

# PARTICIPATION AGREEMENT FOR SMALL GROUP INSURANCE

The Lincoln National Life Insurance Company  
 Group Insurance Service Office  
 8801 Indian Hills Drive  
 Omaha, Nebraska 68114-4066

## General Information Form

Office Use Only - ID# \_\_\_\_\_

### GENERAL INFORMATION

Application, based upon the following statements, is hereby made to become a Participating Employer under group insurance policies issued to: The Lincoln National Life Insurance Company's Tailored Insurance Plan Trust (the Trust).

1. **Applicant's Full Legal Name** (exactly as to be shown in Certificates): \_\_\_\_\_  
 \_\_\_\_\_
2. **Main Office Address** (physical location): Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County/Parish \_\_\_\_\_

### REQUESTED PLAN

1. Requested effective date of insurance (month/day/year): \_\_\_\_\_
2. Coverages elected, premium percentage to be contributed by the Employer for each, and Benefits Supplement Form to be completed for each coverage:

Coverage	Employer Contribution %	Complete Form #	Coverage	Employer Contribution %	Complete Form #
<input type="checkbox"/> Life and AD&D*	_____ %	1	<input type="checkbox"/> Long Term Disability*	_____ %	2
<input type="checkbox"/> Dependent Life*	_____ %	1	<input type="checkbox"/> Employees Dental	100 %	1
<input type="checkbox"/> Short Term Disability*	_____ %	2	<input type="checkbox"/> Family Dental	_____ %	1

\*Employer must contribute at least 25% for these coverages.

### BUSINESS INFORMATION

1. **Nature of Business** (Describe service, product, any special hazards): \_\_\_\_\_  
 \_\_\_\_\_  
 Years in Business\* \_\_\_\_\_ Years at Location \_\_\_\_\_ Federal Tax ID# \_\_\_\_\_ State Tax ID# \_\_\_\_\_  
 \*Minimum is 2 years for LTD and 6 months for other coverages.
2. **Business is Organized As** (select one):  
 Corporation     Proprietorship     Non-Profit Organization  
 Partnership     Union     Political Subdivision     Other \_\_\_\_\_
3. **Financial Risk** (If Yes to any part, please explain below.)  
 Yes     No    Has Applicant ever filed for bankruptcy, or do they anticipate filing for bankruptcy?  
 Yes     No    Does Applicant anticipate ceasing or materially reducing active business operations?  
 Yes     No    Has Applicant opted out (or do they anticipate opting out) of Workers' Compensation?  
 Yes     No    Is Applicant's business dependent upon government contracts or private grants?  
 Yes     No    Do any family members of owner(s), officers or partners work for firm? (If Yes, show names and relationships below.)  
 Explanation: \_\_\_\_\_  
 \_\_\_\_\_

### OTHER INSURANCE

If Yes to 2 or 3, please provide details below and **enclose a copy of each inforce contract** to be supplemented or replaced.

1.  Yes     No    Does Applicant have any other group policy inforce with The Lincoln National Life Insurance Company?  
 If Yes, show Policy Number \_\_\_\_\_
2.  Yes     No    Will all or part of this plan **supplement** similar coverage now in force or being applied for?
3.  Yes     No    Will all or part of this plan **replace** similar coverage?

Coverages	Carrier	Effective Date	If Replacement, Termination Date
_____	_____	_____	_____
_____	_____	_____	_____

If Yes to any part, please provide details below. Attach and sign additional sheets, if needed.

1.  Yes  No Is any proposed insured (employee, dependent, or continuee) now disabled?
2.  Yes  No To the best of your knowledge, within the past 12 months has any proposed insured been diagnosed or treated for a serious medical condition (such as cancer, diabetes, stroke or heart disorder)?
3.  Yes  No To the best of your knowledge, within the past 12 months has any eligible employee been absent for more than 10 consecutive working days, due to an injury or sickness (other than normal pregnancy)?

