



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

SUMMARY OF BENEFITS

Sponsored by: American Fence Company

Life Benefit	Employee	Spouse	Dependent
Amount	Choice of \$10,000 increments Not to exceed 5 times your annual salary Employees age 70 and older, maximum benefit is \$50,000	Choice of \$5,000 increments Employee must elect coverage for spouse to be eligible. Not to exceed 50% of employee elected amount.	\$250 Child: 14 days to 6 months \$10,000 Child: 6 months to age 19 (to age 25 if full-time student) Newborn children to age 14 days are not eligible for a benefit Employee must elect coverage for dependents to be eligible.
Minimum Amount	\$10,000	\$5,000	\$10,000
Maximum Amount	\$300,000	\$150,000	\$10,000
Guarantee Issue	\$80,000 under age 60 \$10,000 age 60-69 No Guarantee Issue age 70 and older	\$30,000 if employee is under age 60 No Guarantee Issue if employee is age 60 and older	\$10,000
AD&D Benefit	Employee	Spouse	
Amount	Optional coverage can be purchased by you for additional premium. Benefit amount equal to the life amount elected by you. Cost included in the schedule.	Same as employee	
Benefit Reduction	Employee	Spouse	
Benefits will reduce:	35% at age 65 An additional 25% of original amount at age 70 An additional 15% of original amount at age 75 Benefits terminate at age 80 or retirement, whichever occurs first	35% at employee age 65 Benefits terminate at employee age 70 or retirement, whichever occurs first	
Additional Benefits			
See Definition:	Accelerated Death Benefit		
See Definition:	Portability		
See Definition:	Conversion		
See Definition:	Seat Belt, Airbag, and Common Carrier		
Eligibility	Employee	Spouse and Dependents	
	All full-time employees working 40 or more hours per week in an eligible class are eligible for coverage. A delayed effective date will apply if the employee is not actively at work.	Cannot be in a period of limited activity on the day coverage takes effect.	

Definitions

Accelerated Death Benefit

Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance coverage when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.

AD&D

Accidental Death and Dismemberment (AD&D) insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (e.g., the loss of a hand, foot, or eye). In the event that death occurs from a covered accident, both the life and the AD&D benefit would be payable. This insurance is optional and can be purchased by you and your spouse.

Conversion

If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.

Guarantee Issue

For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance, and it will be provided at your own expense.

Limited Activity

A period when a spouse or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.

Portability

If coverage has been in force for at least 12 months, you may continue coverage for a specified period of time after your employment by paying the required premium. Portability is available if you cease employment for a reason other than total disability or retirement at Social Security Normal Retirement Age. A written application must be made within 31 days of your termination.

Seat Belt, Airbag, and Common Carrier

If you die as a result of a covered auto accident while wearing a seat belt or in a vehicle equipped with an airbag, additional benefits are payable up to \$10,000 or 10% of the principal sum, whichever is less. If loss occurs for you due to an accident while riding as a passenger in a common carrier, benefits will be double the amount that would otherwise apply as outlined in the certificate.

Term Life

Coverage provided to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.

Exclusion: Suicide

Benefits will not be paid if the death results from suicide within 2 years after coverage is effective. May apply if employee contributes toward the premium.

Additional Benefits

BeneficiaryConnectSM

Support services for beneficiaries who have experienced a loss.

TravelConnectSM

Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information

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

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

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American Fence Company

Employee Bi-Weekly Premium Life Premium for sample benefit amounts

Employee and Spouse Premiums are calculated separately.
Refer to Program Specifications for your maximum benefit amounts.
Benefits and premium amounts reflect age reductions.

