-2’s and STD W-2’s. If you have requested that Lincoln print your W-2’s without the FICA match service, your company’s tax identification 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. 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 /FICA reporting obligations still remains the same.

A W-2 is required for non-taxable benefits and should be reported as Third Party Sick Pay (1099s are not issued for Third Party Sick Pay). You can either include the Third Party Sick Pay with the taxable wages received during active employment with the employer, or they may choose 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 NON-FICA Matched STD W-2 prepared by the employer. Lincoln will report the FIT amount on their 941 and no further reporting is required by you.

**Withholding Federal and State taxes**
Lincoln will withhold federal taxes per the claimant’s request. There is a minimum of $88.00 per month that must be withheld in Federal Income Tax if the employee is requesting this be withheld. 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 614008
   Orlando, FL 32861
   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 will receive a dental identification card 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 their employee or the employee 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 800-423-2765.

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

Carryover Provision
If the employee has satisfied his or her deductible in the last three months of the year, then he or she will not have to satisfy another deductible in the following plan year.

Accessing Dental Health Information
To access the Lincoln DentalConnect® health center website, go to LincolnFinancial.com:

- If you’re a new user, click ‘Register’ from the drop-down menu of LOG IN/REGISTER; 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 Benefits’ from the Employee Benefits drop-down menu and filling in your user name. On the next screen, you will be asked to enter your user name 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’ from 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**.
- To find dentists located in your area, a separate tab will appear to enter the zip code.

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)
  - 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 on 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 (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 following link to 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.

**Applying for 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:** 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 [www.lfc.lfg.com](http://www.lfc.lfg.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 800-440-8453.

**Vision ID Card**  
Employees may follow these steps to print an ID card:  
- Log in to [www.lfc.lfg.com](http://www.lfc.lfg.com) using your User Name and Password. For new users, click the RegisterNow button to establish your User Name 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  
Fax: 248-733-6060
ONLINE 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 only one designated individual has complete access to a company’s data. This user is defined as 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 a company selects their super user, Lincoln provides both super users 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 866-360-0683.

Super Users and Delegates

What do super users do, and what information can they access?
A super user can see all the information regarding their 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 either the CEO or someone in the Human Resources department. Another name for a super user is the primary group administrator.

Can brokers be named as a super user?
No, only designated employees of the client company can be named as the super user. Brokers can only be appointed as a delegate.

Why can’t brokers be assigned as a super user?
Super users are the only user type that can delegate access to administer benefits. By limiting the ability to delegate access, Lincoln helps protect our clients’ data. Each client controls who has access to their employee’s personal information, including claims and salary information.
Who can be a delegate?
Anyone can be a delegate — either from the client (the CEO, or an HR or 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 their 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.

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 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 perhaps 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 their own separate sign on, with their own level of access.
System Access for Super Users and Delegates

How is the super user selected and given access to their company's Lincoln benefit information?
During implementation and onboarding, the client selects the super user and lets their Lincoln case manager know their choice. 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 super users can register their account, in order to have access to their company’s Lincoln benefit information.

How does the super user choose delegates?
After the super user completes their own registration, they can then select delegates. Their registration email also provides links to and instructions about this process. This is when the super user can choose the appropriate level of access for each delegate.

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

What is the maximum time a super user can appoint a delegate for?
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 — for example, from January 1, 2016 to January 1, 2018.
- On September 1, 2017, the super user decides to extend the delegate’s access for two years. The delegate’s access now does not expire until September 1, 2019.

The super user should let delegates know if 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 has some activity on their account (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, their 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 they have chosen?
When a super user’s access is terminated because of a change of position or change in employment
status, delegated access to the client’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 described in the step-by-step process below.

When a super user leaves, how can a company avoid disruption and ensure their 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 also contact their Lincoln account manager or customer service representative (call 1-866-360-0683), 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 either a company email address or if mailed, a company letterhead.

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 about to expire, and then weekly until the expiration date arrives. Both the super user’s and 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 delegate to inform them of the expiration.

VALUE-ADD SERVICES

EmployeeConnect℠ employee assistance services

EmployeeConnect℠ services are included as part of standard long-term disability plans. Services include:

- Unlimited phone access to guidance consultants; and legal, financial and work-life services
- Up to four* in-person sessions with a counselor per person, per issue, per year, for short-term problem resolution
• In-person consultations with network lawyers at a reduced fee
• Financial consultations and referrals
• Web-based information, including articles, tutorials, streaming videos and “Ask the Expert” personal responses
• Assistance with topics such as marital and family problems, child/elder care, relocation and education
• Comprehensive, customized personalized information packets to accompany all work-life services

*In California, up to three sessions in six months, starting with initial contact by the employee. Additional information on the EmployeeConnect program is available at www.GuidanceResources.com (user name= LFGsupport; password= LFGsupport1). You may also call to speak with a specialist at 888-628-4824 for more program details.