Name \_\_\_\_\_ Medical Condition \_\_\_\_\_  
 Status:  Employee  Dependent  Continuee Eligible Class \_\_\_\_\_ Benefit Amount \_\_\_\_\_  
 Complete for Employee: Date Last Worked \_\_\_\_\_ Expected Return Date \_\_\_\_\_ Occupation \_\_\_\_\_  
 Complete for Life Plan: Has he/she been approved for prior plan's Extension of Death Benefit?  Yes  No

Name \_\_\_\_\_ Medical Condition \_\_\_\_\_  
 Status:  Employee  Dependent  Continuee Eligible Class \_\_\_\_\_ Benefit Amount \_\_\_\_\_  
 Complete for Employee: Date Last Worked \_\_\_\_\_ Expected Return Date \_\_\_\_\_ Occupation \_\_\_\_\_  
 Complete for Life Plan: Has he/she been approved for prior plan's Extension of Death Benefit?  Yes  No

**PARTICIPATION AGREEMENT.** I hereby apply to become a Participating Employer under group insurance policies issued by The Lincoln National Life Insurance Company to the Trust, and for group insurance as provided in the attached Supplements. The information in this Participation Agreement is true and correct, to the best of my knowledge and belief. It forms the basis for this request for group insurance. Omission or misstatement of known information on this Participation Agreement could affect the validity of any insurance issued and cause the denial of an otherwise valid claim.

- CONDITIONS.** I understand that the requested group insurance:
- (a) will be issued only if the requested insurance is approved in writing by The Lincoln National Life Insurance Company and is legally permissible;
  - (b) will be issued under a group Policy held by the Trust, in the Certificate language customarily used by The Lincoln National Life Insurance Company;
  - (c) will be subject to The Lincoln National Life Insurance Company's usual underwriting requirements (including Evidence of Insurability, if required);
  - (d) will take effect on the date determined by The Lincoln National Life Insurance Company, subject to the Active Work requirement; and
  - (e) will be subject to all exclusions and limitations of the Policy.

- DUTIES.** I understand that no agent or broker has the authority to guarantee acceptance of the requested insurance, and agree not to:
- (a) collect or pay premiums for such insurance, before receiving The Lincoln National Life Insurance Company's notice of approval; or
  - (b) distribute material describing Policy coverage to persons to be insured, without The Lincoln National Life Insurance Company's prior written consent.

If accepted, I agree to distribute Certificates to all insured employees, maintain and furnish records needed for plan administration, report changes in the group, and pay premium by each due date. Failure to pay premium by the end of the 31-day grace period will automatically cancel coverage; and my firm will remain liable for premium during the grace period. If dental insurance is requested I agree to provide employees and dependents notice of any applicable continuation rights required by state or federal law.

- PREMIUM.** Premium rate quotes were based on data submitted to The Lincoln National Life Insurance Company; final premium rates will be determined by actual group composition. The Lincoln National Life Insurance Company may change any premium rate:
- (a) on any premium due date on or after the first Policy Anniversary; or
  - (b) when any of the Policy's terms are changed or any change in law affects the Policy.

- RENEWAL.** I understand that coverage is renewable at The Lincoln National Life Insurance Company's option. In accord with the terms of the Policy, The Lincoln National Life Insurance Company may cancel the insurance by giving 31 days' prior written notice (or any longer period required by law), on any premium due date when:
- (a) the premium rate has been in effect for at least 12 months;
  - (b) the required participation rate (100% for noncontributory plans and 75% for contributory plans) is not met; or
  - (c) the firm ceases to be a Participating Employer in accord with Policy provisions.
- A Participating Employer may cancel the insurance at any time, by giving The Lincoln National Life Insurance Company prior written notice.

**CONTRACT.** This application and the payment of premium constitutes the consideration for any Certificates issued. After receipt of the Certificates, payment of premium is deemed acceptance of the Policy's terms (including any corrections, additions or changes shown in the spaces marked "For Group Insurance Service Office Use Only"). This Participation Agreement, including the attached Supplements, shall be made a part of any contract issued.

**NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health Insurance coverage.**

Writing Agent  
or Broker \_\_\_\_\_

Typed or Printed Name \_\_\_\_\_

License Number \_\_\_\_\_ State \_\_\_\_\_

Licensed Resident Agent's  
Signature (If required) \_\_\_\_\_

Typed or Printed Name \_\_\_\_\_

License Number \_\_\_\_\_ State \_\_\_\_\_

Signed by Applicant's Authorized Representative:

Signature \_\_\_\_\_

Typed or Printed Name \_\_\_\_\_

Title \_\_\_\_\_

Witness' Signature \_\_\_\_\_

Signed At \_\_\_\_\_ Date \_\_\_\_\_  
(Must be signed prior to Effective Date)

**ELIGIBILITY AND WAITING PERIOD**

*General Information Form...continued*

If requirements differ by coverage types, please explain below.

- Minimum Hours** - All Eligible Employees must work a minimum of \_\_\_\_\_ regularly scheduled hours per week. (Minimum is 20 hours for Life or STD, and 30 hours for Dental or LTD.)
- Waiting Period - New Employees** (hired after this Policy's Issue Date) must be employed in an eligible class with the Applicant for \_\_\_\_\_ before becoming eligible for insurance. (Minimum is 30 days and maximum is 180 days.)
- Effective Date** - Subject to the Active Work Rule, **New Employees** become insured on the 1st day of the insurance month coinciding with or next following completion of the Waiting Period, and **Present Employees** become insured on the Applicant's effective date of Participation under the Policy.  
  
Subject to Active Work Rule, **benefit increases** will take effect on the 1st day of the Insurance Month coinciding with or next following the increase. **Benefit decreases** will take effect on the date of the change.
- Excluded Classes** - The Policy standardly excludes temporary, seasonal and part-time employees working less than the Minimum Hours elected above. Also exclude the following:  
  
 Other \_\_\_\_\_
- Participation** for each coverage requested:  
  
Total Number of Eligible Employees \_\_\_\_\_ Number to be insured for:  
Life/AD&D \_\_\_\_\_ STD \_\_\_\_\_ LTD \_\_\_\_\_ Dental \_\_\_\_\_  
If applicable, Number with Eligible Dependents \_\_\_\_\_ Number to elect Dependent Life \_\_\_\_\_ Family Dental \_\_\_\_\_

**ADMINISTRATIVE INFORMATION**

- Applicant's Mailing Address** (if different from physical location): P.O. Box, if any \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_
- Plan Administrator** - Name \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_ FAX(\_\_\_\_\_) \_\_\_\_\_  
Address:  Same as Applicant's Mailing Address  
 Other:  
P.O. Box(if any) \_\_\_\_\_ Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_
- Shipping Address** for initial certificate supply (Do not show P.O. Box):  
 Plan Administrator  Regional Group Office  Broker at below address  Other at below address  
Name/Firm \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_
- Billing Mode:**  Monthly  Quarterly  Semi-annually  
NOTE: Minimum is \$100 in premium per bill. An additional billing fee of \$20 per bill will apply.
- Binder** payment submitted for each coverage requested:  
Life/AD&D \$ \_\_\_\_\_ STD \$ \_\_\_\_\_ LTD \$ \_\_\_\_\_ Dental \$ \_\_\_\_\_
- Type of Policy Administration** will be list-billing by The Lincoln National Life Insurance Company, unless requested otherwise in **REMARKS** and agreed upon by The Lincoln National Life Insurance Company.
- Funding** - Employer premium contributions will be funded from:  General Assets  Trust  Section 125/Cafeteria Plan