AGE	Bi-Weekly Rate per \$1,000	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
<30	.0415	\$.42	\$.83	\$1.25	\$1.66	\$2.08	\$2.49	\$2.91	\$3.32	\$3.74	\$4.15
30-34	.0462	\$.46	\$.92	\$1.38	\$1.85	\$2.31	\$2.77	\$3.23	\$3.69	\$4.15	\$4.62
35-39	.0646	\$.65	\$1.29	\$1.94	\$2.58	\$3.23	\$3.88	\$4.52	\$5.17	\$5.82	\$6.46
40-44	.1062	\$1.06	\$2.12	\$3.18	\$4.25	\$5.31	\$6.37	\$7.43	\$8.49	\$9.55	\$10.62
45-49	.1754	\$1.75	\$3.51	\$5.26	\$7.02	\$8.77	\$10.52	\$12.28	\$14.03	\$15.78	\$17.54
50-54	.2631	\$2.63	\$5.26	\$7.89	\$10.52	\$13.15	\$15.78	\$18.42	\$21.05	\$23.68	\$26.31
55-59	.3923	\$3.92	\$7.85	\$11.77	\$15.69	\$19.62	\$23.54	\$27.46	\$31.38	\$35.31	\$39.23
60-64	.6462	\$6.46	\$12.92	\$19.38	\$25.85	\$32.31	\$38.77	\$45.23	\$51.69	\$58.15	\$64.62
65-69		\$6,500	\$13,000	\$19,500	\$26,000	\$32,500	\$39,000	\$45,500	\$52,000	\$58,500	\$65,000
	1.1677	\$7.59	\$15.18	\$22.77	\$30.36	\$37.95	\$45.54	\$53.13	\$60.72	\$68.31	\$75.90
70-74		\$4,000	\$8,000	\$12,000	\$16,000	\$20,000	N/A	N/A	N/A	N/A	N/A
	1.6569	\$6.63	\$13.26	\$19.88	\$26.51	\$33.14	N/A	N/A	N/A	N/A	N/A
75-79		\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	N/A	N/A	N/A	N/A	N/A
	3.5723	\$8.93	\$17.86	\$26.79	\$35.72	\$44.65	N/A	N/A	N/A	N/A	N/A

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:

Use this formula to calculate premium for benefit amounts over \$100,000.

Example:	Age	Bi-Weekly Rate Per \$1,000	X	Benefit In \$1,000's	=	Bi-Weekly Cost
	35	.0646	X	150	=	\$9.69
			X		=	

Dependent Children Rate = \$0.92 Bi-Weekly

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

American Fence Company

Spouse Bi-Weekly Premium Life Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.
Spouse premiums will be calculated based on Employee age.
Refer to Program Specifications for your maximum benefit amounts.
Benefits and premium amounts reflect age reductions.

AGE	Bi-Weekly Rate per \$1,000	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
<30	.0415	\$.21	\$.42	\$.62	\$.83	\$1.04	\$1.25	\$1.45	\$1.66	\$1.87	\$2.08
30-34	.0462	\$.23	\$.46	\$.69	\$.92	\$1.15	\$1.38	\$1.62	\$1.85	\$2.08	\$2.31
35-39	.0646	\$.32	\$.65	\$.97	\$1.29	\$1.62	\$1.94	\$2.26	\$2.58	\$2.91	\$3.23
40-44	.1062	\$.53	\$1.06	\$1.59	\$2.12	\$2.65	\$3.18	\$3.72	\$4.25	\$4.78	\$5.31
45-49	.1754	\$.88	\$1.75	\$2.63	\$3.51	\$4.38	\$5.26	\$6.14	\$7.02	\$7.89	\$8.77
50-54	.2631	\$1.32	\$2.63	\$3.95	\$5.26	\$6.58	\$7.89	\$9.21	\$10.52	\$11.84	\$13.15
55-59	.3923	\$1.96	\$3.92	\$5.88	\$7.85	\$9.81	\$11.77	\$13.73	\$15.69	\$17.65	\$19.62
60-64	.6462	\$3.23	\$6.46	\$9.69	\$12.92	\$16.15	\$19.38	\$22.62	\$25.85	\$29.08	\$32.31
65-69		\$3,250	\$6,500	\$9,750	\$13,000	\$16,250	\$19,500	\$22,750	\$26,000	\$29,250	\$32,500
	1.1677	\$3.80	\$7.59	\$11.39	\$15.18	\$18.98	\$22.77	\$26.57	\$30.36	\$34.16	\$37.95
70+		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:

Use this formula to calculate premium for benefit amounts over \$50,000.

