Lincoln Financial Group®

## Voluntary Disability Insurance

SUMMARY OF BENEFITS

**Sponsored by: Gallup-McKinley County Schools** **Effective date: November 1, 2011**

| | |
|---|---|
| **Eligibility** | All full-time active employees working 20 or more hours per week in an eligible class are eligible for coverage on the policy effective date. |
| **Maximum Monthly Benefit** | Any $100 Increment, $200 minimum up to a maximum of $7,500<br>Not to exceed 66.67% of annual salary |
| **Own Occupation Period** | 24 Months |
| **Maximum Benefit Duration for Accident** | Later of Age 65 or Social Security Normal Retirement Age |
| **Maximum Benefit Duration for Illness** | 5 years |
| **Elimination Period** | Benefits begin on:<br>1st day from Hospitalization<br>1st day from an accident<br>4th day from an illness |
| **Pre-Existing Condition** | You may not be eligible for benefits if you have received treatment for a condition within the past 3 months until you have been covered under this plan for 12 months. |
| **Waiver of Premium** | Your premium will be waived after you have received a disability benefit for 90 consecutive days. |
| **Survivor Income Benefit** | A survivor benefit may be paid to your beneficiary if you should die while receiving qualifying disability payments. |
| **Enrollment** | You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again. |
| **Benefit Limitations** | Mental Illness: 24 months<br>Substance Abuse: 24 months<br>Specified Illness: 24 months |
| **Conversion** | If you terminate your employment, you may be able to convert this policy. |

## 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 six 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. |
| **Benefit Exclusions** | You will not receive benefits in the following circumstances:<br>• Your disability is the result of a self-inflicted injury.<br>• You are not under the regular care of a doctor when requesting disability benefits.<br>• You were involved in a felony commission, act of war, or participation in a riot.<br>• 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:<br>• Any compulsory benefit act or law (such as state disability plans);<br>• Any governmental retirement system earned as a result of working for the current policyholder;<br>• Any disability or retirement benefit received under a retirement plan;<br>• Any Social Security, or similar plan or act, benefits;<br>• Earnings the insured earns or receives from any form of employment;<br>• Workers compensation;<br>• 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 describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

## Gallup-McKinley Schools Rate Sheet for 0/3 Elimination Period

| Monthly Benefit | Monthly Premium | Monthly Benefit | Monthly Premium |
|---|---|---|---|
| 200 | 7.56 | 4,100 | 154.98 |
| 300 | 11.34 | 4,200 | 158.76 |
| 400 | 15.12 | 4,300 | 162.54 |
| 500 | 18.90 | 4,400 | 166.32 |
| 600 | 22.68 | 4,500 | 170.10 |
| 700 | 26.46 | 4,600 | 173.88 |
| 800 | 30.24 | 4,700 | 177.66 |
| 900 | 34.02 | 4,800 | 181.44 |
| 1,000 | 37.80 | 4,900 | 185.22 |
| 1,100 | 41.58 | 5,000 | 189.00 |
| 1,200 | 45.36 | 5,100 | 192.78 |
| 1,300 | 49.14 | 5,200 | 196.56 |
| 1,400 | 52.92 | 5,300 | 200.34 |
| 1,500 | 56.70 | 5,400 | 204.12 |
| 1,600 | 60.48 | 5,500 | 207.90 |
| 1,700 | 64.26 | 5,600 | 211.68 |
| 1,800 | 68.04 | 5,700 | 215.46 |
| 1,900 | 71.82 | 5,800 | 219.24 |
| 2,000 | 75.60 | 5,900 | 223.02 |
| 2,100 | 79.38 | 6,000 | 226.80 |
| 2,200 | 83.16 | 6,100 | 230.58 |
| 2,300 | 86.94 | 6,200 | 234.36 |
| 2,400 | 90.72 | 6,300 | 238.14 |
| 2,500 | 94.50 | 6,400 | 241.92 |
| 2,600 | 98.28 | 6,500 | 245.70 |
| 2,700 | 102.06 | 6,600 | 249.48 |
| 2,800 | 105.84 | 6,700 | 253.26 |
| 2,900 | 109.62 | 6,800 | 257.04 |
| 3,000 | 113.40 | 6,900 | 260.82 |
| 3,100 | 117.18 | 7,000 | 264.60 |
| 3,200 | 120.96 | 7,100 | 268.38 |
| 3,300 | 124.74 | 7,200 | 272.16 |
| 3,400 | 128.52 | 7,300 | 275.94 |
| 3,500 | 132.30 | 7,400 | 279.72 |
| 3,600 | 136.08 | 7,500 | 283.50 |
| 3,700 | 139.86 | | |
| 3,800 | 143.64 | | |
| 3,900 | 147.42 | | |
| 4,000 | 151.20 | | |

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

**The Lincoln National Life Insurance Company**
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

# ENROLLMENT FORM FOR GROUP INSURANCE

| Please Use Ink or Type | GROUP ID: GALLUPSCH | GROUP POLICY #: 000010149900 000010149901 | Billing Division or Location: |
|---|---|---|---|

## A. Employee Information (Complete for ALL Enrollments)

| Employer Name/Company Name (Please Print) | County | Employer ZIP | State |
|---|---|---|---|
| Gallup-McKinley County Schools | McKinley | 87301 | NM |

| Employee Last Name First Name Middle Initial | Social Security Number | Date of Birth |
|---|---|---|
| | | |

| Street Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Gender: ☐Male ☐Female | Marital Status: ☐Married ☐Single | Home Phone ( ) | Work Phone ( ) |
|---|---|---|---|
| | | | |

## Completed By Employer

| Average Hours Worked Per Week: | Occupation: |
|---|---|
| | |

| Earnings: ☐ Hourly ☐ Monthly ☐ Weekly ☐ 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 Disability-0/3 Elimination Period ☒Yes ☐No | ☐ $200<br>☐ $500<br>☐ $1,000<br>☐ $1,500 | ☐ $2,000<br>☐ $2,500<br>☐ $3,000<br>☐ Other $_____ | $ |

## 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.

NOTICE: 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.

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:_____