The Lincoln National Life Insurance Company
A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066
(800) 423-2765 Online: www.LincolnFinancial.com

CERTIFIES THAT Group Policy No. GL 000010251022 has been issued to
Pima County
(The Group Policyholder)

The issue date of the Policy is April 1, 2019.

Certificate of Insurance for Class 3 of Plan 1

You are entitled to the benefits described in this Certificate only if you are eligible, become and remain insured under the provisions of the Policy. This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. If the provisions of this Certificate and the Policy do not agree, the provisions of the Policy will apply.

Dennis R. Glass
PRESIDENT

**CERTIFICATE OF GROUP INSURANCE**
**PROVIDING**
**WEEKLY DISABILITY INCOME INSURANCE**

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

**Pima County**
**000010251022**
**SCHEDULE OF INSURANCE**

## ELIGIBLE CLASS

**Class 3 - All Full-Time and Regular Part-Time Temporary Employees with at least 6 months of service**

The Policy does not replace or provide benefits required by Workers' Compensation laws or any state disability insurance plan laws.

**Pima County**
**000010251022**
**SCHEDULE OF INSURANCE**
**For**
**Class 3 - All Full-Time and Regular Part-Time Temporary Employees with at least 6 months of service**

MINIMUM HOURS: 20 hours per week

WAITING PERIOD: (For date insurance begins, refer to "Effective Date" section)
90 days of continuous Active Work

CONTRIBUTIONS: You are not required to contribute to the cost of the Weekly Disability Income Insurance.

## WEEKLY DISABILITY INCOME INSURANCE

BENEFIT PERCENTAGE: 66 2/3%

MAXIMUM WEEKLY BENEFIT: $1,500

MINIMUM WEEKLY BENEFIT: 10% of your Weekly Total Disability Benefit

DAY BENEFITS BEGIN: 15th consecutive day of Disability due to Accidental Injury; and
15th consecutive day of Disability due to Sickness.

The Day Benefits Begin may be reached by days of Total Disability, Partial Disability, or any combination thereof.

MAXIMUM BENEFIT PERIOD: 24 weeks

The Maximum Weekly Benefit will not exceed the Benefit Percentage times Basic Weekly Earnings.

Weekly Disability Income Insurance will terminate when you retire.

ADDITIONAL FEATURES:

Family Income Benefit: 3 times your last Weekly Benefit payable immediately prior to death.

Rehabilitation Assistance Benefit:
- Rehabilitation Incentive Benefit of 5% of Basic Weekly Earnings
- Reasonable Accommodation Benefit
- Vocational Rehabilitation Benefit

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## DEFINITIONS

**As used throughout the Policy, the following terms shall have the meanings indicated below. Other parts of the Policy contain definitions specific to those provisions.**

**ACTIVE WORK** or **ACTIVELY AT WORK** means your performance of all Main Duties of your Own Occupation, for the regularly scheduled number of hours, at:

(1) the Employer's place of business; or
(2) any other business location where the Employer requires you to travel.

Unless disabled on the prior workday or on the day of absence, you will be considered Actively at Work on the following days:

(1) a Saturday, Sunday or holiday that is not a scheduled workday;
(2) a paid vacation day, or other scheduled or unscheduled non-workday; or
(3) a non-medical leave of absence of 12 weeks or less, whether taken with the Employer's prior approval or on an emergency basis.

This includes a Military Leave or an approved Family or Medical Leave that is not due to your own health condition.

**BASIC WEEKLY EARNINGS** or **PREDISABILITY INCOME** means your average weekly base salary or hourly pay from the Employer before taxes on the Determination Date. The **"Determination Date"** is the last day worked just prior to the date the Disability begins.

It does **not** include commissions, bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Employer. It will not exceed the amount shown in the Employer's financial records, the amount for which premium has been paid, or the Maximum Covered Weekly Earnings permitted by the Policy; whichever is less. (Maximum Covered Weekly Earnings equals the Maximum Weekly Benefit divided by the Benefit Percentage shown in the Schedule of Insurance.) Exception: For purposes of determining the Partial Disability Weekly Benefit, Basic Weekly Earnings will not exceed the amount shown in the Employer's financial records.

**COMPANY** means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

**DAY** or **DATE** means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, standard time, at the Group Policyholder's place of business. When used with regard to effective dates, it means 12:01 a.m. When used with regard to termination dates, it means 12:00 midnight.

**DISABILITY or DISABLED** means Total Disability or Partial Disability.

**DISABILITY BENEFIT**, when used with the term Retirement Plan, means a benefit that:

(1) is payable under a Retirement Plan due to disability as defined in that plan; and
(2) does not reduce the benefits that would have been paid as Retirement Benefits at the normal retirement age under the plan if the disability had not occurred.

If the payment of the benefit does cause such a reduction, the benefit will be deemed a Retirement Benefit as defined in the Policy.

**EMPLOYEE or FULL-TIME EMPLOYEE or REGULAR PART-TIME EMPLOYEE** means a person:

(1) whose employment with the Employer is the person's main occupation;
(2) whose employment is for regular wage or salary, on a full-time or part-time basis;
(3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance;
(4) who is a member of an Eligible Class which is eligible for coverage under the Policy; and
(5) who is a citizen of the United States or legally works in the United States.

**EMPLOYER** means the Group Policyholder. It includes any division, subsidiary or affiliated company named in the Application or Participation Agreement.

**EVIDENCE OF INSURABILITY** means a statement of proof of your medical history. The Company uses this to determine your acceptance for insurance or an increased amount of insurance. Such proof will be provided at your own expense.

**FAMILY OR MEDICAL LEAVE** means an approved leave of absence that:
(1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
(2) is taken in accord with the Employer's leave policy and the law which applies; and
(3) does not exceed the period approved by the Employer and required by that law.

Under the federal FMLA law, such leaves are permitted for up to 12 weeks in a 12-month period as defined by the Employer. The 12 weeks:
(1) may consist of consecutive or intermittent work days; or
(2) may be granted on a part-time equivalency basis.
If you are entitled to a leave under both the federal FMLA law and a similar state law, you may elect the more favorable leave (but not both). If you are on an FMLA leave due to your own health condition on the date Policy coverage takes effect, you are not considered Actively at Work.