Age	Bi-Weekly Rate Per \$1,000	X	Benefit In \$1,000's	=	Bi-Weekly Cost
Example: 35	.0646	X	75	=	\$4.85
		X		=	

Dependent Children Rate = \$0.92 Bi-Weekly

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

American Fence Company

Employee Bi-Weekly Premium

Life and Accidental Death and Dismemberment Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.

Refer to Program Specifications for your maximum benefit amounts.

Benefits and premium amounts reflect age reductions.

AGE	Bi-Weekly Rate per \$1,000	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
<30	.0600	\$.60	\$1.20	\$1.80	\$2.40	\$3.00	\$3.60	\$4.20	\$4.80	\$5.40	\$6.00
30-34	.0646	\$.64	\$1.29	\$1.93	\$2.59	\$3.23	\$3.88	\$4.52	\$5.17	\$5.81	\$6.47
35-39	.0831	\$.83	\$1.66	\$2.49	\$3.32	\$4.15	\$4.99	\$5.81	\$6.65	\$7.48	\$8.31
40-44	.1246	\$1.24	\$2.49	\$3.73	\$4.99	\$6.23	\$7.48	\$8.72	\$9.97	\$11.21	\$12.47
45-49	.1938	\$1.93	\$3.88	\$5.81	\$7.76	\$9.69	\$11.63	\$13.57	\$15.51	\$17.44	\$19.39
50-54	.2815	\$2.81	\$5.63	\$8.44	\$11.26	\$14.07	\$16.89	\$19.71	\$22.53	\$25.34	\$28.16
55-59	.4108	\$4.10	\$8.22	\$12.32	\$16.43	\$20.54	\$24.65	\$28.75	\$32.86	\$36.97	\$41.08
60-64	.6646	\$6.64	\$13.29	\$19.93	\$26.59	\$33.23	\$39.88	\$46.52	\$53.17	\$59.81	\$66.47
65-69		\$6,500	\$13,000	\$19,500	\$26,000	\$32,500	\$39,000	\$45,500	\$52,000	\$58,500	\$65,000
	1.1862	\$7.71	\$15.42	\$23.13	\$30.84	\$38.55	\$46.26	\$53.97	\$61.68	\$69.39	\$77.10
70-74		\$4,000	\$8,000	\$12,000	\$16,000	\$20,000	N/A	N/A	N/A	N/A	N/A
	1.6754	\$6.70	\$13.41	\$20.10	\$26.81	\$33.51	N/A	N/A	N/A	N/A	N/A
75-79		\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	N/A	N/A	N/A	N/A	N/A
	3.5908	\$8.98	\$17.95	\$26.93	\$35.90	\$44.88	N/A	N/A	N/A	N/A	N/A

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:

Use this formula to calculate premium for benefit amounts over \$100,000.

Example:	Age	Bi-Weekly Rate Per \$1,000	X	Benefit In \$1,000's	=	Bi-Weekly Cost
	35	.0831	X	150	=	\$12.47
			X		=	

Dependent Children Rate = \$0.92 Bi-Weekly

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

American Fence Company

Spouse Bi-Weekly Premium

Life and Accidental Death and Dismemberment Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.

Spouse premiums will be calculated based on Employee age.

Refer to Program Specifications for your maximum benefit amounts.

Benefits and premium amounts reflect age reductions.

