Lincoln Financial Group®

College of Sequoias provides this valuable benefit at no cost to you.

All Full-Time Employees

Term Life and AD&D Insurance

Safeguard the most important people in your life.

Think about what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like covering everyday expenses, paying off debt, and protecting savings. AD&D provides even more coverage if you die or suffer a covered loss in an accident.

AT A GLANCE:

- A cash benefit of $100,000 to your loved ones in the event of your death, plus a matching cash benefit if you die in an accident
- A cash benefit to you if you suffer a covered loss in an accident, such as losing a limb or your eyesight
- *Accident Plus* - If you suffer an AD&D loss in an accident, you may also receive benefits for the following on top of your core AD&D benefits: coma, plegia, education, child care, spouse training, and more.
- *LifeKeys*® services, which provide access to counseling, financial, and legal support
- *TravelConnect*℠ services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

You also have the option to increase your cash benefit by securing additional coverage at affordable group rates. See the enclosed life insurance information for details.

ADDITIONAL DETAILS

Conversion: You can convert your group term life coverage to an individual life insurance policy without providing evidence of insurability if you lose coverage due to leaving your job or for another reason outlined in the plan contract. AD&D benefits cannot be converted.

Benefit Reduction: Coverage amounts begin to reduce at age 70 and benefits terminate at retirement. See the plan certificate for details.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

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Lincoln Financial Group®

Full-Time Employees of College of Sequoias

Benefits At-A-Glance

AD&D Insurance

The Lincoln AD&D Insurance Plan:

- Provides a cash benefit to your loved ones if you die in an accident
- Provides a cash benefit to you if you suffer a covered loss in an accident
- Features group rates for College of Sequoias employees
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support
- Also includes *TravelConnect*℠ services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

Employee	
Maximum coverage amount	5 times your annual salary ($300,000 maximum) in $10,000 increments
Minimum coverage amount	$10,000

Your employee AD&D coverage amount will reduce by 50% when you reach age 70. Benefits end when you retire.

Spouse / Domestic Partner	
Maximum coverage amount	50% of the employee coverage amount ($150,000 maximum) in $5,000 increments
Minimum coverage amount	$5,000

You can secure AD&D insurance for your spouse / domestic partner if you select coverage for yourself.

Benefits end when you reach age 70 or retire, whichever comes first.

Dependent Children	
6 months to age 19 (to age 25 if full-time student) Maximum coverage amount	Up to $10,000 in $2,000 increments
Minimum coverage amount	$2,000
Age 14 Days to 6 months Maximum coverage amount	$250

You can secure AD&D insurance for your dependent children when you choose coverage for yourself.

Additional Plan Benefits	
Safe Driver Benefit	Included
Education Benefit	Included
Spouse Training Benefit	Included
Felonious Assault	Included
Child Care Benefit	Included
Coma Benefit	Included
Common Disaster Benefit	Included
Exposure Benefit	Included
Disappearance Benefit	Included
Common Carrier Benefit	Included
Repatriation Benefit	Included

Note: See the policy for details and specific requirements for each of these benefits

Benefit Exclusions

Like any insurance, this AD&D insurance policy does have exclusions. Benefits will not be paid if death results from suicide, or death/dismemberment occurs while:

- Intentionally inflicting or attempting to inflict injury to one's self
- Participating in a war, act of war, or riot
- Serving on full-time active duty in the armed forces of any state or country (this does not include duty of 30 days or less training in the Reserves or National Guard)
- Flying on any non-commercial airplane or aircraft, such as a hot air balloon or glider (see the contract for details and exceptions)
- Flying on a commercial airline or aircraft as a pilot or crewmember
- Committing or attempting to commit a felony
- Deliberately inhaling gas (such as carbon monoxide) or using drugs other than those taken as prescribed by a licensed physician
- Driving while intoxicated, impaired, or under the influence of drugs

In addition, this AD&D insurance policy does not cover sickness or disease, including the medical and surgical treatment of a disease.

A complete list of benefit exclusions is included in the policy. State variations apply.

Voluntary Accidental Death & Dismemberment Insurance
Here's how little you pay with group rates.

Monthly Premium Calculation for You

The estimated monthly premium for AD&D insurance is determined by multiplying the desired amount of coverage (in increments of $10,000) by the premium rate. **See table at right for select coverage amounts.**

$_____ X 0.0000300 = $_____
coverage amount premium rate monthly premium

Note: Rates are subject to change and can vary over time.