**FULL-TIME**, as it applies to the Partial Disability Benefit, means the average number of hours you were regularly scheduled to work, at your Own Occupation, during the week just prior to:
(1) the date Disability begins; or
(2) the date an approved leave of absence begins, if Disability begins while you are continuing coverage during a leave of absence.

**GROUP POLICYHOLDER** means the person, company, trust or other organization as shown on the Title Page of the Policy.

**INJURY** means bodily Injury which results directly from an accident, independently of all other causes. In determining Weekly Benefits, a Disability will be considered caused by a Sickness if:
(1) the Disability begins more than 60 days after the Injury; or
(2) the Injury occurred before your Effective Date under the Policy.

The term "Injury" shall not include any:
(1) condition to which a Sickness, its natural progression or its treatment is a substantial contributing cause (based upon the preponderance of medical evidence);
(2) condition caused by emotional stress or trauma; infection (except pyogenic bacterial infection of an Injury); or medical or surgical treatment (except when needed solely for an Injury);
(3) repetitive trauma condition which results from repetitious, physically traumatic activities that occur over time; or
(4) pregnancy; except for complications that result from an Injury.

**INSURANCE MONTH** or **POLICY MONTH** means that period of time:
(1) beginning at 12:01 a.m. Standard Time, at the Group Policyholder's place of business on the first day of any calendar month; and
(2) ending at 12:00 midnight on the last day of the same calendar month.

**INSURED PERSON** means a Person for whom Policy coverage is in effect.

**MAIN DUTIES** or **MATERIAL AND SUBSTANTIAL DUTIES** means those job tasks that:
(1) are normally required to perform your Own Occupation; and
(2) could not reasonably be modified or omitted.

To determine whether a job task could reasonably be modified or omitted, the Company will apply the Americans with Disabilities Act's standards concerning reasonable accommodation. It will apply the Act's standards, whether or not:
(1) the Employer is subject to the Act; or
(2) you have requested such a job accommodation.
An Employer's failure to modify or omit other job tasks does **not** render you unable to perform the Main Duties of the job.

Main Duties include those job tasks:
(1) as described in the U.S. Department of Labor Dictionary of Occupational Titles; and
(2) as performed in the general labor market and national economy.
Main Duties are **not** limited to those specific job tasks as performed for a certain firm or at a certain work site.

**MEDICALLY APPROPRIATE TREATMENT** means diagnostic services, consultation, care or services that are consistent with the symptoms or diagnosis causing your Disability. Such treatment must be rendered:
(1) by a Physician whose license and any specialty are consistent with the disabling condition; and
(2) according to generally accepted, professionally recognized standards of medical practice.

**MILITARY LEAVE** means a leave of absence that:
(1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
(2) is taken in accord with the Employer's leave policy and the federal USERRA law; and
(3) does not exceed the period required by that law.

**OWN OCCUPATION** or **REGULAR OCCUPATION** means the occupation, trade or profession:
(1) in which you were employed with the Employer prior to Disability; and
(2) which was your main source of earned income prior to Disability.

It means a collective description of related jobs, as defined by the U.S. Department of Labor Dictionary of Occupational Titles. It includes any work in the same occupation for pay or profit, regardless of:
(1) whether such work is with the Employer, with some other firm, or on a self-employed basis; or
(2) whether a suitable opening is currently available with the Employer or in the local labor market.

**PARTIAL DISABILITY** or **PARTIALLY DISABLED** means that, due to an Injury or Sickness, you:
(1) are unable to perform one or more of the Main Duties of your Own Occupation, or are unable to perform such duties Full-Time; and
(2) are engaged in Partial Disability Employment.

**PARTIAL DISABILITY EMPLOYMENT** means you are working at your Own Occupation or any other occupation; however, because of a Partial Disability:
(1) your hours or production is reduced;
(2) one or more Main Duties of the job are reassigned; or
(3) you are working in a lower-paid occupation.

During Partial Disability Employment, your current earnings:
(1) must be at least 20% of Predisability Income; and
(2) may not exceed the percentage specified in the Partial Disability Benefit section.

**PERSON** means an Employee of the Employer:
(1) who is a member of an Employee class which is eligible for coverage under the Policy; and
(2) who has completed an enrollment form.

**PERSONAL INSURANCE** means the insurance provided by the Policy on Insured Persons.

**PHYSICIAN** means:
(1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
(2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license. He or she must be qualified to provide Medically Appropriate Treatment for your disabling condition.

Physician does **not** include you or your relatives. Relatives include:
(1) your spouse, siblings, parents, children and grandparents; and
(2) your spouse's relatives of like degree.

**POLICY** means the group insurance Policy issued by the Company to the Group Policyholder.

**PREDISABILITY INCOME**--See Basic Weekly Earnings definition.

**REGULAR CARE OF A PHYSICIAN** means you:
(1) personally visit a Physician, as often as medically required according to standard medical practice to effectively manage and treat your disabling condition; and
(2) receive Medically Appropriate Treatment, by a Physician whose license and any specialty are consistent with the disabling condition.

**REGULAR OCCUPATION**--See Own Occupation or Regular Occupation definition.

**RETIREMENT BENEFIT**, when used with the term Retirement Plan, means a benefit that:
(1) is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
(2) does not represent contributions made by you (Payments representing Employee contributions are deemed to be received over your expected remaining life, regardless of when they are actually received.); and
(3) is payable upon:
  (a) early or normal retirement; or
  (b) disability (if the payment does reduce the benefit which would have been paid at the normal retirement age under the plan, if disability had not occurred).

**RETIREMENT PLAN** means a defined benefit or defined contribution plan that:
(1) provides Retirement Benefits to Employees; and
(2) is not funded wholly by Employee contributions.

The term shall **not** include any 401(k), profit-sharing or thrift plan; informal salary continuance plan; individual retirement account (IRA); tax sheltered annuity (TSA); stock ownership plan; or a non-qualified plan of deferred compensation.

An Employer's Retirement Plan is deemed to include any Retirement Plan:
(1) which is part of any federal, state, county, municipal or association retirement system; and
(2) for which you are eligible as a result of employment with the Employer.

**SICK LEAVE** or **SALARY CONTINUANCE PLAN** means a plan that:
(1) is established and maintained by the Employer for the benefit of Employees; and
(2) continues payment of all or part of your Predisability Income for a specified period after you become Disabled.