1. **Summary Plan Description (SPD)** - ERISA requires distribution of SPD's for most employee benefit plans. The Certificate can serve as the SPD, if certain plan information and a Statement of ERISA Rights are added.
- Yes     No    Should ERISA information be included to form a combined SPD/Certificate? If Yes, please supply the information requested in A through E below.
- A. Plan Year ends on each \_\_\_\_\_ (month and day).
- B. Plan Number assigned to each line of coverage by Applicant (3 digits starting with "5" -- 501, 502, etc.):  
Life/AD&D \_\_\_\_\_    STD \_\_\_\_\_    LTD \_\_\_\_\_    Dental \_\_\_\_\_
- C. Plan Administrator or Fiduciary:     Same as Applicant     Other as shown below  
Name/Title \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_
- D. Agent for Service of Legal Process:     Same as Plan Administrator     Other as shown below  
Name/Title \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_
- E. Plan Trustees, if applicable: \_\_\_\_\_
2.  Yes     No    **Union Contract** - Is there any relevant Collective Bargaining Agreement? If Yes, please attach a copy of the pertinent sections and indicate number of Eligible Employees whose positions are subject to the agreement: \_\_\_\_\_
3. **Plan Fiduciary Responsibilities** - The Lincoln National Life Insurance Company cannot be named a plan fiduciary and shall not be responsible for any tax or legal aspects of the employer's plan. The Participating Employer is responsible for compliance with tax, employment and fringe benefits laws, and for obtaining any necessary counsel from their own tax and legal advisors. The Lincoln National Life Insurance Company's obligations are governed solely by the Policy provisions.

**REMARKS (Identify by section name and item number)**

**FOR GROUP INSURANCE SERVICE OFFICE USE ONLY**

Accepted for The Lincoln National Life Insurance Company by \_\_\_\_\_ Date \_\_\_\_\_

Office Use Only - ID# \_\_\_\_\_

**LIFE & AD&D BENEFITS FOR SMALL GROUPS (Select Plan 1 or 2)**

PLAN	CLASSIFICATION	LIFE AND AD&D	DEPENDENT LIFE
<input type="checkbox"/> Plan 1	Class 1: All active, eligible managers  Class 2: All other active, eligible employees	Amount: \$25,000  Amount: \$10,000	Is Dependent Life to be included? <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Dependent Life</b> (for Classes 1 and 2): Spouse (Coverage terminates at age 70) \$ 2,000 Child (14 Days - 6 Mo.) \$ 100 Child (6 Mo. - 19 Yrs.; 23 Yrs. if full-time student) \$ 2,000
<input type="checkbox"/> Plan 2	Class 1: All active, eligible employees	Amount: \$25,000	Is Dependent Life to be included? <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Dependent Life:</b> Spouse (Coverage terminates at age 70) \$ 2,000 Child (14 Days - 6 Mo.) \$ 100 Child (6 Mo. - 19 Yrs.; 23 Yrs. if full-time student) \$ 2,000

**AGE REDUCTIONS AND TERMINATION**

**Age Reductions** - Life and AD&D Benefits reduce 35% at age 65, another 25% of the original amount at 70, and another 15% of the original amount at 75. These Age Reductions will take effect on the insured person's birthday. If an employee first enrolls at age 65 or older, these Age Reductions will apply to the maximum amount for which he or she is eligible.

**Termination** - Life and AD&D Benefits terminate when the insured employee retires. Spouse Life Insurance will terminate when the spouse attains age 70, or the insured employee retires, if earlier.

**DENTAL INSURANCE FOR SMALL GROUPS (Select Plan 1, 2 or 3)**

CLASSIFICATION	PLAN	DEDUCTIBLE		PERCENTAGES PAYABLE			MAXIMUM	DEPENDENT DENTAL
		Cal. Year Deductible	Applies To Preventive	Preventive Care	Basic Care	Major Care	Cal. Year Maximum	Is Dependent Dental to be included?
Class 1: All active, eligible employees	<input type="checkbox"/> Plan 1	\$50	Yes	80%	80%	50%	\$1,000	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Plan 2	\$50	No	100%	80%	50%	\$1,500	
	<input type="checkbox"/> Plan 3	\$25	No	100%	80%	50%	\$1,500	

**STANDARD DENTAL PLAN FEATURES**

**Elimination Period:** 6 months for Major Care.

**Percentages Payable** apply to Usual, Reasonable and Customary charges incurred for Covered Services in excess of the Deductible.