Coverage Amount	Monthly Premium
$10,000	$0.30
$50,000	$1.50
$100,000	$3.00
$150,000	$4.50
$300,000	$9.00

Monthly Premium Calculation for Your Spouse / Domestic Partner

The estimated monthly premium for AD&D insurance is determined by multiplying the desired amount of coverage (in increments of $5,000) by the premium rate. **See table at right for select coverage amounts.**

$_____ X 0.0000300 = $_____
coverage amount premium rate monthly premium

Note: Rates are subject to change and can vary over time.

Coverage Amount	Monthly Premium
$5,000	$0.15
$20,000	$0.60
$50,000	$1.50
$100,000	$3.00
$150,000	$4.50

Monthly Premium Calculation for Your Dependent Children

The estimated monthly premium for AD&D insurance is determined by multiplying the desired amount of coverage (in increments of $2,000) by the premium rate. **See table at right for select coverage amounts.**

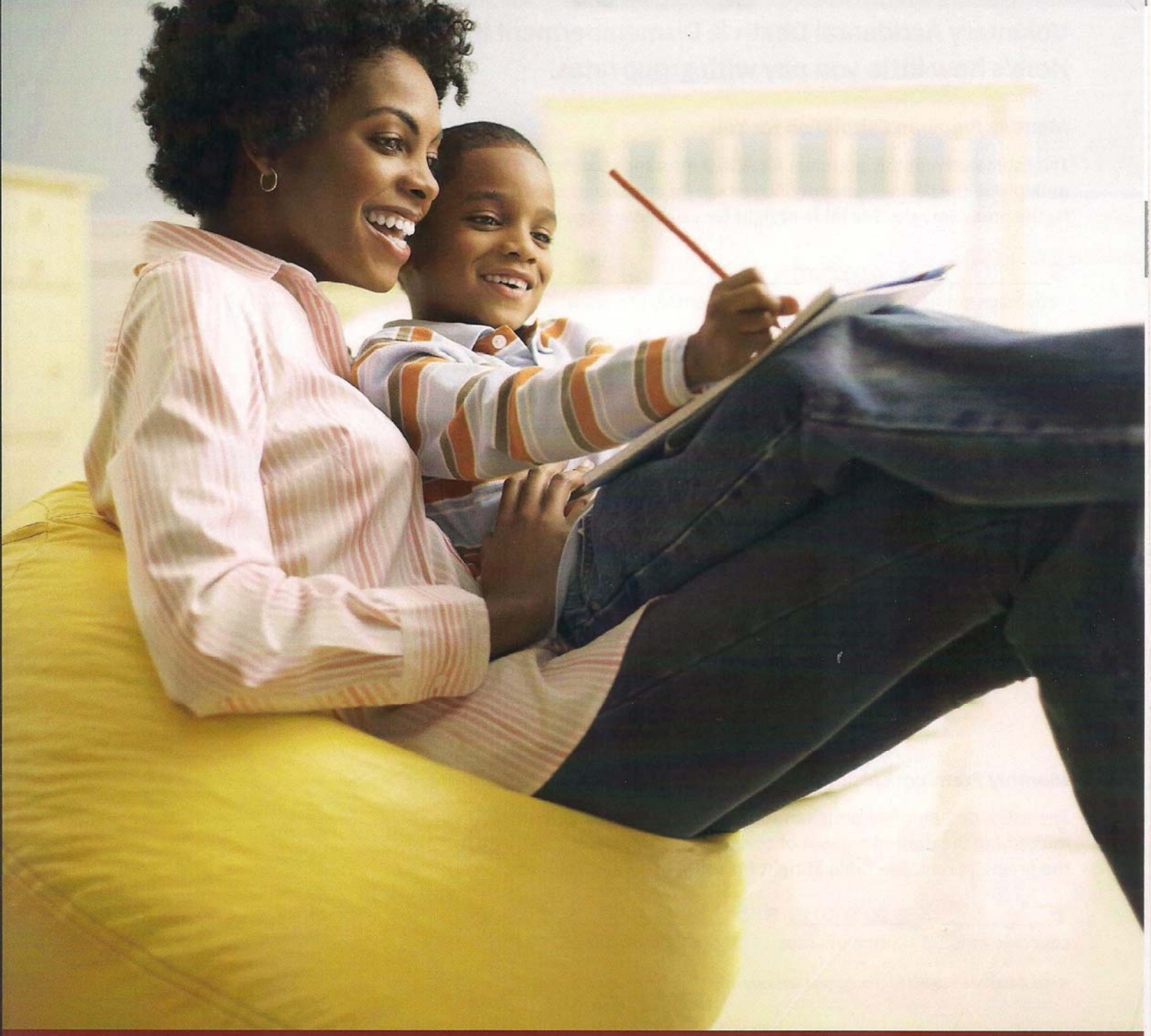
$_____ X 0.0000300 = $_____
coverage amount premium rate monthly premium