It does **not** include compensation the Employer pays you for work actually performed during a Disability.

**SICKNESS** means illness, pregnancy or disease.

**TOTAL DISABILITY** or **TOTALLY DISABLED** means your inability, due to Sickness or Injury, to perform each of the Main Duties of your Own Occupation. A Person engaging in any employment for wage or profit is not Totally Disabled. The loss of a professional license, an occupational license or certification, or a driver's license for any reason does **not**, by itself, constitute Total Disability.

**WAITING PERIOD** means the period of time you must be employed in an eligible class with the Employer, before you become eligible to enroll for coverage under the Policy. The period of service must be continuous, except as explained in the Eligibility provision captioned Prior Service Credit Towards Waiting Period.

**WEEKLY BENEFIT** means the amount payable weekly by the Company to you while you are Totally Disabled or Partially Disabled.

**WORKERS' COMPENSATION OR SIMILAR COVERAGE** means coverage under a law that compensates for job related Injury or Sickness. It includes (but is not limited to):
(1) coverage under any Workers' Compensation or occupational disease law;
(2) coverage under the Jones Act; the Longshoreman's and Harbor Worker's Act; the Maritime Doctrine of Maintenance, Wages or Cure; or
(3) any plan provided in place of one of those plans.

## GENERAL PROVISIONS

**ENTIRE CONTRACT.** The entire contract between the parties shall consist of:

(1) the Policy and any amendments to it;
(2) the Group Policyholder's application (a copy of which is attached to the Policy);
(3) any Participating Employers' applications or Participation Agreements; and
(4) any individual applications of Insured Persons.

In the absence of fraud, all statements made by the Group Policyholder and by Insured Persons are representations and not warranties. No statement made by an Insured Person will be used to contest the coverage provided by the Policy, unless:

(1) it is contained in a written statement signed by that Insured Person; and
(2) a copy of the statement has been furnished to that Insured Person.

**INCONTESTABILITY.** Except for the non-payment of premiums or fraud, the Company may not contest the validity of the Policy after it has been in force for two years from its date of issue; and as to any Insured Person, after his or her coverage has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:

(1) the Policy's eligibility requirements, exclusions and limitations; and
(2) other Policy provisions unrelated to the validity of coverage.

**RESCISSION**. The Company has the right to rescind any insurance for which Evidence of Insurability was required, if:

(1) you incur a claim during the first two years of coverage; and
(2) the Company discovers that you made a Material Misrepresentation on your application.

A **"Material Misrepresentation"** is an incomplete or untrue statement that caused the Company to issue coverage that it would have disapproved, had it known the truth. **"To rescind"** means to cancel insurance back to its effective date. In that event, the Company will refund all premium paid for the rescinded insurance, less any benefits paid for your claims. The Company reserves the right to recover any claims paid in excess of such premiums.

**MISSTATEMENTS OF FACTS.** If relevant facts about any Person were misstated:

(1) a fair adjustment of the premium will be made; and
(2) the true facts will decide if and in what amount insurance is valid under the Policy.

If your age has been misstated, any benefits shall be in the amount the paid premium would have purchased at the correct age.

**GROUP POLICYHOLDER'S AGENCY.** For all purposes of the Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

**CURRENCY.** In administering the Policy:

(1) all Predisability Income will be expressed in U.S. dollars; and
(2) all premium and benefits must be paid in U.S. dollars.

**WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE.** The Policy does not replace or provide benefits required by:

(1) Workers' Compensation laws; or
(2) any state temporary disability insurance plan laws.

**ASSIGNMENT.** The rights and benefits under this Certificate may not be assigned.

## ELIGIBILITY AND EFFECTIVE DATES

**ELIGIBLE CLASSES.** The classes of Employees eligible for insurance are shown in the Schedule of Insurance. The Company has the right to review and terminate any or all classes eligible under the Policy, if any class ceases to be covered by the Policy.

**ELIGIBILITY.** A Person becomes eligible for coverage provided by the Policy on the later of:
(1) the Policy's date of issue; or
(2) the date the Waiting Period is completed.

**Prior Service Credit Towards Waiting Period.** The Waiting Period is shown in the Schedule of Insurance. Prior service in an Eligible Class will apply toward the Waiting Period, when:
(1) you are a former Employee and are rehired within one year after your employment ends;
(2) you return from an approved Family or Medical Leave within:
  (a) the 12-week period required by federal law; or
  (b) any longer period required by a similar state law; or
(3) you return from a Military Leave within the period required by federal USERRA law.

**EFFECTIVE DATE.** Your initial amount of Personal Insurance becomes effective at 12:01 a.m. on the latest of:
(1) the next day following the date you become eligible for the coverage;
(2) the date you resume Active Work, if not Actively at Work on the day you become eligible;
(3) the date you make written application for coverage and sign:
  (a) a payroll deduction order, if you pay any part of the Policy premiums; or
  (b) an order to pay premiums from your Flexible Benefits Plan account, if Employer contributions are made through such an account; or
(4) the date the Company approves your Evidence of Insurability, if required.

Any increased or additional coverage becomes effective at 12:01 a.m. on the latest of:

(1) the Policy Anniversary Date coinciding with or next following the date on which you become eligible for the increase, if Actively at Work on that day;
(2) the date you resume Active Work, if not Actively at Work on the day the increase would otherwise take effect; or
(3) the date any required Evidence of Insurability is approved by the Company.

Any decrease will take effect on the Policy Anniversary Date coinciding with or next following the day of the change, whether or not you are Actively at Work.

**Evidence of Insurability.** Evidence of Insurability satisfactory to the Company must be submitted (at your expense); when:
(1) you make written application for coverage (or an increased amount of coverage) more than 31 days after becoming eligible for the coverage; or
(2) you make written application for coverage after you have requested:
  (a) to cancel insurance;
  (b) to stop payroll deductions for the insurance; or
  (c) to stop premium payments from the Flexible Benefits Plan account.

**Effective Date for Change in Eligible Class.** You may become a member of a different Eligible Class. Coverage under the different Eligible Class will be effective:
(1) on the first day of the Insurance Month coinciding with or next following the date of the change;
(2) except as stated in the Effective Date provision for increases or decreases.

