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**Voluntary Life Insurance with Accidental Death and Dismemberment (AD&D)**  
**SUMMARY OF BENEFITS**

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**Sponsored by: American Conference of Cantors**

<b>Life Benefit</b>	<b>Employee</b>	<b>Spouse</b>	<b>Dependent</b>
Amount	Choice of \$10,000 increments. Not to exceed five 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 six months \$10,000 Child: Six 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 dependent to be eligible.
Minimum Amount	\$10,000	\$5,000	\$10,000
Maximum Amount	\$500,000	\$150,000	\$10,000
Guarantee Issue	\$100,000 under age 60 \$20,000 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
<b>AD&amp;D Benefit</b>	<b>Employee</b>	<b>Spouse</b>	
Amount	The benefit amount is equal to the life amount elected by you. Cost included in the schedule.	Same as employee	
<b>Benefit Reduction</b>	<b>Employee</b>	<b>Spouse</b>	
Benefits will reduce:	35% at age 65 An additional 15% of original amount at age 70 Benefits terminate at retirement	35% at employee age 65 Benefits terminate at employee age 70 or retirement, whichever occurs first	
<b>Additional Benefits</b>			
See Definition:	Accelerated Death Benefit		
See Definition:	Portability		
See Definition:	Conversion		
<b>Eligibility</b>	<b>Employee</b>	<b>Spouse and Dependents</b>	
	All full-time active employees working 30 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

<b>Accelerated Death Benefit</b>	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 The death benefit will be reduced by the amount withdrawn.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.
<b>AD&amp;D</b>	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.
<b>Conversion</b>	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.
<b>Guarantee Issue</b>	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.
<b>Limited Activity</b>	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.
<b>Portability</b>	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. A written application must be made within 31 days of your termination.
<b>Term Life</b>	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. This insurance is optional and can be purchased by you and your spouse.
<b>Exclusion: Suicide</b>	Benefits will not be paid if the death results from suicide within two years after coverage is effective. May apply if employee contributes toward the premium.
<b>Additional Benefits</b>	
<b>BeneficiaryConnect<sup>SM</sup></b>	Support services for beneficiaries who have experienced a loss.
<b>TravelConnect<sup>SM</sup></b>	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](http://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 Conference of Cantors

### Spouse Monthly Premium

#### Life with Accidental Death and Dismemberment Premium for sample benefit amounts

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

AGE	Monthly 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	0.100	\$0.50	\$1.00	\$1.50	\$2.00	\$2.50	\$3.00	\$3.50	\$4.00	\$4.50	\$5.00
30-34	0.100	\$0.50	\$1.00	\$1.50	\$2.00	\$2.50	\$3.00	\$3.50	\$4.00	\$4.50	\$5.00
35-39	0.130	\$0.65	\$1.30	\$1.95	\$2.60	\$3.25	\$3.90	\$4.55	\$5.20	\$5.85	\$6.50
40-44	0.190	\$0.95	\$1.90	\$2.85	\$3.80	\$4.75	\$5.70	\$6.65	\$7.60	\$8.55	\$9.50
45-49	0.290	\$1.45	\$2.90	\$4.35	\$5.80	\$7.25	\$8.70	\$10.15	\$11.60	\$13.05	\$14.50
50-54	0.430	\$2.15	\$4.30	\$6.45	\$8.60	\$10.75	\$12.90	\$15.05	\$17.20	\$19.35	\$21.50
55-59	0.630	\$3.15	\$6.30	\$9.45	\$12.60	\$15.75	\$18.90	\$22.05	\$25.20	\$28.35	\$31.50
60-64	1.020	\$5.10	\$10.20	\$15.30	\$20.40	\$25.50	\$30.60	\$35.70	\$40.80	\$45.90	\$51.00
65-69	1.810	\$3,250	\$6,500	\$9,750	\$13,000	\$16,250	\$19,500	\$22,750	\$26,000	\$29,250	\$32,500
		\$5.88	\$11.77	\$17.65	\$23.53	\$29.41	\$35.30	\$41.18	\$47.06	\$52.94	\$58.83
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	Monthly Rate Per \$1,000	X	Benefit in \$1,000's	=	Monthly Cost
Example:	35	0.130	X	60	=	\$7.80
			X		=	