Note: Rates are subject to change and can vary over time.

Coverage Amount	Monthly Premium
$2,000	$0.06
$4,000	$0.12
$6,000	$0.18
$8,000	$0.24
$10,000	$0.30

Note: You must be an active College of Sequoias employee to select coverage for a spouse / domestic partner and/or dependent children. To be eligible for coverage, a spouse / domestic partner or dependent child cannot be confined to a health care facility or unable to perform the typical activities of a healthy person of the same age and gender.

The Lincoln National Life Insurance Company
Please see prior page for product information.
Voluntary AD&D Insurance Premium Calculation



Protect yourself and your loved ones with benefits *you* choose.

Your employer has partnered with Lincoln to give you even more benefit options that you can purchase at affordable group rates—in addition to the benefits you get at no cost. So you can secure the financial future for yourself and your loved ones by choosing the benefits that are right for you.

Lincoln Financial Group®

Full-Time Employees of College of Sequoias

Benefits At-A-Glance

Term Life Insurance

The Lincoln Term Life Insurance Plan:

- Provides a cash benefit to your loved ones in the event of your death
- Features group rates for College of Sequoias employees
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services
- Also includes *TravelConnect*℠ services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

Employee	
Newly hired employee guaranteed coverage amount	$150,000
Continuing employee guaranteed coverage annual increase amount	Choice of $10,000 or $20,000
Maximum coverage amount	5 times your annual salary ($300,000 maximum in increments of $10,000)
Minimum coverage amount	$10,000
Spouse / Domestic Partner	
Newly hired employee guaranteed coverage amount	$50,000
Continuing employee guaranteed coverage annual increase amount	Choice of $5,000 or $10,000
Maximum coverage amount	50% of the employee coverage amount ($150,000 maximum in increments of $5,000)
Minimum coverage amount	$5,000
Dependent Children	
6 months to age 19 (to age 25 if full-time student) guaranteed coverage amount	$10,000
Age 14 days to 6 months guaranteed coverage amount	$250

What your benefits cover

Employee Coverage

Guaranteed Life Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to $150,000 without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase your coverage amount by $10,000 or $20,000 without providing evidence of insurability . If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.
- You can increase this amount by up to $20,000 during the next limited open enrollment period.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 5 times your annual salary ($300,000 maximum) with evidence of insurability. See the Evidence of Insurability page for details.
- The maximum coverage amount for employees 70 and older who are electing coverage for the first time is $50,000.
- Your coverage amount will reduce by 50% when you reach age 70

Spouse / Domestic Partner Coverage - You can secure term life insurance for your spouse / domestic partner if you select coverage for yourself.

Guaranteed Life Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to 50% of your coverage amount ($50,000 maximum) for your spouse / domestic partner without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase the coverage amount for your spouse / domestic partner by $5,000 or $10,000 without providing evidence of insurability. If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.
- You can increase this amount by up to $10,000 during the next limited open enrollment period.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 50% of your coverage amount ($150,000 maximum) for your spouse / domestic partner with evidence of insurability.

Dependent Children Coverage - You can secure term life insurance for your dependent children when you choose coverage for yourself.

Guaranteed Life Insurance Coverage Options: $2,000, $4,000, $6,000, $8,000, and $10,000.

Additional Plan Benefits

Accelerated Death Benefit	Included
Premium Waiver	Included
Conversion	Included
Portability	Included

Benefit Exclusions

Like any insurance, this term life insurance policy does have exclusions. A suicide exclusion may apply. A complete list of benefit exclusions is included in the policy. State variations apply.