**REINSTATEMENT RIGHTS.** If your coverage terminates due to one of the following breaks in service, you will be entitled to reinstate the coverage upon resuming Active Work with the Employer within the required timeframe. **"Reinstatement"** or **"to reinstate"** means to re-enroll for Policy coverage, without satisfying a new Waiting Period or providing Evidence of Insurability. Reinstatement is available upon:

(1) return from an approved Family or Medical Leave within:
  (a) the 12-week period required by federal law; or
  (b) any longer period required by a similar state law;
(2) return from a Military Leave within the period required by federal USERRA law; or
(3) return from any other approved leave of absence within six months after the leave begins.

To reinstate coverage, you must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an Eligible Class. The reinstated amount of insurance may not exceed the amount that terminated. Reinstatement will take effect on the date you return to Active Work.

## INDIVIDUAL TERMINATIONS

**TERMINATION OF COVERAGE.** Your coverage will terminate at 12:00 midnight on the earliest of:

(1) the date the Policy terminates or the Employer's participation ends (but without prejudice to any claim incurred prior to termination);
(2) the date your class is no longer eligible for insurance;
(3) the date you cease to be a member of an Eligible Class;
(4) the last day of the Insurance Month in which you request termination;
(5) the last day of the last Insurance Month for which premium payment is made on your behalf;
(6) the end of the period for which the last required premium has been paid;
(7) with respect to any particular insurance benefit, the day the portion of the Policy providing that benefit terminates;
(8) the date your employment with the Group Policyholder or Participating Employer terminates (unless coverage is continued as provided below); or
(9) the date you enter the armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.)

**CONTINUATION RIGHTS.** Ceasing Active Work results in termination of your eligibility for coverage, but coverage may be continued as follows.

**Disability.** If you are absent due to Total Disability or engaged in Partial Disability Employment, coverage may be continued:

(1) until the Day Benefits Begin; and
(2) during the period for which benefits are payable.

The Company must receive the required premium from the Employer.

**Family or Medical Leave.** If you go on an approved Family or Medical Leave and are **not** entitled to the more favorable continuation available during Disability, coverage may be continued until the earliest of:

(1) the end of the leave period approved by the Employer;
(2) the end of the leave period required by federal law, or any more favorable period required by a similar state law;
(3) the date you notify the Employer that you will not return; or
(4) the date you begin employment with another employer.

The required premium payments must be received from the Employer, throughout the period of continued coverage.

**Military Leave.** If you go on a Military Leave, coverage may be continued for the same period allowed for an approved Family or Medical Leave. The required premium payments must be received from the Employer, throughout the period of continued coverage.

**Lay Off or Other Leave.** If you cease work due to a temporary lay off, or due to an approved leave of absence (other than an approved Family or Medical Leave or a Military Leave); coverage may be continued for three Insurance Months after the lay off or leave begins. The required premium payments must be received from the Employer, throughout the period of continued coverage.

**Conditions.** In administering the above continuations, the Employer must not act so as to discriminate unfairly among Insured Persons in similar situations. Insurance may **not** be continued when you cease Active Work due to a labor dispute, strike, work slowdown or lockout.

**INDIVIDUAL TERMINATION DURING DISABILITY.** Termination of your coverage during a Disability will have no effect on benefits payable for that period of Disability.

## CLAIMS PROCEDURES
## FOR WEEKLY DISABILITY INCOME BENEFITS

**NOTICE AND PROOF OF CLAIM -- Notice of Claim**. Written notice of a Disability claim must be given:
(1) within 20 days after the Injury or Sickness causing Disability begins; or
(2) as soon as reasonably possible after that.*

The notice must be sent to the Company's Group Insurance Service Office. It should include your name and address, and the number of the Policy.

**Claim Forms.** When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, you may send the Company written proof of Disability in a letter. It should state the date the Disability began, its cause and degree. The Company will periodically send you additional claim forms.

**Proof of Claim.** The Company must be given written proof of a Disability claim:
(1) within 90 days after the Day Benefits Begin; or
(2) as soon as reasonably possible after that.*

Proof of claim must be provided at your own expense. It must show the date the Disability began, its cause and degree. Documentation must include the following:
(1) completed statements by you and your Employer;
(2) a completed statement by the attending Physician, which must describe any restrictions on the performance of the duties of your Regular Occupation;
(3) proof of any other income received, and of any other benefits available from other income sources, which may affect Policy benefits;
(4) a signed authorization for the Company to obtain more information; and
(5) any other items the Company may reasonably require in support of the claim.

Proof of continued Disability, Regular Care of a Physician, and any Other Income Benefits affecting the claim must be given to the Company. This must be supplied within 45 days after the Company requests it. If it is not, benefits may be denied or suspended.

***Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim, if it is shown that it was done:
(1) as soon as reasonably possible; and
(2) in no event more than one year after it was required.

These time limits will not apply while you lack legal capacity.

**EXAMINATION.** The Company may have you examined:
(1) by a Physician, specialist or vocational rehabilitation expert of the Company's choice;
(2) as often as reasonably required while a claim or appeal is pending.

Any such exam will be at the Company's expense.

The Company may determine that (in its opinion) you have:
(1) failed to cooperate with an examiner;
(2) failed to take an exam scheduled by the Company; or
(3) postponed such an exam more than twice.

In that event, benefits may be denied or suspended, until the required exam is completed.

**TIME OF PAYMENT OF CLAIMS.** Weekly Disability Income Benefits payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability. Such benefits will be paid biweekly, during any period for which the Company is liable. If benefits are due for less than a week, they will be paid on a pro rata basis. The daily rate will equal 1/7 of the Weekly Benefit. Any balance, which remains unpaid at the end of the period of liability, will be paid immediately after the Company receives complete proof of claim and confirms liability.

## CLAIMS PROCEDURES
## (Continued)

**TO WHOM PAYABLE**. All Weekly Disability Income Benefits are payable to you, while living. After your death, such benefits will be payable to your estate.

**NOTICE OF CLAIM DECISION**. The Company will send you a written notice of its claim decision. If the Company denies any part of the claim, the written notice will explain:

(1) the reason for the denial, under the terms of the Policy and any internal guidelines;
(2) how you may request a review of the Company's decision; and
(3) whether more information is needed to support the claim.

This notice will be sent within 15 days after the Company resolves the claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

**Delay Notice**. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send you a written delay notice:

(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain:

(1) what additional information is needed to determine liability; and
(2) when a decision can be expected.

