Lincoln Life & Annuity Company of New York
Service Office Address: PO Box 2616, Omaha, NE 68103-2616
Home Office: Syracuse, NY
toll free (800) 423-2765
www.LincolnFinancial.com

GROUP ADMINISTRATION REFERENCE GUIDE

Welcome! Enclosed you will find guidelines for our Group products. We hope you will find these guidelines informative and helpful in the administration of your Employee's Group coverage.

For your convenience, below is a list of the most frequently used telephone and fax numbers.

Toll-Free Phone Numbers

For Customer Assistance Call
(800) 423-2765

One Call STD Claim Submissions	**(866) STD-CALL** (866) 783-2255

FAX Numbers

Enrollments/Adjustments/Changes	**(877) 573-6177**
Dental Claims	**(877) 843-3945**
Disability Claims	
Omaha	**(877) 843-3950**
Atlanta	**(800) 259-2335**
Life Claims	**(800) 462-4660**
Telephonic	**(402) 361-1016**

✔ Check it out . . . our Administration and Claim Forms are available through the Lincoln Financial Group Web site at **www.LincolnFinancial.com (choose Products and Performance, Group Insurance, then Group Insurance Forms)**.

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ADMINISTRATION GUIDELINES FOR SELF BILLED GROUPS

These guidelines provide helpful instructions to assist you in the enrollment and billing procedures of your employee benefits plan. The plan administrator in your office will be responsible for maintaining all policy and enrollment records as well as calculating, reporting and submitting premiums to our company. For assistance, please contact a Client Management Representative at *1-800-423-2765*.

WHEN DO I FILL OUT AN ENROLLMENT FORM?

- Fill out a group enrollment form (GLAD 4*) for each new Employee hired.
- This form serves as the basic insurance record.
- The Employee's signature serves as the payroll deduction authorization.
- File the completed enrollment form with **your** office records.
- Be sure to keep current Beneficiary designation records (applicable to Life Coverage only).
- **DO NOT** fax or mail the enrollment forms to our company, except for Dental coverage, late entrants or when Employees are applying for a benefit above the guarantee issue amount.
- In order to ensure that we will consider paying full benefits, we will require you to submit necessary records including but not limited to payroll records, enrollment forms, change forms, adjustment forms and current beneficiary designations at the time of a claim submission.
- When you need a new supply of certificates for new hires, please contact a Client Management Representative at **1-800-423-2765.**

WHO IS CONSIDERED A LATE APPLICANT?

- An Employee is considered a late applicant if applying for coverage more than 31 days after the date of eligibility.
- **Non-Contributory Coverage (Employer Paid):**
  - ⇛ Non-contributory means the cost of coverage is fully paid by the Employer.
  - ⇛ 100% of all eligible Employees **must** be enrolled.
  - ⇛ The coverage for the late applicant will be made effective on the Employee's original effective date.
  - ⇛ Your company **must pay all back premiums**.
  - ⇛ Eligible Employees **cannot** waive non-contributory coverage.
  - ⇛ **Exception:** Dental coverage may be waived **only** if the Employee has coverage elsewhere.
- **Contributory Coverage's (Employee Paid):**
  - ⇛ Contributory means any portion of the cost of coverage is paid by the Employee.
  - ⇛ The late applicant must submit a completed Enrollment Form and an Evidence of Insurability form.
  - ⇛ The Employee will be added after written Notice of Approval is received.
  - ⇛ **Do not** begin payroll deduction until written Notice of Approval is received.
  - ⇛ If coverage is waived, a waiver **must** be signed and submitted.
  - ⇛ For **Dental Coverage Only**, no Evidence of Insurability is required, but a Late Entrant to plan will have limitations. See your policy for details.

WHAT IS A QUALIFYING EVENT?

- For **Dental Coverage Only**, a qualifying event is loss of previous coverage and/or acquiring a dependent (marriage, birth, adoption, etc.). If an employee signs up for coverage within 31 days of an approved qualifying event, late entrant penalties are waived.
- For **Life Coverage Only**, a qualifying event is acquiring a dependent (marriage, birth adoption, etc.). If an employee signs up for coverage within 31 days of an approved qualifying event, late entrant penalties (Evidence of Insurability) are waived.
- For **Disability Coverage Only**, there are no approved qualifying events. All late applicants must complete Evidence of Insurability.

HOW DO I ENROLL A REHIRED EMPLOYEE?

- Any Employee who returns to work after temporary termination may request insurance coverage.
- A new enrollment form with the rehire date and current information must be completed.
- The rehired employee is an addition on the Statement of Premium Due.
- The rehire date will be used to determine eligibility, unless otherwise noted in the group insurance contract.
- The rehired Employee may be considered a late applicant if applying for coverage more than 31 days after the date of eligibility.

WHAT IS GUARANTEE ISSUE?

- The Guarantee Issue amount is the maximum benefit our company will underwrite without requiring evidence of insurability.
- Evidence of Insurability is required **whenever** an Employee requests a benefit amount, which exceeds the Guarantee Issue or any benefit increase.
- An Evidence of Insurability form must be submitted and the benefit amount will be approved through written notification.
- **Do not** report such amounts or an increase on the Statement of Premium Due until written Notice of Approval is received.

* This form is available on the Company's Web site at www.LincolnFInancial.com. Choose Products & Performance/Group Insurance/Group Insurance Forms.

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EVIDENCE OF INSURABILITY GUIDELINES

GENERAL QUESTIONS

WHEN IS A COMPLETED EVIDENCE OF INSURABILITY (EOI) FORM REQUIRED?

An Evidence of Insurability (EOI) form needs to be completed for:

- Late applicants (those applying more than 31 days after the eligibility waiting period).
- Applicants applying for coverage in excess of any Guarantee Issue amounts

NOTE: Do not begin payroll deductions for applicants requiring Evidence Underwriting until you receive written notification of approval.

WHERE MAY EOI FORMS BE OBTAINED?

You may obtain EOI forms via:

- www.LincolnFinancial.com (path Product & Performance / Group Insurance / Group Insurance Forms / New Business / Evidence of Insurability)
- Our secured on-line administration website www.LincolnFinancial.com

General Information

The EOI form must be completed in full and received in the Home Office within 60 days of the signed date before processing can begin. Forms with unanswered questions, incomplete information or old dates will be returned to the applicant so that the applicant (employee or spouse) may complete the requested information, re-sign and re-date the form, and return to Lincoln Life & Annuity Company of New York.

WHAT UNDERWRITING REQUIREMENTS WILL NEED TO BE COMPLETED ?

During the underwriting process our underwriters may request additional requirements based on the applicant's age and amount of coverage applied for, or the medical history provided. These requirements include:

- Paramedical exam and/or laboratory testing
- Medical records
- Telephone Interview

There is no charge for medical requirements when application is made at initial eligibility or within 31 days of the eligibility – waiting period.