AGE	Bi-Weekly Rate per \$1,000	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
<30	.0600	\$.30	\$.60	\$.90	\$1.20	\$1.50	\$1.80	\$2.10	\$2.40	\$2.70	\$3.00
30-34	.0646	\$.32	\$.64	\$.97	\$1.29	\$1.61	\$1.93	\$2.27	\$2.59	\$2.91	\$3.23
35-39	.0831	\$.41	\$.83	\$1.25	\$1.66	\$2.08	\$2.49	\$2.91	\$3.32	\$3.74	\$4.15
40-44	.1246	\$.62	\$1.24	\$1.87	\$2.49	\$3.11	\$3.73	\$4.37	\$4.99	\$5.61	\$6.23
45-49	.1938	\$.97	\$1.93	\$2.91	\$3.88	\$4.84	\$5.81	\$6.79	\$7.76	\$8.72	\$9.69
50-54	.2815	\$1.41	\$2.81	\$4.23	\$5.63	\$7.04	\$8.44	\$9.86	\$11.26	\$12.67	\$14.07
55-59	.4108	\$2.05	\$4.10	\$6.16	\$8.22	\$10.27	\$12.32	\$14.38	\$16.43	\$18.48	\$20.54
60-64	.6646	\$3.32	\$6.64	\$9.97	\$13.29	\$16.61	\$19.93	\$23.27	\$26.59	\$29.91	\$33.23
65-69		\$3,250	\$6,500	\$9,750	\$13,000	\$16,250	\$19,500	\$22,750	\$26,000	\$29,250	\$32,500
	1.1862	\$3.86	\$7.71	\$11.57	\$15.42	\$19.28	\$23.13	\$26.99	\$30.84	\$34.70	\$38.55
70+		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:

Use this formula to calculate premium for benefit amounts over \$50,000.

Age	Bi-Weekly Rate Per \$1,000	X	Benefit In \$1,000's	=	Bi-Weekly Cost
35	.0831	X	75	=	\$6.23
		X		=	

Dependent Children Rate = \$0.92 Bi-Weekly

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



Financial Group®

Voluntary Short-Term Disability Insurance

SUMMARY OF BENEFITS

Sponsored by: American Fence Company

Short-term disability is intended to protect your income for a short duration in case you become ill or injured.

Eligibility	All full-time active employees working 40 or more hours per week in an eligible class are eligible for coverage.
Maximum Weekly Benefit	60% of weekly salary, with a minimum of \$100 up to \$1,000 per week
Maximum Benefit Duration	13 weeks
Elimination Period	Benefits begin on: 8 th day for an accident 8 th day for an illness
Pre-Existing Condition	You may not be eligible for benefits if you have received treatment for a condition within the past 12 months until you have been covered under this plan for 12 months.
Waiver of Premium	You will not be required to pay premium during any time of approved total or partial disability.
Enrollment (Newly Eligible)	You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again.

Bi-Weekly Premium Calculation

List your weekly earnings
(Maximum covered payroll is
\$1,667 weekly)

\$ _____

EXAMPLE
Age 35

\$610

Find your age and premium factor and multiply

_____ .00914

Estimated Bi-Weekly premium

\$ _____

\$5.58

Attained Age	Premium Factors
<30	.00858
30 – 34	.00858
35 – 39	.00914
40 – 44	.01080
45 – 49	.01329
50 – 54	.01606
55 – 59	.02188
60 – 64	.02742
65 – 69	.03129
70 – 74	.03434
75+	.03711

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Understanding Your Benefits

Total Disability	You are considered totally disabled if, due to an injury or illness, you are unable to perform each of the main duties of your regular occupation.
Partial Disability	You are considered partially disabled if you are unable, due to an injury or illness, to perform the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer as well as continue to receive benefits, which may enable you to receive 100% of your income during your time of disability.
Continuation of Disability	If you return to work full-time but become disabled from the same disability within 2 weeks of returning to work, you will begin receiving benefits again immediately.
Pre-Existing Condition	Any sickness or injury for which you have received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to the coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date.
Benefit Exclusions	You will not receive benefits in the following circumstances: <ul style="list-style-type: none">• Your disability is the result of a self-inflicted injury.• You are not under the regular care of a doctor when requesting disability benefits.• Your disability is covered under a worker's compensation plan and/or is due to a job-related sickness or injury.• You are receiving payment under a salary continuance or retirement plan sponsored by the group policyholder.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources: <ul style="list-style-type: none">• Any governmental retirement system earned as a result of working for the current policyholder;• Any disability or retirement benefit received under a retirement plan;• Any Social Security, or similar plan or act, benefits;• Earnings the insured earns or receives from any form of employment.
Benefit Termination	This coverage will terminate when you terminate employment with this policyholder, or at your retirement.