If you do not receive a written decision by the 105th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

**Exception:** The Company may need more information from you to process a claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

**REVIEW PROCEDURE**. Within 180 days after receiving a denial notice, you may request a claim review by sending the Company:

(1) a written request; and
(2) any written comments or other items to support the claim.

You may review certain non-privileged information relating to the request for review.

**Notice of Decision.** The Company will review the claim and send you a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

(1) any further appeal procedures available under the Policy;
(2) the right to access relevant claim information; and
(3) the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

**Delay Notice.** If the Company needs more than 45 days to process an appeal, in a special case:

(1) an extension of up to 45 more days will be permitted; and
(2) the Company will send you a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:

(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

**Exception:** The Company may need more information from you to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

**Claims Subject to ERISA (**Employee Retirement Income Security Act of 1974**).** Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:

(1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
(2) the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

**RIGHT OF RECOVERY.** If benefits have been overpaid on any claim, full reimbursement to the Company is required within 60 days. If reimbursement is not made, the Company has the right to:

(1) reduce future benefits and suspend payment of the Minimum Weekly Benefit under the Policy, until full reimbursement is made;
(2) reduce benefits payable to you or your beneficiary under any group insurance policy issued by the Company, until full reimbursement is made; or
(3) recover such overpayments from you or your estate.

Such reimbursement is required whether the overpayment is due to fraud, the Company's error in processing a claim, or any other reason.

**LEGAL ACTIONS**. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

**COMPANY'S DISCRETIONARY AUTHORITY**. Except for the functions that the Policy clearly reserves to the Group Policyholder or Employer, the Company has the authority to manage the Policy, interpret its provisions, administer claims and resolve questions arising under it. The Company's authority includes (but is not limited to) the right to:

(1) establish administrative procedures, determine eligibility and resolve claims questions;
(2) determine what information the Company reasonably requires to make such decisions; and
(3) resolve all matters when an internal claim review is requested.

Any decision the Company makes in the exercise of its authority shall be conclusive and binding; subject to your rights to request a state insurance department review or to bring legal action.
This provision does not apply to residents of California.

## WEEKLY DISABILITY INCOME INSURANCE

**TOTAL DISABILITY BENEFIT**. The Company will pay a Weekly Total Disability Benefit for each week the Total Disability continues, if you:

(1) become Totally Disabled while insured for this benefit;
(2) are under the Regular Care of a Physician; and
(3) at your own expense, submit proof of continued Total Disability and Physician's care to the Company upon request.

**Duration.** Benefits start on the Day Benefits Begin, and end on the earliest of:

(1) the date you cease to be Totally Disabled or die;
(2) the date the Maximum Benefit Period ends; or
(3) the date you are able, but choose not to engage in Partial Disability Employment in your Own Occupation.

Proportional benefits will be paid for a partial week of Total Disability.

At the Company's option, benefits may also be denied or suspended on any of the following dates:

(1) the date you (without good cause):
    (a) fail to take a required medical exam;
    (b) fail to cooperate with an examiner; or
    (c) postpone a required exam more than twice;
(2) the 45th day after the Company requests additional proof, if not given; or
(3) the 45th day after the Company requests proof of your application for any Other Income Benefits to which you may be entitled (and which affect Policy benefits); if not given.

**Amount.** The amount of the Weekly Total Disability Benefit equals the lesser of:

(1) your Basic Weekly Earnings multiplied by the Benefit Percentage; minus Other Income Benefits except any pay received under the Employer's Sick Leave or Salary Continuance Plan;
(2) 100% of your Basic Weekly Earnings; minus Other Income Benefits including any pay received under the Employer's Sick Leave or Salary Continuance Plan; or
(3) the Maximum Weekly Benefit.

In no event will the amount of the Weekly Total Disability Benefit plus any pay received under the Employer's Sick Leave or Salary Continuance Plan exceed 100% of your Basic Weekly Earnings.

The amount of the Weekly Total Disability Benefit will not be less than the Minimum Weekly Benefit, unless the Minimum Weekly Benefit plus Other Income Benefits would exceed 100% of your Basic Weekly Earnings.

The Day Benefits Begin, Maximum Benefit Period, Benefit Percentage, Maximum Weekly Benefit, and Minimum Weekly Benefit are shown in the Schedule of Insurance.

**PARTIAL DISABILITY BENEFIT**. The Company will pay a Weekly Partial Disability Benefit, if you:

(1) become Partially Disabled while insured for this benefit;
(2) are engaged in Partial Disability Employment;
(3) are earning at least 20% of Basic Weekly Earnings when Partial Disability Employment begins;
(4) are under the Regular Care of a Physician; and
(5) at your own expense, submit proof of continued Partial Disability, Physician's care and reduced earnings to the Company upon request.

You are not required to be Totally Disabled prior to receiving Weekly Partial Disability Benefits. The Day Benefits Begin may be reached by days of Total Disability, Partial Disability, or any combination of these. Proportional benefits will be paid for a partial week of Partial Disability.

**Duration.** Benefits start on the Day Benefits Begin, and will cease on the earliest of:
(1) the date you cease to be Partially Disabled or die;
(2) the date the Maximum Benefit Period ends;
(3) the date you earn more than 99% of Basic Weekly Earnings; or
(4) the date you are able, but choose not to work Full-Time or part-time in your Own Occupation.

At the Company's option, benefits may also be denied or suspended on any of the following dates:
(1) the date you (without good cause):
  (a) fail to take a required medical exam;
  (b) fail to cooperate with an examiner; or
  (c) postpone a required exam more than twice;
(2) the 45th day after the Company requests additional proof, if not given; or
(3) the 45th day after the Company requests proof of your application for Other Income Benefits to which you may be entitled (and which affect Policy benefits); if not given.

**Amount.** The amount of the Weekly Partial Disability Benefit equals the lesser of A or B below:
(A) (1) Your Basic Weekly Earnings multiplied by the Benefit Percentage (limited to the Maximum Weekly Benefit); minus
  (2) Other Income Benefits, except for earnings you receive from Partial Disability Employment; or
(B) Your Basic Weekly Earnings minus Other Income Benefits.

The amount of the Weekly Partial Disability Benefit will not be less than the Minimum Weekly Benefit, unless the Minimum Weekly Benefit plus Other Income Benefits would exceed 100% of your Basic Weekly Earnings.