- We will send notification to the applicant's home address when a medical exam and/or lab testing is required. Our paramedical vendor will then initiate contact with the applicant to schedule an appointment at a mutually convenient time and location.
- If the medical requirements are not completed within 30 days, we will close our files and send two copies of the withdraw letter to the Plan Administrator.

NOTE: Applicants applying after initial eligibility are responsible for the following fees and will receive a request for the amount to be remitted for the medical requirements.

- The fee for medical and/or laboratory testing is $80.
- The fee to obtain medical records is $40 per record; however, the applicant has the option to obtain the records from their physician and forward to Lincoln Financial Group. If this option is chosen, any fees charged by the physician are the responsibility of the applicant.
- If the requested fees are not received within 30 days, we will close our files and send two copies of the withdraw letter to the Plan Administrator.

HOW WILL DECISIONS BE COMMUNICATED?

The following E of I decision correspondence is sent to the Plan Administrator for distribution to the employee(s).

- **Approval** – The approval letter notes the coverage(s) approved and the effective date. Two copies of the letter are sent if you have generic certificates. If you have named certificates, a single copy of the approval letter will be attached to the employee certificate of coverage.

- **Declination** – The declination letter provides notification of the declination for requested coverage. Instructions are provided for the employee should they wish to request more detailed information. Two copies of the letter are provided.
- **Withdrawn** – A withdrawn letter is sent when medical requirements or missing information is not received within 30 days of our request. Two copies of the letter are provided.

NOTE: Denial and withdrawn decisions will not affect any coverage the employee currently has in force.

WHERE SHOULD I DIRECT STATUS INQUIRIES AND REPORT REQUESTS?

- Please direct status inquiries to a Client Management Representative at 1-800-423-2765.
- The Evidence of Insurability Decision Code Summary Report provides status information and decision activity. This report may be requested from a Client Management Representative. A similar report is also available through our online administration website.

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www.LincolnFinancial.com

GROUP ENROLLMENT "QUICK HIT" LIST

The Lincoln Life & Annnuity Company of New York group enrollment form (GLAD 4) can be found on the company's Web site, at www.LincolnFinancial.com. Choose Products & Performance/Group Insurance/Group Insurance Forms.

Please fax all completed Enrollment Forms to: **1-877-573-6177**
Or mail to:

Lincoln Life & Annuity Company of New York
Service Office Address: P. O. Box 2616
Omaha, NE 68103-2616

- ✔ Is the handwriting legible and the information accurate?
- ✔ Has the enrollment form been signed and dated by the employee?
- ✔ Has the section marked "Completed by the Employer" been completed?
- ✔ Has all critical information been provided, including but not limited to:
  - ➨ ***Policy Number or Group ID***
  - ➨ ***Company Name and Division/Billing Location***
  - ➨ ***Social Security Number***
  - ➨ ***Date of Full Time Employment or Rehire Date***
  - ➨ ***Salary and Hours Worked***
  - ➨ ***Occupation and Class Code***
  - ➨ ***Date of Birth***
  - ➨ ***Employee's Full Address and Telephone Number***
- ✔ If applicable, has the beneficiary information been filled out?
- ✔ If applicable, are all dependents to be enrolled in the Dental plan legibly listed with full names and dates of birth for each?
- ✔ Have the desired coverages been checked for Contributory (Employee paid) plans.
- ✔ Employer-paid (noncontributory) coverages may not be waived. The only exception to this business rule will be for dental coverage, which may be waived if proof of current dental insurance for the employee is submitted at time of enrollment. Sections D and F must be completed in full if dental coverage is being waived.

In accordance with the National Medical Support Notice, all employers and health plan administrators are required to make health care coverage (including dental coverage) available to children of non-custodial parents who are eligible and qualified for such coverage. If you receive a National Medical Support Notice, please notify us as soon as possible of any dental enrollment changes.

For assistance, please contact a Client Management Representative at *1-800-423-2765*

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ADMINISTRATION GUIDELINES FOR LIST BILLED GROUPS

These guidelines will assist you in the administration of your group insurance program.
For assistance, please contact a Client Management Representative at *1-800-423-2765*.

WHEN DO I FILL OUT AN ENROLLMENT FORM?

- Fill out a group enrollment form (GLAD 4*) immediately after a new Employee is hired.
- This form serves as the basic insurance record.
- Keep a copy for your records.
- Fax all completed enrollment forms to: **1-877-573-6177**
  Or mail the completed form to: **Lincoln Life & Annuity Company of New York**
  Service Office Address: PO Box 2616, Omaha, NE 68103-2616
- **Do not** mail enrollment forms with your premium payment.
- **Do not** mail the originals if you have faxed in your enrollments.
- **Note:** Incomplete forms may be returned, therefore causing a delay in processing.

HOW DOES NON-CONTRIBUTORY (EMPLOYER PAID) COVERAGE WORK?

- If the cost of coverage is fully paid by the Employer, 100% of all eligible Employees must be enrolled by submitting an enrollment form.
- Eligible Employees **cannot** waive non-contributory coverages.
- **Exception:** Dental coverage may be waived **only** if the Employee has coverage elsewhere. In this case, an enrollment form still must be submitted and the name of the other Dental carrier must be listed.
- Lincoln Financial Group assumes liability on all eligible employees, whether or not an enrollment form has been submitted. Therefore, your company is responsible for paying any back premium on Employees whose enrollment forms were overlooked or sent in late.

HOW DOES CONTRIBUTORY (EMPLOYEE PAID) COVERAGE WORK?

- If any portion of the cost of coverage is paid by the Employee, the Employer should offer the Employee the coverage.
- If coverage is elected, an enrollment form **must** be completed and submitted.
- If coverage is waived, Section F on the enrollment form must be marked and the enrollment form must be signed, dated and submitted.
- The Employee's signature serves as the payroll deduction authorization.

HOW DO I ENROLL A REHIRED EMPLOYEE?

- Any member who returns to work after temporary termination may request insurance coverage.
- A new enrollment form with the rehire date and current information must be completed.
- The rehire date will be used to determine eligibility, unless otherwise noted in the group insurance contract.
- The rehired Employee may be considered a late applicant if applying for coverage more than 31 days after the date of eligibility.
- If the Employee is a late applicant, do not begin payroll deductions until written Notice of Approval has been received.

WHO IS CONSIDERED A LATE APPLICANT?

- An Employee is considered a late applicant if applying for coverage more than 31 days after the date of eligibility.
- **Non-contributory Coverage (Employer Paid):**
- The coverage for the late applicant will be made effective on the Employee's original effective date.
  - ⇛ Your company **must pay all back premiums.**
- **Contributory Coverage (Employee Paid):**
  - ⇛ The Employee must submit a completed Enrollment Form and an Evidence of Insurability form.
  - ⇛ The Employee will be added after written Notice of Approval has been sent by our Company.
  - ⇛ **Do not** begin payroll deduction until written Notice of Approval is received.
  - ⇛ For **Dental Coverage Only**, no Evidence of Insurability is required, but a Late Entrant to the plan will have limitations. See your policy for details.