Dependent Children Rate = \$2.00 monthly

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

## American Conference of Cantors

### Employee Monthly Premium

#### Life with 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	Monthly 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	0.100	\$1.00	\$2.00	\$3.00	\$4.00	\$5.00	\$6.00	\$7.00	\$8.00	\$9.00	\$10.00
30-34	0.100	\$1.00	\$2.00	\$3.00	\$4.00	\$5.00	\$6.00	\$7.00	\$8.00	\$9.00	\$10.00
35-39	0.130	\$1.30	\$2.60	\$3.90	\$5.20	\$6.50	\$7.80	\$9.10	\$10.40	\$11.70	\$13.00
40-44	0.190	\$1.90	\$3.80	\$5.70	\$7.60	\$9.50	\$11.40	\$13.30	\$15.20	\$17.10	\$19.00
45-49	0.290	\$2.90	\$5.80	\$8.70	\$11.60	\$14.50	\$17.40	\$20.30	\$23.20	\$26.10	\$29.00
50-54	0.430	\$4.30	\$8.60	\$12.90	\$17.20	\$21.50	\$25.80	\$30.10	\$34.40	\$38.70	\$43.00
55-59	0.630	\$6.30	\$12.60	\$18.90	\$25.20	\$31.50	\$37.80	\$44.10	\$50.40	\$56.70	\$63.00
60-64	1.020	\$10.20	\$20.40	\$30.60	\$40.80	\$51.00	\$61.20	\$71.40	\$81.60	\$91.80	\$102.00
65-69	1.810	\$6,500	\$13,000	\$19,500	\$26,000	\$32,500	\$39,000	\$45,500	\$52,000	\$58,500	\$65,000
		\$11.77	\$23.53	\$35.30	\$47.06	\$58.83	\$70.59	\$82.36	\$94.12	\$105.89	\$117.65
70-74	2.540	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	N/A	N/A	N/A	N/A	N/A
		\$12.70	\$25.40	\$38.10	\$50.80	\$63.50	N/A	N/A	N/A	N/A	N/A
75-99	5.440	\$27.20	\$54.40	\$81.60	\$108.80	\$136.00	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.

	Age	Monthly Rate Per \$1,000	X	Benefit in \$1,000's	=	Monthly Cost
Example:	35	0.130	X	120	=	\$15.60
			X		=	

Dependent Children Rate = \$2.00 monthly

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

**ENROLLMENT FORM FOR GROUP INSURANCE**

Please Use Ink or Type	GROUP ID: <b>CONCANIL</b>	GROUP POLICY #: 000400001000-06611	Billing Division or Location: 555404
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**A. Employee Information (Complete for ALL Enrollments)**

Employer Name/Company Name (Please Print) American Conference of Cantors			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		Home Phone ( )	Work Phone ( )

**Completed By Employer**

Average Hours Worked Per Week:	Occupation:	
Earnings: <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly \$	Date of Full-Time Employment:	Rehire Date:

**B. Product Selection (Complete for ALL Enrollments)**

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

TYPE OF COVERAGE	AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life/AD&D Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Voluntary Spouse Life/AD&D Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	\$	\$
Voluntary Dependent Child Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No	\$10,000	\$

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

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

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

**E. Request for Coverages**

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

- REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
- NOT ENROLL myself in the Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
- NOT ENROLL my dependents in the Program.** I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

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

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

Employee Full Name: \_\_\_\_\_ Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# 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

Attach this form with your enrollment card and submit to The Lincoln National Life Insurance Company (herein referred to as "the Company"). Please complete a form for each applicant. No coverage will be effective until approved in writing by the Company. Complete all blanks in ink and print clearly. Incomplete forms will cause coverage to be delayed.