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 detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

LifeKeys® services are provided by ComPsych® Corporation, Chicago, IL. TravelConnect℠ travel assistance services are provided by On Call International, Salem NH. On Call International must coordinate and provide all arrangements in order for eligible services to be covered. ComPsych® and On Call International are not Lincoln Financial Group companies and Lincoln Financial Group does not administer these Services. Each independent company is solely responsible for its own obligations. Coverage is subject to contract language that contains specific terms, conditions, and limitations.

Insurance products (policy series GL1101) 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. Product availability and/or features may vary by state. Limitations and exclusions apply.

Lincoln Financial Group®

Monthly Supplemental Life Insurance Premium
Here's how little you pay with group rates.

Employee Age Range	Life Premium Rate
0 - 24	0.0000300
25 - 29	0.0000300
30 - 34	0.0000400
35 - 39	0.0000700
40 - 44	0.0001300
45 - 49	0.0001900
50 - 54	0.0004000
55 - 59	0.0006200
60 - 64	0.0006400
65 - 69	0.0011600
70 - 74	0.0030900
75 - 79	0.0125900
80 - 99	0.0125900

Group Rates for You

The estimated monthly premium for life insurance is determined by multiplying the desired amount of coverage (in increments of $10,000) by the employee age-range premium rate.

$_____ X _____ = $_____
coverage amount premium rate monthly premium

Note: Rates are subject to change and can vary over time.

Employee Age Range	Life Premium Rate
0 - 24	0.0000300
25 - 29	0.0000300
30 - 34	0.0000400
35 - 39	0.0000700
40 - 44	0.0001300
45 - 49	0.0001900
50 - 54	0.0004000
55 - 59	0.0006200
60 - 64	0.0006400
65 - 69	0.0011600

Group Rates for Your Spouse / Domestic Partner

The estimated monthly premium for life insurance is determined by multiplying the desired amount of coverage (in increments of $5,000) by the employee age-range premium rate.

$_____ X _____ = $_____
coverage amount premium rate monthly premium

Note: Rates are subject to change and can vary over time.

Dependent Children Monthly Premium for Life Insurance Coverage

Coverage Amount	Monthly Premium
$2,000	$0.40
$4,000	$0.80
$6,000	$1.20
$8,000	$1.60
$10,000	$2.00

Group Rates for Your Dependent Children

One affordable monthly premium covers all of your eligible dependent children.

Note: You must be an active College of Sequoias employee to select coverage for a spouse / domestic partner and/or dependent children. To be eligible for coverage, a spouse / domestic partner or dependent child cannot be confined to a health care facility or unable to perform the typical activities of a healthy person of the same age and gender.

The Lincoln National Life Insurance Company

Please see prior page for product information.

Supplemental Life Insurance Premium Calculation

LFE-ENRO-BRC001-CA

The Lincoln National Life Insurance Company
Group Insurance Service Office
P.O. Box 2616, Omaha, NE 68114
Phone: 800-423-2765 Fax: 877-573-6177
Email: lfgenrollments@LFG.com

EVIDENCE OF INSURABILITY INFORMATION

Instructions for Employee Applicant (Please complete the required sections as noted below.)

1. If you are providing evidence of insurability for:
   a. **Applicant (Employee) insurance only — Complete Sections A, C, D, E, F, G and H.**
   b. **Dependent (Spouse, Domestic Partner) insurance only — Complete *all* sections of this form.**
   c. **Applicant (Employee) and Dependent (Spouse, Domestic Partner) insurance — Complete *all* sections of this form.**
   NOTE: Evidence of insurability is not required for children.

2. Complete the form in ink, and sign and date after **Section H**. Retain a copy of this form for your records.

3. Complete, sign, and date the **AUTHORIZATION** for Applicant and Dependent Applicant.

4. Read the **NOTICE OF INSURANCE INFORMATION PRACTICES** and retain it for your records.

5. Return your completed form to:

The Lincoln National Life Insurance Company
Group Insurance Service Office
P.O. Box 2616
Omaha, NE 68114
Email: lfgenrollments@LFG.com

Or fax the form to:
877-573-6177

Please take the following steps to avoid delays in our evaluation of your request for insurance:
-Follow all instructions on this sheet.
-Answer all questions (yourself and your dependents) on the form.
-Provide full and complete information for any questions requiring additional details.
-Provide complete names and addresses of any doctors and hospitals.

Any incomplete or incorrect information could result in a delay.