WHAT IS A QUALIFYING EVENT?

- For **Dental Coverage Only**, a qualifying event is loss of previous coverage and/or acquiring a dependent (marriage, birth, adoption, etc.). If an employee signs up for coverage within 31 days of an approved qualifying event, late entrant penalties are waived.
- For **Life Coverage Only**, a qualifying event is acquiring a dependent (marriage, birth adoption, etc.). If an employee signs up for coverage within 31 days of an approved qualifying event, late entrant penalties (Evidence of Insurability) are waived.
- For **Disability Coverage Only**, there are no approved qualifying events. All late applicants must complete Evidence of Insurability.

WHAT IS GUARANTEE ISSUE?

- The Guarantee Issue amount is the maximum benefit our company will underwrite without requiring evidence of insurability.
- Evidence of Insurability is required **whenever** an Employee requests a benefit amount or benefit increase, which exceeds the Guarantee Issue.
- An Evidence of Insurability form must be submitted and the benefit amount will be underwritten. Do not begin deducting any such amounts or increases until written Notice of Approval is received.

HOW DO I REPORT ADJUSTMENTS THAT AFFECT OUR GROUP?

- Complete adjustments and changes online or fax to: **1-877-573-6177**
- Or mail the completed form to: **Lincoln Life & Annuity Company of New York**
  Service Office Address: PO Box 2616, Omaha, NE 68103-2616
- **Do not** mail changes and adjustments with your premium payment.
- **Do not** mail the originals if you have faxed in your changes and adjustments.
- Keep a copy for your records.
- Use the **Adjustment Report (GLA-01251*)** to submit any type of the following changes as they occur:
  - ⇛ Terminations
  - ⇛ Class Changes
  - ⇛ Billing Location Changes
  - ⇛ Salary Changes (if benefit is salary based)
- Use the **"Group Insurance Change Request" (GLA-01299*)** to submit any type of the following changes as they occur:
  - ⇛ Name Change
  - ⇛ Beneficiary Change
  - ⇛ Marital Status Change
  - ⇛ Dependent Coverage Change
- Reporting **Salary Changes**
  - ⇛ As they occur, salary changes **must** be reported on all Employees whose coverage is determined according to their earnings. For prompt processing, please e-mail these changes via Excel file to clientservices@LFG.com. The Excel file must contain group name, employee name, SS#, salary amount and effective date of salary change.
  - ⇛ Claims are paid according to the most current salary information we have on record.
  - ⇛ For definition of earnings, please refer to your contract.
- If an Employee terminates after the premium due date, premiums are due for the entire month.
- If an Employee is effective after the premium due date, premium will not be charged until the next premium due date.
- **WE DO NOT PRORATE PREMIUM.**

IF OUR GROUP ADDS NEW EMPLOYEES DUE TO A MERGER, PURCHASE OF ANOTHER COMPANY OR DIVISION, WHAT SHOULD WE DO?

- Notify your Broker and your Regional Lincoln Financial Group Sales Office.
- Provide the following information:
  - ⇛ Complete Census or Enrollment Forms
  - ⇛ Date of Acquisition
  - ⇛ Name of Acquisition
  - ⇛ Effective Date of Coverage

* This form is available on the Company's Web site, at www.Lincoln Financial.com. Choose Products & Performance/Group Insurance/Group Insurance Forms.

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EVIDENCE OF INSURABILITY GUIDELINES

GENERAL QUESTIONS

WHEN IS A COMPLETED EVIDENCE OF INSURABILITY (EOI) FORM REQUIRED?

An Evidence of Insurability (EOI) form needs to be completed for:

- Late applicants (those applying more than 31 days after the eligibility waiting period).
- Applicants applying for coverage in excess of any Guarantee Issue amounts

NOTE: Do not begin payroll deductions for applicants requiring Evidence Underwriting until you receive written notification of approval.

WHERE MAY EOI FORMS BE OBTAINED?

You may obtain EOI forms via:

- www.LincolnFinancial.com (path Product & Performance / Group Insurance / Group Insurance Forms / New Business / Evidence of Insurability)
- Our secured on-line administration website www.LincolnFinancial.com

General Information

The EOI form must be completed in full and received in the Home Office within 60 days of the signed date before processing can begin. Forms with unanswered questions, incomplete information or old dates will be returned to the applicant so that the applicant (employee or spouse) may complete the requested information, re-sign and re-date the form, and return to Lincoln Life & Annuity Company of New York.

WHAT UNDERWRITING REQUIREMENTS WILL NEED TO BE COMPLETED ?

During the underwriting process our underwriters may request additional requirements based on the applicant's age and amount of coverage applied for, or the medical history provided. These requirements include:

- Paramedical exam and/or laboratory testing
- Medical records
- Telephone Interview

There is no charge for medical requirements when application is made at initial eligibility or within 31 days of the eligibility – waiting period.

- We will send notification to the applicant's home address when a medical exam and/or lab testing is required. Our paramedical vendor will then initiate contact with the applicant to schedule an appointment at a mutually convenient time and location.
- If the medical requirements are not completed within 30 days, we will close our files and send two copies of the withdraw letter to the Plan Administrator.

NOTE: Applicants applying after initial eligibility are responsible for the following fees and will receive a request for the amount to be remitted for the medical requirements.

- The fee for medical and/or laboratory testing is $80.
- The fee to obtain medical records is $40 per record; however, the applicant has the option to obtain the records from their physician and forward to Lincoln Financial Group. If this option is chosen, any fees charged by the physician are the responsibility of the applicant.
- If the requested fees are not received within 30 days, we will close our files and send two copies of the withdraw letter to the Plan Administrator.

HOW WILL DECISIONS BE COMMUNICATED?

The following E of I decision correspondence is sent to the Plan Administrator for distribution to the employee(s).

- **Approval** – The approval letter notes the coverage(s) approved and the effective date. Two copies of the letter are sent if you have generic certificates. If you have named certificates, a single copy of the approval letter will be attached to the employee certificate of coverage.

- **Declination** – The declination letter provides notification of the declination for requested coverage. Instructions are provided for the employee should they wish to request more detailed information. Two copies of the letter are provided.
- **Withdrawn** – A withdrawn letter is sent when medical requirements or missing information is not received within 30 days of our request. Two copies of the letter are provided.

NOTE: Denial and withdrawn decisions will not affect any coverage the employee currently has in force.

WHERE SHOULD I DIRECT STATUS INQUIRIES AND REPORT REQUESTS?

- Please direct status inquiries to a Client Management Representative at 1-800-423-2765.
- The Evidence of Insurability Decision Code Summary Report provides status information and decision activity. This report may be requested from a Client Management Representative. A similar report is also available through our online administration website.

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ADMINISTRATION GUIDELINES FOR LIST BILLED PREMIUM

These guidelines will assist you in the administration of your insurance program.
For assistance, please contact a Client Management Representative at *1-800-423-2765*.