The Day Benefits Begin, Maximum Benefit Period, Benefit Percentage, Maximum Weekly Benefit, and Minimum Weekly Benefit are shown in the Schedule of Insurance.

**OTHER INCOME BENEFITS** means Earnings, benefits, awards, or settlements from the following sources. These amounts will be offset, in determining your Weekly Benefit. Except for Retirement Benefits and Earnings, these amounts must result from the same Disability for which a Weekly Benefit is payable under the Policy.

**Compulsory Benefits.** Any disability income benefits you are eligible to receive under:
(1) state temporary disability income benefit laws;
(2) state no fault auto insurance laws; or
(3) any other compulsory benefit act or law (except Workers' Compensation and laws of like intent).

**Other Insurance Plans.** Any disability income benefits for which you are eligible under any no fault auto plan.

**Employee Benefit Plans.** Any disability income benefits for which you are eligible under the Employer's Sick Leave or Salary Continuance Plan. This does **not** include vacation pay, severance pay, or pay for work actually performed during a Disability.

**Employer's Retirement Plan.** Any Disability Benefits or Retirement Benefits you receive under the Employer's Retirement Plan.

**Social Security and other Government Retirement Plans.** The following Social Security or other Government Retirement Plan benefits will be offset:
(1) **disability benefits** for which you and any spouse or child is eligible, because of your Disability;
(2) **unreduced retirement benefits** for which you and any spouse or child is eligible, because of your eligibility for unreduced retirement benefits; or
(3) **reduced retirement benefits** actually received by you and any spouse or child, because of your receipt of reduced retirement benefits.

As used above, **"Government Retirement Plans"** include disability and retirement benefits under:
(1) the federal Social Security Act, Jones Act or Railroad Retirement Act;
(2) the Canada Pension Plan or Quebec Pension Plan;
(3) any similar plan or act of any country, state, province or other political unit; or
(4) any plan provided in place of one of the above plans.

**"Earnings"**, as used in this provision, means pay you earn or receive from any occupation or form of employment, as reported for federal income tax purposes. Earnings include (but are not limited to) a:
(1) salaried or hourly Employee's gross earnings (shown on Form W-2); including:
  (a) wages, tips, commissions, bonuses and overtime pay; and
  (b) any pre-tax contributions to a Section 125 Plan, flexible spending account, or qualified deferred compensation plan;
(2) proprietor's net profit (figured from Form 1040, Schedule C);
(3) professional corporation shareholder's net profit (figured from Form 1040, Schedule C);
(4) partner's net earnings from self-employment (shown on Schedule K-1) and any W-2 earnings; and
(5) Subchapter S Corporation shareholder's net earnings from trade or business activities (shown on Schedule K-1).

**Recovery from Third Party.** Any amount you recover from a third party as a result of the Disability (whether by judgment, settlement or otherwise). The offset:
(1) will be reduced by attorney fees and other reasonable costs of recovery; and
(2) will not exceed 100% of the net settlement.

**Exceptions.** The following will **not** be considered Other Income Benefits, and will not be offset in determining the Weekly Benefit:
(1) a cost-of-living increase in any Other Income Benefit (except Earnings); if it takes effect after the first offset for that benefit during a period of Disability;
(2) reimbursement for hospital, medical or surgical expense;
(3) reimbursement for attorney fees or other reasonable costs of claiming Other Income Benefits;
(4) group credit or mortgage disability insurance;
(5) early retirement benefits that are not elected or received under the federal Social Security Act or other Government Retirement Plan;
(6) any amounts under the Employer's Retirement Plan that:
  (a) represent your contributions; or
  (b) are received upon termination of employment without being disabled or retired;
(7) benefits from a 401(k), profit-sharing or thrift plan; an individual retirement account (IRA); a tax sheltered annuity (TSA); a stock ownership plan; or a non-qualified plan of deferred compensation; or
(8) vacation pay, holiday pay, or severance pay.

**RULES CONCERNING OTHER INCOME BENEFITS.** If you may be entitled to Other Income Benefits that affect Policy benefits, you are required to actively claim them. For example, if Social Security or other Government Retirement Plan benefits may be payable, you:
(1) must promptly apply for such benefits; and, if denied
(2) must file an appeal or request an administrative hearing, upon Company request.
If you fail to promptly pursue such benefits, the Company has the option to deny or suspend Weekly Benefits or to reduce them by an estimated amount.

If Workers' Compensation or similar benefits may be payable for the same Disability, you and your Employer are required to cooperate in filing for those benefits. The Company will require proof of the denial or duration of those benefits to confirm its liability under the Policy.

**Refunding Overpayments.** Upon receiving Other Income Benefits, you must refund any resulting overpayment of Weekly Benefits under the Policy. If you do not promptly refund an overpayment to the Company within 60 days, in a lump sum, then:
(1) the Company will reduce or eliminate future payments; and
(2) the Minimum Weekly Benefit will not apply, until the amount is repaid.

**Cost of Living Freeze.** After the first deduction for each of the Other Income Benefits (except Earnings), its amount will be frozen. The Weekly Benefit will not be further reduced due to any cost-of-living increases payable under these Other Income Benefits.

**RECURRENT DISABILITY. "Recurrent Disability"** means a Disability caused by an Injury or Sickness which is the same as, or related to, the cause of a prior Disability for which Weekly Benefits were payable.

(1) A Recurrent Disability will be treated as a new period of Disability, if you:
   (a) have returned to your Own Occupation; and
   (b) have worked on a full-time basis, for two consecutive weeks or more.

   A new Day Benefits Begin and new Maximum Benefit Period will apply.

(2) A Recurrent Disability will be treated as part of the prior Disability, if you:
   (a) have returned to your Own Occupation; and
   (b) have worked on a full-time basis, for less than two consecutive weeks.

   The same Day Benefits Begin and same Maximum Benefit Period will apply to the Recurrent Disability as to the prior Disability.

To qualify for a Weekly Benefit for a Recurrent Disability, the Insured Person must earn less than the percentage of Predisability Income specified in the Partial Disability Benefit section. Benefit payments will be subject to all other terms of the Policy that applied to the prior Disability.

This Recurrent Disability provision will cease to apply when you become eligible for coverage under any other group short-term disability policy.