NOTE: Insurance is not effective until the company approves in writing. We will notify you of your approval status.

If you have questions on completing this form, please contact Lincoln Financial Group Customer Service at 800-423-2765, or email us at clientservices@lfg.com.

Continue on Next Page. . .

The Lincoln National Life Insurance Company
Group Insurance Service Office
P.O. Box 2616, Omaha, NE 68103-2616
Phone: 800-423-2765 Fax: 877-573-6177
Email: lfgenrollments@LFG.com

EVIDENCE OF INSURABILITY INFORMATION

Please submit this form to THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (the Company). Insurance that requires evidence of insurability will not be effective until the Company approves in writing.

Employer Completes this Section.	
Group Name:	Group ID/Number/Code:
Billing Division or Location:	Sort Group/Code:
Policy #(s):	

Complete and return this entire form. Print clearly in ink. Incomplete forms will delay processing.

A. Applicant (Employee) Insurance Information

First Name _____ Middle Name/MI _____ Last Name _____

Social Security Number ___-___-___ Date of Birth ___/___/___ State of Birth _____ Employee ID _____

Street Address (Include Apt. or Suite Number) _____ City _____ State _____ Zip _____

Cell Phone ( ) - Home Phone ( ) - Work Phone ( ) - Best Time To Call _____AM/PM

Email Address _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single

Average Hours Worked Per Week: ☐ Full-Time ☐ Part-Time Employee Occupation: _____

Earnings: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly $_____ Date of Employment: ___/___/___

Is the Employee Actively at Work? ☐ Yes ☐ No Date of Rehire: ___/___/___

Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions stated in the policy and certificate. (Spouse includes your Domestic Partner.)

Type of Group Insurance	Current Amount	Additional Amount	Total Amount
☐ Life (Employee)	$_____	$_____	$_____
☐ Dependent Life (Spouse)	$_____	$_____	$_____
☐ Short Term Disability (STD)	$_____	$_____	$_____
☐ Long Term Disability (LTD)	$_____	$_____	$_____
☐ Voluntary/Optional Life (Employee)	$_____	$_____	$_____
☐ Voluntary/Optional Life (Spouse)	$_____	$_____	$_____
☐ Voluntary/Optional/Buy-Up Short-Term Disability (STD)	$_____	$_____	$_____
☐ Voluntary/Optional/Buy-Up Long-Term Disability (LTD)	$_____	$_____	$_____
☐ Critical Illness (Employee)	$_____	$_____	$_____
☐ Critical Illness (Spouse)	$_____	$_____	$_____

Continue on Next Page. . .

B. Applicant (Spouse, Domestic Partner) Information – Only complete if applying for Dependent insurance.

First Name _____ Middle Name/MI _____ Last Name _____

Social Security Number _____-_____-_____ Date of Birth ____/____/____ State of Birth _____ Gender: ☐ Male ☐ Female

Provide contact information if different than the Employee information above.

Street Address (Include Apt. or Suite Number) _____ City _____ State _____ Zip _____

Cell Phone (____) ____- _____ Home Phone (____) ____- _____ Work Phone (____) ____- _____ Best Time To Call _____AM/PM

Email Address _____

Continue on Next Page. . .

STATEMENT OF HEALTH

C. Medical Information – Applicants complete if applying for ANY insurance.

Employee: Height: _____Ft_____In. Weight: _____lbs.

Spouse: Height: _____Ft_____In. Weight: _____lbs.

	Employee	Spouse
In the past 12 months, has anyone applying for insurance smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?	☐Yes ☐No	☐Yes ☐No

D. Medical Information – Applicants complete if applying for Life or Disability insurance. You must answer YES or NO for each question per Applicant to avoid a processing delay.

If you answer YES to ANY part of ANY question below, provide complete details in Section E (Additional Details), including condition, treatment, and names of medication.