BILLING SUMMARY

- Prior to each premium due date, you will receive a Billing Summary.
- Bills are generated on the 10th or 20th of each month.
- Bills will be mailed in separate envelopes for each division/location/account of the group.
- A Billing Summary will list each employee covered under the plan and premium payment due.
- CHECK YOUR BILLING SUMMARY CAREFULLY TO ENSURE ALL ELIGIBLE EMPLOYEES ARE INCLUDED ON THE STATEMENT AND THAT PREMIUMS ARE CORRECT. IF NOT, PLEASE SEE ENROLLMENTS - LIST BILLED SECTION.

PREMIUM REMITTANCE

- Premium is due on or before the due date listed on your Billing Summary. To ensure timely credit of your account, please remit your premium promptly.
- To ensure proper credit, tear off payment coupon on the top of the Billing Summary, complete "Amount Enclosed" and mail to address shown on the payment coupon.
- If more than one division/location/account, send all completed coupons with your payment.
- Do not mail any other items with premium payment. See Enrollments - List Billed section of guide for instructions regarding enrollments, terminations, or other adjustments to the Billing Summary.

REINSTATEMENT PROCESS:

- It is very important to pay as billed to prevent possible lapse of your policy. Paying as billed means paying the "Total Amount Due" shown on the Billing Summary and waiting for submitted adjustments to appear on a subsequent Billing Summary.
- If premiums are not paid-in-full within the grace period, your policy may lapse in accordance with your contract.
- Should your policy lapse, a $100 reinstatement fee, Request For Reinstatement form, along with any unpaid premiums will be due in order to consider reinstatement.

Please note the instructions and sample Billing Summary on the following pages.

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ADMINISTRATION GUIDELINES FOR SELF BILLED PREMIUM

These guidelines will assist you in the administration of your insurance program.
For assistance, please contact a Client Management Representative at *1-800-423-2765*.

MY PRIMARY RESPONSIBILITIES AS THE GROUP ADMINISTRATOR OF A SELF-BILLED GROUP

- Report **LIVES**, **VOLUME** and **PREMIUM** for each line of coverage each month.
- Keep all necessary paperwork on file in your office including but not limited to enrollment forms, change and adjustment forms and beneficiary designation forms.
- DO NOT fax or mail the enrollment forms, beneficiary designation forms, etc. to our company, except for Dental coverage.
- In order to ensure that we will consider paying full benefits, we will require you to submit necessary records including but not limited to payroll records, enrollment forms, change forms, adjustment forms and beneficiary designation forms at the time of a claim submission.

STATEMENT OF PREMIUM DUE

- Prior to each premium due date, you will receive a Statement of Premium Due.
- Bills are generated on the 10th or the 20th of each month.
- Bills will be mailed in separate envelopes for each division/location/account of the group.

PREMIUM REMITTANCE

- Premium is due on or before the due date listed on your Statement of Premium Due.
- To ensure proper credit, complete Statement of Premium Due, tear off payment coupon on the top of the Payment Coupon page, complete amount enclosed and mail to address shown on Payment Coupon.
- If more than one division/location/account, send all completed coupons and statements of Premium Due with your payment.
- Lincoln Financial Group does periodic audits of Self Billed groups to ensure the accuracy of premium remitted.

REINSTATEMENT PROCESS

- It is very important to remit premium by the premium due date listed on the Statement of Premium Due.
- If premiums are not paid within the grace period, your policy may lapse in accordance with your contract.
- Should your policy lapse, a $100 reinstatement fee, a Request For Reinstatement form, along with any unpaid premiums will be due in order to consider reinstatement.

Please note the instructions and Statement of Premium Due on the following pages.

REPORTING PREMIUM

Premium for the current coverage period is due in our office **on or before** the first day of the coverage period. A **completed** Statement of Premium Due must accompany each premium payment. You will receive a blank statement prior to each premium due date. This statement should be completed by the plan administrator.

To complete the Statement of Premium Due, please follow this guide:

STATEMENT OF PREMIUM DUE

STATEMENT OF PREMIUM DUE

GR-AD
ABC CORPORATION
ATTN - JANE DOE
123 MAIN STREET
ANYTOWN, USA 11111

Account # AEKO-BL-26389

Due Date: 1-01-99

Policy Number: 000010021269-00000

Current Changes of Insurance In Force	LIFE		DEP LIFE		AD & D		LTD	
1. In Force on Last Statement	25	625,000	21	126,000	25	625,000	25	51,668
2. Additions	1	25,000	1	6,000	1	25,000	1	2,059
3. Volume Increases		2,000		----		2,000		95
4. Terminations (include deaths and disabilities)	2	42,000	2	12,000	2	42,000	2	3,558
5. Volume Decreases		----		----		----		----
6. In Force on Premium Due Date	24	610,000	20	120,000	24	610,000	24	50,264
7. Current Premium Rate		.55		1.20		.05		.38
8. Unadjusted Premium		$335.50		$24.00		$30.50		$191.00
9. Back Premium Charges(+)		+ 1.10		----		+.10		
10. Back Premium Credits (-)		(9.90)		(1.20)		(.90)		(5.83)
11. Adjusted Premium TOTAL		$326.70		$22.80		$29.70		$185.53

TOTAL PREMIUM (ADD LINE 11 ACROSS)	$546.73
Total Amount Due	$546.73

Jane Doe (402) 123 4567

POLICYHOLDER'S SIGNATURE

COMPLETE FOR EACH LINE OF COVERAGE

LINE 1 Information listed here is from the last paid bill in our system at the time the current Statement of Premium Due generated.

LINE 2 Report the number of new members and volume. (Use the back-side of the Statement of Premium Due to list adjustments being taken.)

LINE 3 Report the total increase in volume for inforce members due to salary changes and/or class changes. (Use the back-side of the Statement of Premium Due to list adjustments being taken.)

LINE 4 Report the number of terminations and volume for inforce members. (Use the back-side of the Statement of Premium Due to list adjustments being taken.)

LINE 5 Report the total decrease in volume due to salary, class and/or age reduction changes for inforce members. (Use the back-side of the Statement of Premium Due to list adjustments being taken.)

LINE 6 For each coverage, calculate the total lives and volume by adding items 1,2 and 3 and subtracting items 4 and 5.

LINE 7 This is the current premium rate for each coverage.

LINE 8 Calculate the unadjusted premium due for each coverage by multiplying each volume recorded on Line 6 by each appropriate rate.

LINE 9 Report any back charges (+) that have not been reported on a previous Statement of Premium Due.

LINE 10 Report any premium credits due (-) which have not been reported on a previous Statement of Premium Due.

LINE 11 For each coverage, calculate the adjusted premium totals by adding items 8 and 9 and subtracting item 10.

TOTAL PREMIUM Add Line 11 across and list the total premium due for all coverages in the box provided at the bottom of page 1.

Please note that the sample provided here may not list the same coverages that are available as part of your group plan. However, the procedures outlined above are applicable for all lines of coverage.

CALCULATING PREMIUM

To calculate the premium due for a particular coverage, please follow the formulas provided below. Please refer to your insurance contract to determine the coverage amounts for your employees.