**EXCLUSIONS.** Weekly Benefits will not be payable for any period of Disability:

(1) which is the result of an intentionally self-inflicted Injury or suicide attempt;
(2) during which you are not under the Regular Care of a Physician;
(3) which is the result of war (declared or undeclared) or any act of war;
(4) which is the result of a Sickness or Injury for which you receive benefits under Workers' Compensation or similar coverage; or
(5) which arises out of (or in the course of) any employment for wage or profit, when the Disability would be covered by Workers' Compensation or similar coverage if:
   (a) the Employer had enrolled you for such coverage; and
   (b) you and your Employer had cooperated in filing a claim under that plan.

## VOCATIONAL REHABILITATION BENEFIT

**BENEFIT.** If you are Disabled and are receiving Weekly Benefits under the Policy, you may be eligible for a Vocational Rehabilitation Benefit. This benefit consists of services which may include:

(1) vocational evaluation, counseling, training or job placement;
(2) job modification or special equipment; and
(3) other services which the Company deems reasonably necessary to help you return to work.

The Company will determine your eligibility and the amount of any benefit payable.

**ELIGIBILITY.** You may be eligible for the Vocational Rehabilitation Benefit if the Company finds that you:

(1) have a Disability that prevents the performance of the Main Duties of your Own Occupation;
(2) have the physical and mental abilities needed to complete a Rehabilitation Program; and
(3) are reasonably expected to return to work after completing the Rehabilitation Program; in view of your degree of motivation and the labor force demand for workers in the proposed occupation.

The Company must also find that the cost of the proposed services is less than its expected claim liability.

**AMOUNT.** The amount of any Vocational Rehabilitation Benefit will not exceed the Company's expected claims liability. This benefit will not be payable for services covered under your health care plan or any other vocational rehabilitation program. Payment may be made to the provider of the services, at the Company's option.

**CONDITIONS.** The Company, you, or your Physician may first propose vocational rehabilitation. When a Rehabilitation Program is approved by the Company, the Policy's definition of "Disability" will be waived during the rehabilitation period; however, it will be reapplied after the Rehabilitation Program ends. The Company will determine the amount and duration of any Weekly Disability benefits payable after the Rehabilitation Program ends.

**LIMITATION.** The Policy will not cover any period of Disability if you have received a Vocational Rehabilitation Benefit and have failed to complete the Rehabilitation Program, without Good Cause.

**DEFINITIONS.**

**"Good Cause,"** as used in this provision, means your:

(1) documented physical or mental impairments, which render you unable to take part in or complete a Rehabilitation Program;
(2) involvement in a medical program, which prevents or interferes with your taking part in or completing a Rehabilitation Program; or
(3) participating in good faith in some other vocational rehabilitation program, which:
    (a) conflicts with taking part in or completing a Rehabilitation Program developed by the Company; and
    (b) is reasonably expected to return you to work.

**"Rehabilitation Program"** means a written vocational rehabilitation program:

(1) which the Company develops with input from:
    (a) you;
    (b) your Physician; and
    (c) any current or prospective employer, when appropriate; and
(2) which describes the Program's goals; each party's responsibilities; and the times, dates and costs of the rehabilitation services.

**OTHER PROVISIONS.** Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, and other provisions of the Policy.

## REHABILITATION INCENTIVE BENEFIT

**BENEFIT.** The Company will pay you a Rehabilitation Incentive Benefit if you are Totally or Partially Disabled and actively participating in a Rehabilitation Program approved by the Company.

**AMOUNT.** The amount of the Rehabilitation Incentive Benefit is shown in the Schedule of Insurance.

The Rehabilitation Incentive Benefit is paid in addition to any other Policy benefits, and is not subject to Policy provisions that would otherwise reduce the benefit amount, such as the Other Income Benefits provision.

**DURATION.** The Rehabilitation Incentive Benefit starts on the latest of:
(1) the date you begin to participate in an approved Rehabilitation Program; or
(2) the date the Company approves your Rehabilitation Program.

The Rehabilitation Incentive Benefit will cease on the earliest of:
(1) the date the Weekly Total or Partial Disability Benefits would otherwise cease under the Policy; or
(2) the date you cease participation in an approved Rehabilitation Program.

**DEFINITION.**

**"Rehabilitation Program"** means a written vocational rehabilitation program:
(1) which the Company develops with input from:
  (a) you;
  (b) your Physician; and
  (c) any current or prospective employer, when appropriate; and
(2) which describes the Program's goals; each party's responsibilities; and the times, dates and costs of the rehabilitation services.

**PROOF.** Written proof of active participation in a Rehabilitation Program must be given:
(1) within 90 days after the Day Benefits Begin; or
(2) as soon as reasonably possible after that.
Proof of active participation must be provided at your own expense. The proof must be sent to the Company's Group Insurance Service Office. It should include your name and address and the number of the Policy.

Exception**:** Failure to furnish proof of active participation in a Rehabilitation Program within the required time period will not invalidate the benefit, if it is shown that it was done:
(1) as soon as reasonably possible; and
(2) in no event more than one year after it was required.
These time limits will not apply while you lack legal capacity.

**OTHER PROVISIONS.** Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, and other provisions of the Policy.

## REASONABLE ACCOMMODATION BENEFIT

**BENEFIT.** If you are Disabled and are receiving Weekly Benefits under the Policy, then the Group Policyholder may be eligible for a Reasonable Accommodation benefit. This benefit reimburses the Group Policyholder for 50% of the expense incurred for reasonable accommodation services for you, but will not exceed the lesser of:

(1) a maximum benefit of $2500 for any one Insured Person; or
(2) the Company's expected liability for your Weekly Disability Income claim.

Such services may include:

(1) providing you a more accessible parking space or entrance;
(2) removing barriers or hazards to you from the worksite;
(3) special seating, furniture or equipment for your work station;
(4) providing special training materials or translation services during your training; and
(5) other services the Company deems reasonably necessary to help you return to work with the Group Policyholder.

**ELIGIBILITY.** The Company will determine the Group Policyholder's eligibility to receive the Reasonable Accommodation benefit. To qualify for the Reasonable Accommodation benefit, the Group Policyholder must have an Insured Person:

(1) whose Disability prevents the performance of his or her Own Occupation at the Group Policyholder's worksite;
(2) who has the physical and mental abilities needed to perform his or her Own Occupation or another occupation at the Group Policyholder's worksite, but only with the help of the proposed accommodation; and
(3) who is reasonably expected to return to work with the help of the proposed accommodation.