For assistance or additional information

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

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Voluntary Long-Term Disability Insurance

SUMMARY OF BENEFITS

Sponsored by: American Fence Company

Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

Eligibility	All full-time active employees working 40 or more hours per week in an eligible class are eligible for coverage.
Maximum Monthly Benefit	60% of salary up to \$3,000 per month
Maximum Benefit Duration	To Age 65/Reduced Benefit Duration
Own Occupation Period	24 Months
Elimination Period	90 days The number of days you must be disabled prior to collecting disability benefits.
Accumulation of Elimination Days	You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability. If you are working on a partial basis, you will have 2x the elimination period days to satisfy the total of 90 days.
Pre-Existing Condition	You may not be eligible for benefits if you have received treatment for a condition within the past 12 months until you have been covered under this plan for 24 months, or if you remain treatment free for a period of 12 consecutive months.
Enrollment (Newly Eligible)	You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again, or may be responsible for the cost of required examinations.
Waiver of Premium	You will not be required to pay premium during any time of approved total or partial disability.
Survivor Income Benefit	A survivor benefit may be paid to your beneficiary if you should die while receiving qualifying disability payments.
EmployeeConnectSM	Access to an employee assistance program for the employee or an immediate household family member who may be experiencing personal or workplace issues.
Benefit Limitations	Mental Illness: 24 months Substance Abuse: No Limit Specified Illness: No Limit
Portability	If your employment is terminated for any reason other than retirement, disability, or a leave of absence, you can keep your current LTD coverage at the same rate for up to 12 months. Your current coverage must have been in force for at least 12 months.

(Please see other side)

Understanding Your Benefits

Own Occupation	The occupation trade or profession you were employed in prior to your disability as defined by the US DOL Dictionary of Occupational Titles.
Total Disability	You are considered totally disabled if, due to an injury or illness, you are unable to perform each of the main duties of your own occupation. Your "own" occupation is covered for a specific period of time. Following this, the definition of total disability becomes the inability to perform any occupation for which you are reasonably suited based on your experience, education, or training.
Partial Disability	You are considered partially disabled if you are unable, due to an injury or illness, to perform the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer as well as continue to receive benefits, which may enable you to receive 100% of your income during your time of disability.
Continuation of Disability	If you return to work full-time but become disabled from the same disability within 6 months of returning to work, you will begin receiving benefits again immediately.
Benefit Duration Reduction	Your benefit duration may be reduced if you become disabled after age 65.
Pre-Existing Condition	Any sickness or injury for which you have received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to the coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date, unless no treatment was received for the specified consecutive months after the coverage effective date.
Benefit Exclusions	You will not receive benefits in the following circumstances:
	<ul style="list-style-type: none">• Your disability is the result of a self-inflicted injury.• You are not under the regular care of a doctor when requesting disability benefits.• You were involved in a felony commission, act of war, or participation in a riot.• You were residing outside of the United States or Canada for more than 12 consecutive months for purposes other than employment with your Employer.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources:
	<ul style="list-style-type: none">• Any compulsory benefit act or law (such as state disability plans);• Any governmental retirement system earned as a result of working for the current policyholder;• Any disability or retirement benefit received under a retirement plan;• Any Social Security, or similar plan or act, benefits;• Earnings the insured earns or receives from any form of employment;• Workers compensation;• Salary continuance or employer contributions to an employer sponsored retirement plan.
Benefit Termination	This coverage will terminate when you terminate employment with this policyholder, or at your retirement.

For assistance or additional information

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

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

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Bi-Weekly Premium Calculation

Example:
John Doe, Age 35

List your monthly earnings
(*Maximum covered payroll is \$5,000 Monthly) \$ _____

Multiply by your premium factor
(see table below) _____ .00258

Your Estimated Bi-Weekly Premium** \$ _____ \$6.45

**This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Attained Age	Premium Factors
<30	.00129
30 – 34	.00180
35 – 39	.00258
40 – 44	.00365
45 – 49	.00655
50 – 54	.00872
55 – 59	.01214
60 – 64	.01075
65 – 69	.00655
70 – 74	.00429
75+	.00462

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
 Group Insurance Service Office: P.O. Box 2616, Omaha, NE 68103-2616
 Phone: (800) 423-2765 Fax: (877) 573-6177

EVIDENCE OF INSURABILITY INFORMATION

Please submit this form to The Lincoln National Life Insurance Company (herein referred to as "the Company"). No coverage for which evidence of insurability is required will be effective until approved in writing by the Company.