LIFE / AD&D INSURANCE (BASIC AND OPTIONAL)

Life and AD&D rates are per $1,000 of coverage, so premium should be calculated based on the actual benefit amounts provided to each employee. Use the formula listed below to calculate the cost:

$$\frac{\text{BENEFIT AMOUNT}}{\$1{,}000} \times \text{RATE} = \text{PREMIUM}$$

EXAMPLE: (Life insurance for John Smith)

$$\frac{25{,}000}{1{,}000} = 25.000 \times .55 = \$13.75$$

EXAMPLE: (Life insurance for all employees of ABC Corporation)

$$\frac{610{,}000}{1{,}000} = 610.000 \times .55 = \$335.50$$

EXAMPLE: (AD&D insurance for John Smith)

$$\frac{25{,}000}{1{,}000} = 25.000 \times .05 = \$1.25$$

EXAMPLE: (AD&D insurance for all employees of ABC Corporation)

$$\frac{610{,}000}{1{,}000} = 610.000 \times .05 = \$30.50$$

DEPENDENT LIFE INSURANCE

Dependent life insurance rates are per family unit. The same rate is charged per family regardless of the actual number of dependents covered. Use the formula below to calculate the cost of dependent life insurance:

FAMILY UNIT X RATE = PREMIUM

EXAMPLE: (Dependent life insurance for John and Sarah Smith and children)

1 Family Unit X 1.20 = $1.20

EXAMPLE: Coverage for all employee families at ABC Corporation)

20 Family Units X 1.20 = $24.00

WEEKLY INCOME / SHORT TERM DISABILITY

The cost of weekly income (or short term disability) insurance is calculated based on the actual benefit provided to the employee if that employee became disabled. Rates are per $10 of benefit. Use the formula below to calculate the cost of WI/STD coverage:

$$\frac{\text{BENEFIT AMOUNT}}{\$10} \times \text{RATE} = \text{PREMIUM}$$

EXAMPLE: (WI/STD coverage for John Smith)
According to the contract under which he is covered, John's benefit amount will be 60% of his weekly earnings. The maximum benefit allowed under this group plan is $250.

60% of John's weekly earnings: $285.09
Maximum Benefit Amount: $250

Cost of John's coverage:

$$\frac{250.0}{10} = 25.0 \times .44 = \$11.00$$

HOW TO CALCULATE PREMIUM FOR EACH EMPLOYEE

Use the following formula to calculate rates for each employee.

- Rates are per $100 of Basic Monthly Earnings by employee

$$\frac{\text{BASIC MONTHLY EARNINGS*}}{\$100} \times \text{RATE} = \text{EMPLOYEE PREMIUM}$$

*__Basic Monthly Earnings__ cannot exceed the __LTD Maximum Covered Monthly Earnings__. (__LTD Maximum Covered Monthly Earnings__ equals the Maximum Monthly Benefit divided by the Benefit Percentage covered by the plan.)

See table below for sample **LTD Maximum Covered Monthly Earnings**. Refer to your policy schedule to determine your plan's Benefit Percentage and Maximum Monthly Benefit.

	MAXIMUM MONTHLY BENEFIT		
BENEFIT PERCENTAGE	**5,000**	**6,000**	**10,000**
LTD MAXIMUM COVERED MONTHLY EARNINGS			
50%	$10,000	$12,000	$20,000
60%	$8,333	$10,000	$16,677
66 2/3%	$7,500	$9,000	$14,999

HOW TO CALCULATE PREMIUM FOR THE ENTIRE GROUP

- Rates are per $100 of Total Covered Payroll.
- Total Covered Payroll is the total amount of Basic Monthly Earnings for all Employees insured under the Policy.

$$\frac{\text{TOTAL COVERED PAYROLL}}{\$100} \times \text{RATE} = \text{GROUP PREMIUM}$$

Examples of how to calculate LTD premiums

Assumptions used in calculations:

- ✓ Maximum Monthly Benefit: $5,000.
- ✓ Benefit Percentage: 60%.
- ✓ Basic Monthly Earnings for sample employee: $3,012.
- ✓ Total Covered Payroll for sample group: $50,264.
- ✓ Basic Monthly Earnings do not exceed LTD Maximum Covered Monthly Earnings.
- ✓ LTD rate: $.38

EMPLOYEE MONTHLY PREMIUM	GROUP MONTHLY PREMIUM
$\frac{\$3,012}{100} = 30.12 \times .38 = \$11.44$	$\frac{50,264}{100} = 502.64 \times .38 = \$191.00$

Lincoln Financial Group®

Lincoln Life & Annuity Company of New York
Service Office Address: PO Box 2616, Omaha, NE 68103-2616
Home Office: Syracuse, NY
toll free (800) 423-2765
www.LincolnFinancial.com

Voluntary Administration Guidelines

Guidelines for each of the Voluntary products which Lincoln Life & Annuity Company of New York offers are included with this letter. We believe you will find the guidelines and the "Quick Hit" list to be informative and helpful in the administration of your employees' Voluntary coverage.

Refer to the Administration Guidelines included in this kit for the specific Voluntary coverage you have elected to offer.

If you have any questions regarding the administration of your group policy, please contact your Client Management representative at 1-800-423-2765.

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Voluntary Administration Quick Hit List

Use the checklist below to complete the enrollment forms for Voluntary coverage:

☐ Is the handwriting legible?

☐ Has the enrollment form been signed and dated? By the employee and the spouse, if applicable?

☐ Has the complete address (city, state and zip code) been included?

☐ Are complete telephone numbers included?

☐ Has the type of coverage been checked?

☐ Have all questions on the Health Statement for both the employee and spouse, if applicable, been answered?
- Height
- Weight
- Yes or No to all health questions. If "Yes" to any health question, a detailed explanation is required.

☐ Have the division number and/or billing location been indicated?

☐ Are the following items completely filled out?
- Salary
- Date of Hire
- Hours worked per week

☐ For Voluntary Life coverage:
- Is the tobacco question answered?
- Has a beneficiary been designated?
- Are the unit amounts indicated?

☐ For Voluntary LTD coverage:
- Are the unit amounts indicated?
- Is the benefit elimination period and duration included?

☐ For Voluntary Dental coverage:
- Have all eligible dependents to be covered been listed?
- Has one of the coverage options been checked?

In accordance with the National Medical Support Notice, all employers and health plan administrators are required to make health care coverage (including dental coverage) available to children of non-custodial parents who are eligible and qualified for such coverage. If you receive a National Medical Support Notice, please notify us as soon as possible of any dental enrollment changes.

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VOLUNTARY LIFE INSURANCE ADMINISTRATION GUIDELINES

WHEN ARE EMPLOYEES ELIGIBLE?

Employees are eligible for coverage after completing the waiting period. All new employees will be added to the bill effective the first of the month following completion of the waiting period or upon signing the enrollment form, whichever is later. There will be no mid-month premium calculation.