**Dependent Dental** covers spouse and dependent children under age 19, or 23 if full-time students. (Higher age limits apply in certain states.)

**REPLACEMENT DENTAL PLAN**

If this plan will be a replacement group Dental plan providing Prior Insurance Credit, then please:

- enclose a copy of the inforce contract and most current billing statement; and
- indicate how long Dental insurance has been continuously in force \_\_\_\_\_

**REMARKS (Identify by section name and item number)**

**GROUP INSURANCE SERVICE OFFICE USE ONLY**

Office Use Only - ID#

**SHORT TERM DISABILITY INSURANCE FOR SMALL GROUPS (Select Option 1 or 2)**

OPTION	CLASSIFICATION	BENEFIT AMOUNT	DAY BENEFITS BEGIN		BENEFIT DURATION
<input type="checkbox"/> Option 1	<input type="checkbox"/> Class 1: All active, eligible employees  <input type="checkbox"/> Other: _____ _____ _____	100% of Basic Weekly Earnings  Maximum Weekly Benefit: <input type="checkbox"/> \$100 <input type="checkbox"/> \$200	Accidents: <input type="checkbox"/> 1st day <input type="checkbox"/> 8th day <input type="checkbox"/> 15th day	Sickness & Pregnancy: <input type="checkbox"/> 8th day <input type="checkbox"/> 15th day	Maximum Benefit Period: <input type="checkbox"/> 13 Wks <input type="checkbox"/> 26 Wks  Period reduces 50% at age 70
<input type="checkbox"/> Option 2	<input type="checkbox"/> Class 1: All active, eligible employees  <input type="checkbox"/> Other: _____ _____ _____	Percent of Basic Weekly Earnings: <input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66 2/3%  Maximum Weekly Benefit: \$ _____ (In \$10 increments from \$50 to 500)	Accidents: <input type="checkbox"/> 1st day <input type="checkbox"/> 8th day <input type="checkbox"/> 15th day	Sickness & Pregnancy: <input type="checkbox"/> 8th day <input type="checkbox"/> 15th day	Maximum Benefit Period: <input type="checkbox"/> 13 Wks <input type="checkbox"/> 26 Wks  Period reduces 50% at age 70

**STANDARD STD PLAN FEATURES**

- Partial Disability Benefits
- Full Maternity Benefits
- 3/6/12 Pre-Existing Conditions Exclusion
- Exclusion for Job-Related Disabilities
- Termination at Retirement

**LONG TERM DISABILITY INSURANCE FOR SMALL GROUPS**

CLASSIFICATION	BENEFIT AMOUNT	ELIMINATION PERIOD	MAXIMUM BENEFIT PERIOD	CONVERSION	PREMIUM BAND
<input type="checkbox"/> Class 1: All active, eligible employees  <input type="checkbox"/> Other: _____ _____ _____	Percent of Basic Monthly Earnings <input type="checkbox"/> 50% <input type="checkbox"/> 60%  Maximum Monthly Benefit: \$ _____ (Any \$100 increment from \$100 to \$6,000)	<input type="checkbox"/> 90 days  <input type="checkbox"/> 180 days	<input type="checkbox"/> To Age 65, RBD* <input type="checkbox"/> 5 Years, RBD*  * Reducing Benefit Duration for disabilities starting at age 60 or older	Is conversion privilege to be included?  <input type="checkbox"/> Yes <input type="checkbox"/> No  Not available in MN or OR.	Percent High Risk: <input type="checkbox"/> under 20% <input type="checkbox"/> 21% - 30% <input type="checkbox"/> 31% - 40% <input type="checkbox"/> 41% - 50% <input type="checkbox"/> 51% - 60% <input type="checkbox"/> 61% - 75%