Complete all blanks in ink and print clearly. Incomplete forms will cause consideration for coverage to be delayed.

SECTION 1. Group Information:

Group Name	Group ID
Group Policy No(s).	Billing Division/Location

SECTION 2. Employee Information: (Complete even if employee is not applying for coverage.)

First Name _____ Last Name _____ Middle Initial _____
 Social Security No. _____ - _____ - _____ State of Birth _____ Date of Birth ____ / ____ / ____
 Annual Earnings \$ _____ Date of Hire/Rehire ____ / ____ / ____
 Home Mailing Address:
 (Street) _____ (City) _____ (State) _____ (Zip) _____
 Phone No(s): Home (____) _____ - _____ Work (____) _____ - _____ Best Time to Call ____ AM/PM
 Email Address: _____ Home Work
 Beneficiary (for Life or AD&D Insurance) _____ Relationship _____

SECTION 3. Spouse Information: (Complete only if applying for Dependent coverage.)

First Name _____ Last Name _____ Middle Initial _____
 Social Security No. _____ - _____ - _____ State of Birth _____ Date of Birth ____ / ____ / ____
 Home Mailing Address (if different than above):
 (Street) _____ (City) _____ (State) _____ (Zip) _____
 Phone No(s): Home (____) _____ - _____ Work (____) _____ - _____ Best Time to Call ____ AM/PM
 Email Address: _____ Home Work

SECTION 4. Plan(s) Applied for: (Only include the amount of coverage in excess of any existing amount or guaranteed issue amount.)

Basic Coverage(s)	Requested Basic Coverage Amount	Optional/Voluntary Coverage(s)	Requested Optional/Voluntary Coverage Amount
Life <input type="checkbox"/>	\$ _____	Employee Life <input type="checkbox"/>	\$ _____
Dependent Life <input type="checkbox"/>	\$ _____	Employee Life & AD&D <input type="checkbox"/>	\$ _____
STD <input type="checkbox"/>		Spouse Life <input type="checkbox"/>	\$ _____
LTD <input type="checkbox"/>		Spouse Life & AD&D <input type="checkbox"/>	\$ _____
LTD with Critical Illness <input type="checkbox"/>		Short Term Disability (STD) <input type="checkbox"/>	\$ _____
		Long Term Disability (LTD) <input type="checkbox"/>	\$ _____
		Critical Illness (Mark Categories below) <input type="checkbox"/>	Enter Principal Sum for:
		Heart Category <input type="checkbox"/>	Employee \$ _____
		Cancer Category <input type="checkbox"/>	Spouse \$ _____
		Organ Category <input type="checkbox"/>	Child \$ _____
		Quality of Life Category <input type="checkbox"/>	

STATEMENT OF HEALTH

SECTION 5. Medical Information - To be completed by applicants applying for ANY coverages.					
Employee Applicant	Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Height: _____ Ft. _____ In.	Weight: _____ lbs.
Spouse Applicant	Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Height: _____ Ft. _____ In.	Weight: _____ lbs.
				Employee YES NO	Spouse YES NO
In the past 12 months, have you smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?				<input type="checkbox"/>	<input type="checkbox"/>

SECTION 6. Medical Information - To be completed if applying for LIFE or DISABILITY coverages.				
	Employee YES	Employee NO	Spouse YES	Spouse NO
1. Within the past 7 years, have you had, or been told by a physician that you had, or been treated for a condition listed below? (FOR CONDITIONS ANSWERED YES, PLEASE PROVIDE DETAILS IN SECTION 7.)				
a. Heart or circulatory disorder; liver or kidney disorder; lung or respiratory disorder; mental or nervous disorder; alcoholism, drug or substance abuse; diabetes, cancer, tumor, epilepsy, hepatitis or stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. High blood pressure? If answered YES, please provide last reading and date of reading:	 BP Reading (Employee) _____ Date _____			
	 BP Reading (Spouse) _____ Date _____			
c. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for antibodies to HIV (Human Immunodeficiency Virus)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past 5 years, have you been diagnosed with a physical disorder not listed above? (IF ANSWERED YES, PLEASE PROVIDE DETAILS IN SECTION 7.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently under observation, receiving treatment or taking medication? (IF ANSWERED YES, PLEASE PROVIDE DETAILS IN SECTION 7.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. If applying for DISABILITY coverage, please complete these additional questions.				
a. Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Within the past 5 years, have you been diagnosed or treated for:				
i. Disorder of the back, neck, or spine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Osteoarthritis, Rheumatoid Arthritis, or degenerative joint disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Knee Disorder, Injury or Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(FOR CONDITIONS ANSWERED YES, PLEASE PROVIDE DETAILS IN SECTION 7.)				