Please note that employees contractually have 31 days from the effective date to enroll. If employees enroll during this 31-day eligibility period, the effective date will be the first of the month following the date of signature. We strongly suggest that employees complete and submit applications during the waiting period.

WHEN DO EMPLOYEES OR SPOUSES NEED TO COMPLETE THE MEDICAL QUESTIONS?

- If the amount applied for is over the Guarantee Issue amount
- If they are late enrollees (did not enroll initially and are now requesting coverage)

(Note: Applicants will be responsible for any medical fees incurred if a late enrollee)

- If spouse coverage is over the Guarantee Issue amount
- If spouse is applying for coverage after initially declining
- If an employee wants to increase coverage for either self or the spouse
- If an employee is age 60 or over

HOW DO I CALCULATE AN EMPLOYEE'S AGE FOR PREMIUM PURPOSES?

Use the employee's age on the eligibility date to calculate premium. If a person's age changes from one age band to another, premium will not increase until the employer's next policy anniversary date.

DO I DEDUCT THE ENTIRE PREMIUM OR ONLY THE GUARANTEE ISSUE AMOUNT?

Deduct premiums to cover the Guarantee Issue amount. Upon approval from the Home Office, begin deductions to the full amount of premium.

Please note that for accurate administration, deductions should begin on the first of the month only.

WHEN WILL I RECEIVE MY BILL?

Bills are generated on the 20th of the month. The initial bill takes approximately three weeks to process from the receipt of enrollment forms.

WHERE DO I SEND MY PREMIUM PAYMENT?

Detach the coupon from your monthly statement; attach your check and mail in the enclosed envelope.

WHERE DO I SEND NEW ENROLLMENT FORMS?

You may either FAX them to: (877) 573-6177
Or, MAIL them to: Lincoln Life & Annuity Company of New York
Service Office Address: P. O. Box 2616
Omaha, NE 68103-2616

WHOM DO I CALL WITH QUESTIONS?

Contact Client Management at (800) 423-2765.

WHAT ARE THE DIFFERENT COMBINATIONS OF COVERAGE?

Our standard contract include the following:

Employee Only	Employee and Child
Employee and Spouse	Employee, Spouse and Child

However, some contracts may allow spouse only or spouse and child coverage. Please contact a Client Management Representative at (800) 423-2765 for details.

WHAT IF THE EMPLOYEE NO LONGER WANTS THE COVERAGE?

- If deductions are made post-tax, complete an Adjustment Report requesting that the coverage be dropped and fax to: (877) 573-6177.
- If deductions are made pre-tax, changes can only be made during the annual enrollment period each year.

CAN EMPLOYEES ENROLL THROUGHOUT THE YEAR?

- If deductions are made post-tax, yes. However, there is not a Guarantee Issue amount and the medical questions (Statement of Health) must be completed.
- If deductions are made pre-tax, current employees may only enroll during the annual enrollment
  The Statement of Health would have to be completed.

WHAT ARE THE CHARACTERISTICS OF PORTABILITY AND EMPLOYEE CONVERSION?

Portability	Conversion
• Term life insurance (no cash value)	• Non-term products which build a cash value (e.g., whole life insurance)
• Age-banded rates (increase with current age)	• Age-banded rates, fixed at age when conversion coverage is issued
• Employee can take the same coverage at the same group rate until normal retirement age	• Employee changes coverage to an individual policy, which may have a higher premium
• Must be covered for one year to port	• Can convert at any time unless group contract terminates or is amended - in that case, the employee must have been covered for 5 years to convert
• Guaranteed full amount when employment terminates for reasons other than disability or retirement. Spouse and child coverage is also portable when employment terminates for reasons other than disability or retirement. See Certificate plan details	• When the life insurance terminates because the insured person's employment or membership in an eligible class has ended, an individual policy can be issued without evidence of insurability wihtin 31 days of coverage termination

WHEN DO I USE THE CHANGE REQUEST (GLA-01299*) VS. THE ADJUSTMENT REPORT (GLA-01251*)?

Change Request	Adjustment Report
• Name Change	• Termination of employees
• Beneficiary Change	
• Coverage Changes (increases, decreases, terminations, additions, deleteions or changing dependant coverage)	

Please fax all reports (Change Request and Adjustment Reports) to (877) 573-6177.
All new enrollment forms should be faxed (front and back) to the same number.
Do not send changes with the bill - this will only delay the processing of the change!
Premium payments with coupons go directly to a lockbox for processing.
Fax your adjustments separately to the number above.

HOW WILL I KNOW WHO IS PENDING IN UNDERWRITING?

You will receive a list with the initial bill indicating who is pending in Underwriting. Use this list to cross-reference as approvals/declines are received from Underwriting. You may call a Client Management Representative at (800) 423-2765 at any time to follow up on specific individuals.

WHAT IS TRAVEL ASSISTANCE?

Your employee benefits package includes travel assistance as part of your group life insurance coverage. Travel assistance includes your immediate family members. When you travel 100 miles or more from home, services available to you include: lost luggage service; replacement assistance for lost or stolen travel documents; emergency funds transfer; emergency pet housing and return; medical, dental, vision, and pharmaceutical referrals; translation services; emergency medical evacuation and transportation; emergency security evacuation; and many more.

To utilize this service, please call our Travel Assistance provider, United Healthcare Global, at 1-800-527-0218.

WHAT IS *LIFEKEYS*℠?

LifeKeys is a service provided to all employees and their dependents covered by the Life / AD&D policy. These services include online access to information, resources and tools on a broad range of topics, including identity theft and online access to prepare a valid will and testament. This is offered at no cost to you or your employees.

To access the new online services, employees and their dependents can visit www.Lincoln4Benefits.com and select the *LifeKeys* services link. During the log in process, the Web ID is LifeKeys.

ARE THERE OTHER SERVICES OFFERED UNDER *LIFEKEYS* SERVICES?

The *LifeKeys* program includes services designed to help beneficiaries deal with difficult issues after the death of a loved one and for an Insured filing an Accelerated Death Benefit claim. The program includes grief, legal and financial services with unlimited phone sessions and a combined total of six in-person sessions or equivalent working time. In addition, unlimited phone access to a variety of resources including, but not limited to, memorial and funeral planning information, child/elder care referrals, and other resource information based on individual need.

To access *LifeKeys* service, the beneficiary or claimant can call 855-891-3684 or access the website at www.Lincoln4Benefits.com and select the *LifeKeys* services link. During the log in process, the Web ID is LifeKeys.

* This form is available on the Lincoln Financial Group Web site, at www.LincolnFinancial.com. Choose Products & Performance, Group Insurance, Group Insurance Forms.

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VOLUNTARY LONG-TERM DISABILITY ADMINISTRATION GUIDELINES

WHEN ARE EMPLOYEES ELIGIBLE?

Employees are eligible for coverage after completing the waiting period. All new employees will be added to the bill effective the first of the month following completion of the waiting period or upon signing the enrollment form, whichever is later. There will be no mid-month premium calculation.