**STANDARD LTD PLAN FEATURES**

- Minimum Monthly Benefit of \$100 (or 15% of monthly benefit, if more, in Missouri)
- Accumulation of Elimination Period
- 24-Month Own Occupation Period
- Primary & Family Social Security Integration
- Residual Disability Benefit
- 12/24 Pre-Existing Conditions Exclusion in most states (12-Month Exclusion in CO, FL, GA, MD, MS, MT, NC, SC, WA, WI)
- Full Maternity Benefit
- 24-Month Mental Illness Limitation
- Three-Month Survivor Benefit
- Prior Insurance Credit (Continuity of Coverage)

**ADDITIONAL INFORMATION (Complete for STD or LTD Plan)**

**Disability Benefits Supplement Form #2...continued**

**Eligible Employee** includes any owner, proprietor, partner or shareholder to be insured under the STD or LTD plan.

- 1.  Yes     No    **State Plans Available** - Are there any Eligible Employees working in CA, HI, NJ, NY, or RI? If Yes, please indicate in **REMARKS** the state, number of Eligible Employees there, and number covered by state disability plan.
- 2.  Yes     No    **International Employees** - Are there any Eligible Employees working or residing outside the United States? If Yes, please indicate in **REMARKS** the country, number of Eligible Employees there, their citizenship and expected return dates.
- 3.  Yes     No    **Union Employees** - Are there any Eligible Employees whose positions are subject to collective bargaining agreement? If Yes, please indicate number to be insured for STD \_\_\_\_\_ LTD \_\_\_\_\_
- 4.  Yes     No    **Individual Insurance** - To the best of your knowledge, does any Eligible Employee earn more than \$6,000 per month and have individual disability income coverage insuring more than 30% of earnings? If Yes, please indicate in **REMARKS** the employee's name, earnings and amount of individual coverage.
- 5.  Yes     No    **Worker's Compensation** - Is there any Eligible Employee who is not (or will not be) covered by Worker's Compensation? If Yes, please indicate employee's name and explain in **REMARKS**.
- 6. **Other Benefits** - Eligible Employees participate in the following other plans (Check all that apply):
  - Social Security or similar plans
  - Public Employees Disability/Retirement Benefits
  - State Teachers' Retirement System Benefits
  - State Disability Income Benefits
  - Other pension, retirement or disability benefits
  - Worker's Compensation Benefits
  - Sick Leave

**DEFINITION OF EARNINGS (Complete for STD or LTD Plan)**

- 1. **For STD Benefits, Basic Weekly Earnings** will standardly include weekly base salary, or hourly pay for regularly scheduled work week (excluding overtime).

**For LTD Benefits, Basic Monthly Earnings** will standardly include monthly base salary, or hourly pay for regularly scheduled work month (excluding overtime), plus commissions averaged over prior 12 months.

If other definition of earnings is needed, indicate below:

  - For Partners, base on:
    - Income from Partnership's Fed. Income Tax Return for prior \_\_\_\_\_ Tax Year \_\_\_\_\_ Cal. Year.
    - Budgeted annual earnings from current Partnership Agreement.
  - For Proprietors or Professional Corp. Shareholders, base on net taxable income from Fed. Income Tax Return for prior  Tax Year  Cal. Year.
  - For Subchapter S Corp. Shareholders, base on ordinary K-1 income from corporate Fed. Income Tax Return for prior  Tax Year  Cal. Year.
  - Other (specify) \_\_\_\_\_
- 2. **Earnings Determination Date** – Benefits will be based upon earnings determined on **the last day worked**. In no event will earnings exceed the amount shown in the Employer's payroll records, or for which premium has been paid (if less).

**REMARKS (Identify by section name and item number)**

**FOR GROUP INSURANCE SERVICE OFFICE USE ONLY**