SECTION 7. Provide details for any questions answered YES in SECTION 6. (Attach additional sheet, if needed.)						
Question Number	Applicant Name	Condition/Treatment/Medication	Date of Diagnosis	Date of Last Symptom	Current Status or Condition	Attending Physician's Name, Address, and Phone Number

SECTION 8. Medical Information - To be completed if applying for CRITICAL ILLNESS coverage.

	Employee		Spouse	
	YES	NO	YES	NO
1. Within the past 7 years, has anyone applying for coverage been diagnosed with or received treatment for Systemic Lupus, Type I or II Diabetes, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or sarcoidosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If applying for the Heart Category, please complete the questions below.				
2. Within the past 7 years, has anyone applying for coverage been diagnosed with or received treatment for Pacemaker, any type of fibrillation, coronary artery disease, atherectomy or any type of heart surgery, heart attack, congestive heart failure, cardiomyopathy, stroke, transient ischemic attack, congenital heart disease, chronic anticoagulation therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is anyone applying for coverage currently taking three or more high blood pressure (HBP) medications or had HBP medications changed or increased within the past six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If applying for the Cancer Category, please complete the question below.				
4. Within the past 7 years, has anyone applying for coverage been diagnosed with or received treatment for internal cancer, melanoma, bone marrow or stem cell transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If applying for the Organ Category, please complete the question below.				
5. Within the past 7 years, has anyone applying for coverage been diagnosed with or received treatment for Cystic fibrosis, renal hypertension or any kidney disease or disorder (not including stones), chronic obstructive pulmonary disease, emphysema, pulmonary fibrosis, Hepatitis or liver disease or disorder (not including Hepatitis A), cirrhosis of the liver, any organ transplant, or donor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If applying for the Quality of Life Category, please complete the question below.				
6. Within the past 7 years, has anyone applying for coverage been diagnosed with or received treatment for glaucoma or retinitis pigmentosa?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REQUIRED FRAUD WARNINGS

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Services.

DC: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KENTUCKY: Any person who knowingly and with the intent to defraud an insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information containing any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA & RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

OTHER STATES (EXCEPT KANSAS): A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping to defraud) an insurance company.

I HEREBY:

1. request the coverage for which I am (or may become) or my Spouse is (or may become) eligible under group policies issued by The Lincoln National Life Insurance Company;
2. authorize any required deductions from my earnings;
3. name the above beneficiary to receive any benefits payable in the event of my death;
4. represent to the best of my knowledge and belief that the above Statement of Health is true and complete, and that each item answered yes is fully disclosed;
5. represent that if the above Statement of Health has been completed to obtain coverage for my Spouse, I have discussed and reviewed with my Spouse the responses and information supplied on behalf of my Spouse in the Statement of Health, and to the best of our knowledge and belief, the Spouse portion of the Statement of Health is true and complete, and each item answered yes is fully disclosed; and
6. acknowledge that I have read the **FRAUD WARNING**.

I understand that for continued eligibility I must remain an active employee working at least the minimum hours or otherwise continue coverage as outlined in the contract. **The attached AUTHORIZATION has been completed and signed by the employee.**

Signature of (Employee) Applicant: _____ Date: _____

Signature of (Spouse) Applicant: _____ Date: _____

Group Insurance Service Office Use:		<input type="checkbox"/> Self Bill	<input type="checkbox"/> List Bill
Approved	_____	Declined	_____
EFFECTIVE DATE: _____			

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

AUTHORIZATION: I (the undersigned) authorize any physician, medical professional, medical facility, pharmacy benefit manager, insurer, reinsurer, consumer reporting agency or the Medical Information Bureau (MIB) to release information from the records of:

Date of Birth: _____ Social Security Number: _____

This Authorization covers any periods of medical treatment during the last seven years.