	Employee	Spouse
1. **Within the past 7 years,** to the best of your knowledge, has anyone applying for insurance had, or been diagnosed or treated by a member of the medical profession for a condition/undergone a procedure listed below:		
a. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement, cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve, atrial fibrillation, abnormal heart rhythm, implantation of pacemaker, or stroke; liver disease, hepatitis, cirrhosis, chronic kidney disease, kidney failure, kidney disease requiring dialysis, kidney stones, polycystic kidney disease, or nephritis; emphysema, chronic obstructive pulmonary disease (COPD), chronic pulmonary disease, cardio-pulmonary disease requiring oxygen, chronic bronchitis, asthma, sarcoidosis, or sleep apnea; mental or nervous disease requiring treatment (including hospital confinement) by a physician, psychiatrist, psychologist, counselor or therapist; alcoholism, drug or substance abuse; internal cancer, lymphoma, melanoma, or leukemia; diabetes, or epilepsy?	☐Yes ☐No	☐Yes ☐No
b. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or as a result of a positive ELISA test followed by a positive Western Blot test, tested positive for antibodies to HIV (Human Immunodeficiency Virus) for the purpose of obtaining insurance? **CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.**	☐Yes ☐No	☐Yes ☐No
2. a. Has anyone applying for insurance ever been diagnosed by a member of the medical profession with hypertension (high blood pressure)?	☐Yes ☐No	☐Yes ☐No
b. If 2a is Yes, within the last year, has that person had a systolic (top number) blood pressure reading higher than 150 more than once or a diastolic (bottom number) blood pressure reading higher than 100 more than once?	☐Yes ☐No	☐Yes ☐No
c. If 2a is Yes, is anyone applying for insurance taking three or more medications for hypertension (high blood pressure) or had their medications changed or increased within the past 6 months?	☐Yes ☐No	☐Yes ☐No
3. a. Is anyone applying for insurance currently under observation or treatment by a physician?	☐Yes ☐No	☐Yes ☐No
b. Is anyone applying for insurance currently taking any medication(s) prescribed by a physician?	☐Yes ☐No	☐Yes ☐No
4. **Within the past 5 years,** to the best of your knowledge, has anyone been diagnosed or treated by a member of the medical profession for a condition/undergone a surgical procedure for:		
a. Thoracic outlet syndrome, backache, or back strain; whiplash, torticollis, ankylosis, vertebrae fracture, spondylosis, spondylolysis, spondylolisthesis, intervertebral rupture, herniation or protrusion of a disc (slipped disc), kyphosis (roundback or Kelso's hunchback), lordosis (curvature of spine), scoliosis; or sciatica?	☐Yes ☐No	☐Yes ☐No
b. Osteoarthritis, Rheumatoid Arthritis, or degenerative joint disease?	☐Yes ☐No	☐Yes ☐No
c. Injury to or damage to the ligaments, cartilage, or meniscus of the knee?	☐Yes ☐No	☐Yes ☐No
5. **Within the past 24 months**, to the best of your knowledge, other than colds, flu or normal pregnancy, has anyone applying for insurance lost time from work more than 5 consecutive days due to disability, illness, injury or mental or nervous disorder?	☐Yes ☐No	☐Yes ☐No
6. Has anyone applying for insurance been told by a member of the medical profession that medical, surgical, psychiatric or rehabilitative care is required in the next 24 months?	☐Yes ☐No	☐Yes ☐No
7. Is anyone applying for **Disability** insurance currently pregnant?	☐Yes ☐No	☐Yes ☐No

Continue on Next Page. . .

E. Additional Details

Provide details for any questions answered YES in SECTION D. (Attach additional sheet, if needed).

Question Number	Applicant Name	Condition & Length of Condition	Treatment/ Names of Medication	Date of Diagnosis	Current Status of Condition	Attending Physician's Name, Address, and Phone Number

Continue on Next Page. . .

F. Medical Information – Applicants complete if applying for Critical Illness insurance. You must answer YES or NO for each question per Applicant to avoid a processing delay.

MUST BE COVERED FOR MEDICAL, HOSPITAL, AND SURGICAL COVERAGE TO APPLY.*	Employee	Spouse
1. **Within the past 7 years,** to the best of your knowledge, has anyone applying for insurance been diagnosed or treated by a member of the medical profession for Systemic Lupus, Type I or II Diabetes, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or sarcoidosis? **CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.**	☐Yes ☐No	☐Yes ☐No
2. **Within the past 7 years,** to the best of your knowledge, has anyone applying for insurance been diagnosed or treated by a member of the medical profession for a condition for which a Pacemaker has been installed, or been diagnosed with or received treatment for 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?	☐Yes ☐No	☐Yes ☐No
3. Is anyone applying for insurance currently taking three or more high blood pressure (HBP) medications or had HBP medications changed or increased within the past six months?	☐Yes ☐No	☐Yes ☐No
4. **Within the past 7 years,** to the best of your knowledge, has anyone applying for insurance been diagnosed or treated by a member of the medical profession for internal cancer, lymphoma, leukemia or melanoma?	☐Yes ☐No	☐Yes ☐No
5. **Within the past 7 years,** to the best of your knowledge, has anyone applying for insurance been diagnosed or treated by a member of the medical profession for Cystic fibrosis, renal hypertension or any chronic kidney disease or condition (not including stones), kidney disease requiring dialysis, kidney failure, 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?	☐Yes ☐No	☐Yes ☐No
6. **Within the past 7 years**, to the best of your knowledge, has anyone applying for insurance been diagnosed or treated by a member of the medical profession for glaucoma or retinitis pigmentosa?	☐Yes ☐No	☐Yes ☐No