The Company must also find that the requested Reasonable Accommodation benefit is less than the expected liability for your Weekly Disability Income claim.

**WRITTEN PROPOSAL.** The reasonable accommodation services must be provided in accord with a written proposal, which is developed with input from:

(1) the Group Policyholder;
(2) you; and
(3) your Physician, when appropriate.

The proposal must state:

(1) the purpose of the proposed accommodation; and
(2) the times, dates, and costs of the services.

**CONDITIONS.** The Company, the Group Policyholder, you, or your Physician may first voluntarily propose an accommodation.

The proposal must be approved by the Company in writing.

The Company will reimburse the Group Policyholder upon receipt of proof that the Group Policyholder:

(1) has provided the services for you; and
(2) has paid the provider for the services.

**OTHER PROVISIONS.** Unless stated otherwise, the Reasonable Accommodation benefit is subject to all the Definitions, Exclusions, Claims Procedures, and other provisions of the Policy.

## FAMILY INCOME BENEFIT

**BENEFIT.** The Company will pay a benefit to the Eligible Survivor(s) when satisfactory written proof is received that you died:

(1) after Disability had continued for at least 14 consecutive days; and
(2) while receiving a Weekly Benefit.

If payment becomes due to your children; then payment will be made to:

(1) the surviving children, in equal shares; or
(2) a person named by the Company to receive payments on the children's behalf.

This payment will be valid and effective against all claims by others representing, or claiming to represent, your children.

If there are no Eligible Survivors, payment will be made to your estate.

**AMOUNT.** The Family Income Benefit is shown in the Schedule of Insurance. Reductions for Other Income Benefits will not apply.

If any state disability plan compulsory death benefits become payable upon your death, then any Family Income Benefit amount payable will be reduced by such compulsory death benefits.

**DEFINITION.**

**"Eligible Survivor(s)"** means your:

(1) surviving spouse; or, if none,
(2) surviving children who are under age 25 on your date of death.

**OTHER PROVISIONS.** Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, and other provisions of the Policy.

Lincoln Financial Group®

# Lincoln Financial Group® Privacy Practices Notice

The Lincoln Financial Group companies* are committed to protecting your privacy. To provide the products and services you expect from a financial services leader, we must collect personal information about you. We do not sell your personal information to third parties. This Notice describes our current privacy practices. While your relationship with us continues, we will update and send our Privacy Practices Notice as required by law. Even after that relationship ends, we will continue to protect your personal information. You do not need to take any action because of this Notice, but you do have certain rights as described below.

## Information We May Collect And Use

We collect personal information about you to help us identify you as our customer or our former customer; to process your requests and transactions; to offer investment or insurance services to you; to pay your claim; to analyze in order to enhance our products and services; or to tell you about our products or services we believe you may want and use; and as otherwise permitted by law. The type of personal information we collect depends on the products or services you request and may include the following:

- **Information from you:** When you submit your application or other forms, you give us information such as your name, address, Social Security number; and your financial, health, and employment history.
- **Information about your transactions:** We maintain information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; and your payment and claims history.
- **Information from outside our family of companies**: If you are purchasing insurance products, we may collect information from consumer reporting agencies such as your credit history; credit scores; and driving and employment records. With your authorization, we may also collect information, such as medical information from other individuals or businesses.
- **Information from your employer**: If your employer purchases group products from us, we may obtain information about you from your employer in order to enroll you in the plan.

## How We Use Your Personal Information

We may share your personal information within our companies and with certain service providers. They use this information to process transactions you have requested; provide customer service; to analyze in order to enhance our products and services; and inform you of products or services we offer that you may find useful. Our service providers may or may not be affiliated with us. They include financial service providers (for example, third party administrators; broker-dealers; insurance agents and brokers, registered representatives; reinsurers and other financial services companies with whom we have joint marketing agreements). Our service providers also include non-financial companies and individuals (for example, consultants; vendors; and companies that perform marketing services on our behalf). Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law.

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners, regulatory authorities and law enforcement officials, and to other non-affiliated or affiliated parties as permitted by law. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or share your information with outside marketers who may want to offer you their own products and services; nor do we share information we receive about you from a consumer reporting agency. You do not need to take any action for this benefit.**

## Security of Information

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. Our employees are authorized to access your information only when they need it to provide you with products, services, or to maintain your accounts. Employees who have access to your personal information are required to keep it confidential. Employees are required to complete privacy training annually.

## Your Rights Regarding Your Personal Information

**Access:** We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you request a copy of the information, we may charge you a fee for copying and mailing costs. In very limited circumstances, your request may be denied. You may then request that the denial be reviewed.

**Accuracy of Information:** If you feel the personal information we have about you is inaccurate or incomplete, you may ask us to amend the information. Your request must be in writing and must include the reason you are requesting the change. We will respond within 30 business days. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years. If your requested change is denied, we will provide you with reasons for the denial. You may write to request the denial be reviewed. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request.

**Accounting of Disclosures:** If applicable, you may request an accounting of disclosures made of your medical information, except for disclosures:

- For purposes of payment activities or company operations;
- To the individual who is the subject of the personal information or to that individual's personal representative;
- To persons involved in your health care;
- For notification for disaster relief purposes;
- For national security or intelligence purposes;
- To law enforcement officials or correctional institutions;
- Included in a limited data set; or
- For which an authorization is required.

You may request an accounting of disclosures for a time period of less than six years from the date of your request.

**Basis for Adverse Underwriting Decision:** You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate, or terminate your coverage.

Your state may provide for additional privacy protections under applicable laws. We will protect your information in accordance with these additional protections.

Questions about your personal information should be directed to:

Lincoln Financial Group
Attn: Enterprise Compliance and Ethics
Corporate Privacy Office, 7C-01
1300 S. Clinton St.
Fort Wayne, IN 46802

**Please include all policy/contract/account numbers with your correspondence.**

*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Financial Group Trust Company, Inc.
Lincoln Investment Advisors Corporation
Lincoln Financial Distributors, Inc.
Lincoln Life & Annuity Company of New York
Lincoln Retirement Services Company, LLC
Lincoln Variable Insurance Products Trust
The Lincoln National Life Insurance Company