2. Information to be released: My complete medical records including:
 - information about the diagnosis, treatment or prognosis of my medical condition (including referral documents from other facilities); and
 - prescription drug records and related information maintained by physicians, pharmacy benefit managers, and other sources.
 3. Information is to be released to: EMSI (Examination Management Services Incorporated), The Lincoln National Life Insurance Company or its reinsurers.
 4. I understand that the purpose of disclosing this information is to evaluate my application for insurance. The Company will use the information obtained with this Authorization to determine eligibility for insurance; and will only release such information:
 - to reinsurance companies, the MIB or providers of a business or legal service concerned with my application; and
 - as otherwise may be required by law or may be further authorized by me.

I further understand that refusal to sign this Authorization may result in denial of eligibility for this insurance coverage.

5. I understand the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law, however, the Company contractually requires the recipient to protect the information.
 6. I understand that I may revoke this Authorization in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my coverage with the Company. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signing. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.
 7. A photocopy of this Authorization is to be considered as valid as the original.
 8. I acknowledge that I have received the attached Notice of Information Practices.
 9. I understand that I am entitled to receive a copy of this Authorization.

Signature of Applicant: _____ **Date:** _____

NOTICE OF INSURANCE INFORMATION PRACTICES

COLLECTION OF INFORMATION

This NOTICE is provided in compliance with your state's Insurance Information and Privacy Protection Act.

In order to provide insurance coverage on a fair and equitable basis, we must collect information about you and others for whom coverage may be provided. This information may include age, occupation, physical condition, health history, prescription drug records, general reputation, mode of living and other personal characteristics.

You will provide much of the information. We may collect or verify information by personal interviews and by otherwise contacting Medical professionals and institutions, pharmacy benefit managers, employers, business associates, friends, neighbors and other insurance companies. We may ask insurance support organizations to collect information and submit an investigative consumer report. That organization may disclose the contents of the report to others for which it performs such services. You may request a copy of the report or a personal interview in connection with it.

DISCLOSURE OF INFORMATION

The law allows disclosure of certain information without your authorization in response to a valid administration or judicial order, as permitted or required by law, or to:

1. Persons or organizations performing professional, business or insurance functions for us;
2. Our agents, insurance support organizations or consumer reporting agencies;
3. Medical professionals and medical-care institutions;
4. Persons or organizations conducting bonafide actuarial or scientific research studies, audits or evaluations;
5. Insurance regulatory, law enforcement or other governmental authorities;
6. Persons or organizations involved in any sale, transfer, merger or consolidation of our business; and
7. Group Policyholders, certificate holders, professional peer review organizations, or persons having legal or beneficial interest in a policy of insurance.

We do NOT disclose to our affiliates any information we receive about you from a consumer reporting agency. We do NOT disclose your nonpublic personal information to third parties except as necessary to provide you our products and services.

MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. We, or our reinsurers, may make a brief report to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact the MIB at 866 692-6901 (TTY 866 346-3642 for hearing impaired). If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

We, or our reinsurers, may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

PERSONAL DISCLOSURE

Also, you have a right to access personal information about you in our files. You may request that we correct, amend or delete information you believe is inaccurate or irrelevant. A description of the appropriate procedures will be sent to you upon written request.

TELEPHONE PERSONAL HISTORY REVIEW

After your application has been received in the Group Insurance Service Office, you may receive a telephone call from a specially trained Group Insurance Service Office Interviewer who will ask you some questions to obtain verification or additional information.

If you have questions about the terms discussed in the NOTICE, please write to:

The Lincoln National Life Insurance Company
Group Insurance Service Office
P. O. Box 2616
Omaha, Nebraska 68103-2616

DETACH THIS COPY AND KEEP FOR YOUR RECORDS