LifeKeys® services

LifeKeys® support services are included as part of standard life insurance plans. Services for employees and their families include:

EstateGuidance® will preparation: Employees and family members can easily and economically create their wills online. A step-by-step guide takes them through the entire process, and online instructions help them execute their wills. They can:
  • Name an executor to manage their estate
  • Choose a guardian for their children
  • Specify wishes for their property
  • Provide funeral and burial instructions

GuidanceResources® Online: Employees and their families can find articles, tutorials, streaming videos and “Ask the Expert” personal responses on topics such as:
  • Law and regulations
  • Money and investments
  • Family and relationships
  • Health and wellness
  • Work and education
  • Leisure and home

Identity theft: Our online resource helps them:
  • Spot the warning signs
  • Take steps to protect cell phones, computers and tax records from fraud
  • Lessen the damage and repair their credit if identity theft occurs
  • Link to essential resources such as credit reporting bureaus, the FBI Internet Crime Complaint Center, ID Theft Resource Center, and more
Services for their beneficiaries:

Assistance at a difficult time: Unlimited phone contact with Master’s-level grief counselors lets their beneficiaries access information, advice and referrals for topics such as:
- Grief and loss
- Stress, anxiety and depression
- Memorial planning
- Concerns about children and teens
- Financial services

Beneficiaries can also call one of our certified financial specialists or use online tools and resources whenever they need help with essential topics such as:
- Estate planning
- Budgeting
- Debt
- Bankruptcy
- Investments

Legal support: If beneficiaries need quick legal information, they can call one of our in-house attorneys. Or, if they need in-depth information, guidance or representation, we’ll refer them to a qualified attorney in their area. They will be eligible for a free 30-minute consultation as well as a 25% reduction in customary legal fees thereafter. They’ll get expert guidance on areas such as:
- Estate and probate law
- Real estate transactions
- Social Security survivor and child benefits
- Important documents beneficiaries need

Support with day-to-day concerns: Through good times and bad, everyone can use assistance. LifeKeysSM services provide in-depth information and guidance — on virtually any topic you can name. Beneficiaries can call for a quick answer or take advantage of specialists who will do the research for them and provide a comprehensive, customized booklet of information. Topics include:
- Planning a memorial service
- Finding child care or elder care
- Selecting a mortgage
- Moving and relocation
- Making major purchases

To access LifeKeys services, call 1-855-891-3684 or visit www.GuidanceResources.com (First-time user: Web ID = LifeKeys).
TravelConnect℠ travel assistance services

As a value-added benefit on Lincoln group life insurance policies, the TravelConnect℠ program offers a wealth of travel, medical and safety-related services to your employees and their family members. Whether traveling for business or leisure, any time a covered individual is more than 100 miles from home, TravelConnect services are available 24 hours a day, seven days a week.

The services can be as simple as getting the weather forecast for a travel destination or as complex as an emergency evacuation from halfway around the world and can be easily accessed via toll-free phone call. This valuable benefit can be especially helpful for employees as they travel or plan a trip—with many domestic and international business travelers, travel assistance is a popular employee benefit.

Medical evacuation and transportation:

Medical evacuation. If a traveler is injured or ill, the program will arrange and pay for a supervised medical evacuation to the nearest healthcare facility if adequate care is not locally available. Once the patient can travel home, the program will arrange and pay for the trip.

Family member transportation. If a traveler is alone and hospitalized for more than seven days, the program will arrange and pay for a family member to be with them.

Child transportation. If a dependent child is left unattended because of a medical emergency, the program will arrange and pay for their return home. This includes employing a qualified escort if necessary.

Transportation after stabilization. Once stabilized after an emergency medical evacuation, the program will arrange and pay for a traveler’s return to their point of origin or home country.

Repatriation. If a traveler passes away, the plan will pay to have the body returned home.

Medical assistance: TravelConnect provides the following medical assistance services:

- Give medical and dental referrals to help find appropriate care
- Monitor treatment until traveler is released or sent to hometown hospital
- Arrange hospital payments in coordination with traveler’s insurance provider
- Transfer insurance information to assist with hospital admission
- Coordinate delivery of medication, vaccine or blood to traveler
- Help replace corrective lens or medical device if broken or lost
- Dispatch a qualified doctor to treat traveler
- Transfer medical records to traveler or attending physician
- Update family, employer and/or home physician on traveler’s condition
- Assist with accommodations before and after hospitalization

Security and political evacuation

In a security emergency, the program will arrange evacuation to the nearest safe haven.

- If a traveler is ordered to leave a country, the program will arrange travel to the nearest safe
• The program will arrange transportation home for an evacuated traveler.

To use TravelConnect services, call UnitedHealthcare Global at 800-527-0218 or 410-453-6330, and provide them with ID number 322541; use group name: Lincoln Financial Group.

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.

LifeKeys services and EmployeeConnectSM employee assistance services are provided by ComPsych Corporation, Chicago, IL. TravelConnect travel assistance services are provided by UnitedHealthcare Global, Baltimore, MD. Lincoln DentalConnect health center Web content is provided by go2dental.com, Santa Clara, CA ComPsych, UnitedHealthcare Global, and go2dental.com are not Lincoln Financial Group companies. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations.

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Lincoln VisionConnect is a registered trademark of Lincoln National Corporation.

Lincoln VisionConnect coverage is provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, located in Islandia, New York; or their affiliates. Administrative services are provided by Spectera, Inc., UnitedHealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX or VPOL.13.TX and associated COC form number VCOC.INT.06.TX or VCOC.CER.13.TX. Plans sold in Virginia use policy form number VPOL.06.VA or VPOL.13.VA and associated COC form number VCOC.INT.06.VA or VCOC.CER.13.VA. This policy has exclusions, limitations and terms under which the policy may be continued in-force or discontinued. For costs and complete details of the coverage, contact Lincoln VisionConnect at 1-800-440-8453.

Insurance products (policy series GL1101, GL3001, GL11, GL11LG, GL41, GL51, WIND) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. In New York, insurance products (policy series GL1101, GL111, GL3001, GL11, WIND) are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group companies. Product availability and/or features may vary by state. Limitations and exclusions apply.

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