Please note that employees contractually have 31 days from the effective date to enroll. If employees enroll during this 31-day eligibility period, the effective date will be the first of the month following the date of signature. We strongly suggest that employees complete and submit applications during the waiting period.

HOW DO I CALCULATE AN EMPLOYEE'S AGE FOR PREMIUM PURPOSES?

Use the employee's age on the eligibility date to calculate premium. If a person's age changes from one age band to another, premium will not increase until the employer's next policy anniversary date.

WHEN WILL I RECEIVE MY BILL?

Bills are generated on the 20th of the month. The initial bill takes approximately three weeks to process from the receipt of enrollment forms.

WHERE DO I SEND MY PREMIUM PAYMENT?

Detach the coupon from your monthly statement, attach your check and mail in the envelope provided.

WHERE DO I SEND NEW ENROLLMENT FORMS?

You may either **FAX** them to:	(877) 573-6177
Or, **MAIL** them to:	Lincoln Life & Annuity Company of New York Service Office Address: P.O. Box 2616 Omaha, NE 68103-2616

WHOM DO I CALL WITH QUESTIONS?

Contact Client Management at (800) 423-2765.

WHEN DO EMPLOYEES HAVE TO ANSWER MEDICAL QUESTIONS TO GET COVERAGE?

Employees who initially decline coverage and now choose the coverage must complete the medical questions provided.

Please note that employees are still subject to pre-existing conditions in addition to the medical underwriting.

WHAT IS THE OPEN ENROLLMENT?

Open Enrollment is the time when coverage is initially offered. During the Open Enrollment period, employees may elect coverage on a guaranteed issue basis. When a new employee is hired, he/she may apply for coverage. Coverage is available on a guaranteed issue basis if enrollment occurs during the employee's enrollment period. Employees who elect to enroll after the enrollment period are subject to evidence of good health and must complete the Health Statement provided.

WHEN CAN EMPLOYEES DROP THE COVERAGE?

At any time, you may fax a "Group Insurance Change Request" (form GLA-01299*) to 877-573-6177. The employee must sign and date the Change Request.

Please note that if the employee wants to add coverage at a later date, he/she is subject to medical underwriting and a new pre-existing condition limitation period.

WHEN DO I USE THE CHANGE REQUEST FORM VS. THE ADJUSTMENT REPORT (form GLA-01251*)?

Change Request	Adjustment Report
• Name Change	• Termination of employees
• Beneficiary Change	
• Coverage Changes (increases, decreases, terminations, additions, deletions or changing dependant coverage)	

Please fax all reports (Change Request and Adjustment Reports) to 877-573-6177.
All new enrollment forms should be faxed (front and back) to the same number.
Do not send changes with the bill — this will only delay the processing of the change!
Premium payments with coupons go directly to a lockbox for processing.
Fax your adjustments separately to the number above.

HOW DO I CALCULATE THE LTD PREMIUM?

Example: Employee's monthly income is $1,200
Rate is .64% per $100 of covered payroll
1200 divided by 100 = 12
12 x .64 = $7.68 per month

HOW DO I SUBMIT A CLAIM?

All three portions of the LTD Claim form (form GLC-01252*) must be completed before the claim can be processed. Complete the employer's portion for submission. Then the employee completes the employee portion of the Claim form and has the doctor's portion completed and forwarded to Lincoln Life & Annuity Company of New York for processing.

Long-Term Disability claims should be submitted as soon as the employee believes that the disability will last as long as the elimination period. It is preferable to receive a claim during the elimination period for tracking of the disability than have to obtain medical information retroactively after the elimination period has been satisfied.

Advise the employee to submit as much medical information as possible.

CAN ADMINISTRATIVE CHANGES AND ADJUSTMENTS BE MADE ELECTRONICALLY?

Yes. On-line Services allow administrators to perform many administrative functions via the Internet. Functionality includes the ability to:

- Submit Life, Life Waiver, and LTD claims on-line
- View Life, Life Waiver, LTD and Dental claims status on-line
- Enroll new members on-line
- Add or terminate members, then recalculate your bill to reflect the actual amount you owe, and pay your bill on-line and in real time
- Review bills and payment status on-line
- Change member information on-line
- Terminate members and coverages on-line
- View and print group forms, administration guidelines, contracts and certificates on-line

Best of all, all changes are made in real time, so changes are reflected automatically. To learn more, call our Client Management department at (800) 423-2765.

* This form is available on the Company's Web site, at www.LincolnFinancial.com (choose Products & Performance/Group Insurance/Group Insurance Forms).

Voluntary Dental Administration Guidelines

Lincoln Life & Annuity Company of New York
Service Office Address: PO Box 2616, Omaha, NE 68103-2616
Home Office: Syracuse, NY
toll free (800) 423-2765
www.LincolnFinancial.com

WHEN ARE EMPLOYEES ELIGIBLE?
Employees are eligible for coverage after completing the eligibility waiting period. All new employees will be added to the bill effective the first of the month following completion of the waiting period or upon signing the enrollment form, whichever is later. There will be no mid-month premium calculation.

WHEN WILL I RECEIVE MY BILL?
Bills are generated on the 20th of the month. The initial bill takes approximately three weeks to process from the receipt of enrollment forms.

WHERE DO I SEND MY PREMIUM PAYMENT?
Detach the coupon from your monthly statement; attach your check and mail in the enclosed envelope.

WHERE DO I SEND NEW ENROLLMENT FORMS?
You may either FAX them to: (877) 573-6177

Or, MAIL them to: Lincoln Life & Annuity Company of New York
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Omaha, NE 68103-2616

WHOM DO I CALL WITH QUESTIONS?
Dental Claims and Eligibility: (800) 423-2765

IF I DON'T ENROLL FOR COVERAGE DURING THE INITIAL BENEFIT WAITING PERIOD, WHEN CAN I ENROLL FOR COVERAGE?
If you did not enroll during the initial benefit waiting period, you may only enroll for coverage at the policy anniversary date.

DOES LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK REQUIRE PRE-AUTHORIZATION FOR DENTAL WORK?
Pre-authorization is not required but is strongly advised for any claim expected to be over $300 of covered services. Pre-authorization requests should be sent to the address listed above.

WHO WILL RECEIVE DENTAL ID CARDS?
Every employee will receive a Dental Identification card and a Certificate of Coverage outlining the covered services, as well as the terms of coverage under the plan. If a replacement or duplicate copy is needed, contact a Client Management Representative at (800) 423-2765.

HOW DOES PRIOR INSURANCE CREDIT WORK?
If you are currently covered under a Dental plan and have satisfied the waiting periods for Type II, III, and IV coverages, you will not have to satisfy another waiting period.

Please note that this is only applicable if you had the applicable dental coverage prior to the Lincoln Life & Annuity Company of New York contract.

WHAT IS THE ANNUAL ENROLLMENT PERIOD?
The Annual Enrollment period is held once a year during the month before the Plan Anniversary. During this time, employees who chose not to enroll in the Dental plan the prior year may now enroll.