Is each Applicant covered by an individual or group insurance policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans?
☐Yes ☐No (If No, Critical Illness insurance shall not be issued.)

***FOR CRITICAL ILLNESS INSURANCE: A PERSON MUST BE COVERED BY AN INDIVIDUAL OR GROUP POLICY OR CONTRACT THAT ARRANGES OR PROVIDES MEDICAL, HOSPITAL, AND SURGICAL COVERAGE NOT DESIGNED TO SUPPLEMENT OTHER PRIVATE OR GOVERNMENTAL PLANS. BOTH THE EMPLOYEE AND SPOUSE MUST BE COVERED BY SUCH A PLAN IF APPLYING FOR CRITICAL ILLNESS FOR DEPENDENT SPOUSE.**

Continue on Next Page. . .

G. Fraud Warning/State Disclosure(s)

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. THE FALSITY OF ANY STATEMENT IN THIS APPLICATION SHALL NOT BAR THE RIGHT TO RECOVERY UNDER THE POLICY UNLESS SUCH FALSE STATEMENT WAS MADE WITH ACTUAL INTENT TO DECEIVE OR UNLESS IT MATERIALLY AFFECTED EITHER THE ACCEPTANCE OF THE RISK OR THE HAZARD ASSUMED BY THE INSURER.

H. Acknowledgments and Declarations (Initial each item and sign where indicated.)

1. I request the insurance 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; _____ (initials)
2. I 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; _____ (initials)
3. I represent that if the above Statement of Health has been completed to obtain insurance 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; _____ (initials)
4. I acknowledge that I have read the **Fraud Warning/State Disclosure(s)**; _____ (initials)
5. I understand that for continued eligibility I must remain an active employee working at least the minimum hours or otherwise continue insurance as outlined in the contract; and _____ (initials)
6. **The attached AUTHORIZATION has been completed and signed by me (Employee Applicant). A separate authorization has been completed and signed by the (Spouse) Applicant.** _____ (initials)

Signature of (Employee) Applicant: **X**_____ Date: ____/____/____

Signature of (Spouse) Applicant: **X**_____ Date: ____/____/____

PAYROLL DEDUCTION AUTHORIZATION (Sign where indicated):

I authorize any required deductions from my earnings.

Signature of (Employee) Applicant: X_____ **Date:**____/____/____

PLEASE COMPLETE THE ATTACHED AUTHORIZATION
(EACH APPLICANT MUST COMPLETE AND SIGN HIS/HER OWN AUTHORIZATION)
Return all pages to avoid processing delays.

Continue on Next Page. . .

AUTHORIZATION FOR RELEASE OF INFORMATION

AUTHORIZATION: I (the undersigned) authorize any physician, medical professional, medical facility, pharmacy benefit manager, insurer, reinsurer, consumer reporting agency or MIB, Inc. ("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.

5. I authorize The Lincoln National Life Insurance Company, or its reinsurers, to disclose Protected Health Information or personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

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

6. 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.

7. 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 insurance 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.

8. A photocopy of this Authorization is to be considered as valid as the original.

9. I acknowledge that I have received the attached Notice of Information Practices.

10. I understand that I am entitled to receive a copy of this Authorization.

Signature of Applicant: **X**_____ **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 on a fair and equitable basis, we must collect information about you and others for whom insurance 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.

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.

MIB, Inc.
Information regarding your insurability will be treated as confidential. The Lincoln National Life Insurance Company or its reinsurers may, however, make a brief report thereon 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, 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 MIB at 866 692-6901. 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 MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

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