### Applicant Information:

Name \_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_ Male  Height \_\_\_\_\_  
 of Birth \_\_\_\_\_ of Birth \_\_\_\_\_ Female  Weight \_\_\_\_\_  
 Relationship to employee \_\_\_\_\_ Amount \_\_\_\_\_ Total \_\_\_\_\_  
 Applied For \$ \_\_\_\_\_ Benefit Amount \$ \_\_\_\_\_

Address \_\_\_\_\_  
 (Street) (City) (State) (Zip)

Phone Number Home \_\_\_\_\_ Work \_\_\_\_\_ Best Time to call \_\_\_\_\_ Home  Work

Beneficiary (for Life or AD&D Insurance) \_\_\_\_\_ Relationship \_\_\_\_\_

**Plan Applied for:** Life  Optional Employee Life  Voluntary Employee Life   
 Dependent Life  Optional Employee AD&D  Voluntary Employee AD&D   
 STD  Optional STD  Voluntary Spouse Life   
 LTD  Optional LTD  Voluntary Spouse AD&D   
 Critical Illness  Optional Spouse Life  Voluntary STD   
 Optional Spouse AD&D  Voluntary LTD

### Employee Information:

Group Name \_\_\_\_\_  
 Group Policy \_\_\_\_\_  
 Name \_\_\_\_\_ Number \_\_\_\_\_ Group ID \_\_\_\_\_  
 Employee Social \_\_\_\_\_ Annual \_\_\_\_\_ Date of \_\_\_\_\_  
 Security Number \_\_\_\_\_ Earnings \$ \_\_\_\_\_ Hire/Rehire \_\_\_\_\_

## STATEMENT OF HEALTH

- |                                                                                                                                                                                                                           | YES                      | NO                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. 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"/> |
| 2. Within the past 7 years, have you ever (a) had, or (b) been told by a physician that you had, or (c) received treatment for a condition listed below? <b>CIRCLE CONDITIONS ANSWERED YES AND PROVIDE DETAILS BELOW.</b> |                          |                          |
| A. Heart or artery disorder, heart attack, tuberculosis, liver disorder, kidney trouble, lung or other respiratory disorder?.....                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| B. High blood pressure? If YES, please note last two readings and date of reading:.....                                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Date _____ Reading _____ Date _____ Reading _____                                                                                                                                                                         |                          |                          |
| C. Diabetes? If YES, please note age of onset, and treatment prescribed?.....                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Age at onset: _____ Type of treatment: _____                                                                                                                                                                              |                          |                          |
| D. Cancer, leukemia, malignant growth or any form of tumor?.....                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Epilepsy or any mental/nervous disorder?.....                                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Alcoholism, drug, or substance abuse?.....                                                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Within the past 7 years, have you been diagnosed as having, or been treated for:                                                                                                                                       |                          |                          |
| A. Any disorder of the immune system, including AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-Related Complex), or tested positive for antibodies to HIV (Human Immunodeficiency Virus)?.....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Hepatitis or any sexually transmitted disease?.....                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any physical examinations in the last 5 years? If YES, provide details below and note reason for exam, symptoms, treatment or medication and results. ....                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Within the past 5 years, have you had any physical disorder not listed above?.....                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered YES to questions 2-5, please give complete details below:

Item No.	Condition, injury, or findings of exam. If surgery performed, state type.	Date of Onset	Date Last Treated	Results/Degree of Recovery	Name & Address of Attending Physician

Item No.	Condition, injury, or findings of exam. If surgery performed, state type.	Date of Onset	Date Last Treated	Results/Degree of Recovery	Name & Address of Attending Physician

**YES NO**

6. Are you:
- A. Under observation or receiving treatment? .....
- B. Taking medication? .....

**If you answered YES to questions 6A or 6B, please provide details below:**

Condition	Date of Onset	Name of Medication	Dosage and Frequency	Name and Address of Attending Physician

**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 with the intent to defraud an Insurance Company or other person files an application for insurance containing 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.

**LOUISIANA:** 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:** A person commits 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.

**OTHER STATES:** 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.

**CONTINUED ON NEXT PAGE**

# 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

## I HEREBY:

1. request the coverage for which I am (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.

I understand that for continued eligibility I must remain an active employee working at least the minimum hours as outlined in the contract.

**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:

1. Applicant/Patient Name: \_\_\_\_\_  
(Last) (First) (Middle)

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: \_\_\_\_\_

Group Insurance Service Office Use:  Self Bill  List Bill

Approved \_\_\_\_\_ Declined \_\_\_\_\_

EFFECTIVE 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](http://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**