Please note that the benefit waiting period(s) apply.

GLM-01564NY
7/15

HOW DO I SUBMIT A CLAIM?

Have the dentist submit the Dental Claim form to the following address:

Dental Claims Processing Center
P. O. Box 614008
Orlando, FL 32861

Fax - (877) 843-3945

To verify benefits, call (800) 423-2765
For electronic claims: Payor ID Number CX061

If you assign payments, then Lincoln Life & Annuity Company of New York can pay your dentist directly. If you do not assign payments, then the payment will be made to you.

DO I HAVE ACCESS TO DENTAL HEALTH INFORMATION?

Lincoln DentalConnect® is an online information tool that is automatically added to your group Dental plan. You are required to have Dental coverage to enter the Web site. Simply log on to www.LincolnFinancial.com.

DENTAL PPO - HOW TO LOCATE PARTICIPATING DENTISTS

1. Visit LincolnFinancial.com.
2. Select **Find a Dentist**, listed under **Quick Links** located on the right side of the screen.
   - For Chrome or Safari, on the next screen, select Find a **Dentist** listed at the bottom of the screen.
   - For Internet Explorer, go to step 3.
3. To find dentists located in your area, a separate screen will appear to enter the zip code.

To search for a dentist:

The **Participating Dentist** function allows you to search for a dentist by:

- Dentist Name
- Specialty
- Proximity (to your home or office)
  - Enter your five digit ZIP code.
  - Select the distance you are willing to travel (up to 50 miles).

The site will automatically provide you with up to 100 dentists that most closely match your criteria.

To nominate a dentist:

If your search does not locate the dentist you prefer, you can nominate a dentist.

- On the **Find A Network Dentist** results page, click on the **Nominate a Dentist** link located at the top right hand corner.
- Complete the form online. The information will be automatically sent to Lincoln Financial.
- You may also complete the form, print it and mail it to:

  Lincoln Financial Group
  8801 Indian Hills Drive
  Omaha, NE 68114

For additional assistance:

Please contact Lincoln Financial Group customer service at (800) 423-2765.

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ADMINISTRATIVE SERVICES ONLY (ASO) GUIDE

Administrative Services Only (ASO) is a self-funding arrangement in which a Plan Sponsor (employer, union, association, etc.) retains the services of a carrier, to perform specific administrative functions of an employee short-term disability program. The primary administrative function is the review, investigation, and payment of claims by the carrier in accordance with the Plan Sponsor's Plan Document. The Plan Sponsor is responsible to make final claim decisions.

The ASO program is provided to employer's who prefer our expertise in paying claims. A standard contract is used for definitions of disability and is provided to the employer for reference. We issue benefit payments to the client's employees.

Our standard (we are creating a new ASO form) claim form should be submitted for review, including the completed portions for the employee, employer, and physician. Submit the claim form to us via mail or fax. Once the entire claim is received, we log it to our claim system within 48 hours and forward to a Claim Representative for handling.

Each claim is reviewed for medical necessity and eligibility within 4 working days to be approved for payment, denied, or pended for additional information. We will send a letter to the claimant notifying them of our findings when a decision is made. We will contact the physician's office directly if additional information is required to make an initial determination of medical eligibility, and pay any fees associated with obtaining the requested information.

We will send a report listing the paid claims to the employer on a monthly basis. Also, a billing statement reflecting the total paid claims for the month will be sent to the employer on a monthly basis. Claim reimbursement is due within 15 days of receiving the billing statement.

GENERAL QUESTIONS AND ANSWERS

DO I HAVE CLAIM PAYMENT OPTIONS?

Yes, we offer three Self-Funded Product options for you to choose from.

- Durational Advice to Pay: The carrier provides advice on all short-term disability claims as to the duration of the benefit. The employer is responsible to determine the benefit calculation and pay the employee.
- Financial Advice to Pay: The carrier provides both advice on duration, as well as the benefit calculation to the employer. The employer then pays the employee the benefit.
- ASO: A self-funding arrangement in which a Plan Sponsor (employer, union, association, etc.) retains the services of a carrier, to perform specific administrative functions of an employee short-term disability program. The primary administrative function is the review, investigation, and payment of claims by the carrier in accordance with the Plan Sponsor's Plan Document. The Plan Sponsor is responsible to make final claim decisions.

HOW DO I FILE A CLAIM FOR DISABILITY?

Submit the STD Claim form (GLC-01363), which consists of the Employer, Employee and Physician's portion. All pages must be completed and submitted.

HOW SOON AFTER FILING A CLAIM SHOULD I EXPECT A DECISION?

We should make an initial decision within 4 working days after claim receipt. The initial decision will be to approve the claim for payment, deny payment, or pend the claim for additional information.

CAN I FILE MY ASO CLAIM TELEPHONIC?

Yes. your claim can be filed through our telephonic system.

ARE BENEFITS GUARANTEED ONCE A CLAIM IS FILED?

No. Benefits are paid based on evidence supporting total disability and not simply on a physician's opinion.

HOW MUCH LONGER WILL IT TAKE TO REVIEW A CLAIM IF ADDITIONAL INFORMATION IS REQUESTED?
Periodically, information may be needed from the Attending Physician, Employer or Claimant. Since we are waiting on information from an outside source, decision time will depend on when the information is submitted. Once received, we will review the information within 3 working days.

WHAT ARE OFFICE AND TREATMENT RECORDS?
They are the records a physician creates following each patient visit, including test result and x-rays. These documents are considered objective information.

AM I GUARANTEED BENEFITS IF MY DOCTOR INDICATES ON THE CLAIM FORM I AM DISABLED?
No. The medical documentation submitted must support the contract definition of disability. Documentation such as office and treatment notes must be submitted to support the statement.

WHAT ARE NATIONAL DURATION GUIDELINES?
We follow a set of guidelines designed to help outline the length of disability for a specific diagnosis or procedure. Several factors are taken into account when applying the guidelines, such as occupation, age, and variability within a diagnosis.

ARE BENEFITS PAYABLE ON A MATERNITY CLAIM?
Benefits are payable up to 6 weeks for normal and C-section deliveries. Benefits may be approved prior to delivery if documentation submitted supports a disability status. Pregnancy in itself is not disabling until after delivery. Additional documentation may be requested to determine if benefits are payable prior to delivery.

DISABILITY QUESTIONS AND ANSWERS

APPROXIMATELY HOW MANY CLAIMS REPRESENTATIVES WILL BE HANDLING OUR CLAIMS?
We will assign two dedicated contacts to your account We will have one for the STD portion and another for LTD)

WHAT STEPS WILL BE TAKEN IF THERE ARE PROBLEMS OBTAINING COMPLETED PAPERWORK AND DOCUMENTATION FROM THE PHYSICIAN?
We will call the physician to follow up for information requested by letter. In addition, we will also communicate with the employee by phone and letter if we encounter problems obtaining information necessary to make a claim determination.

WILL WE RECEIVE COPIES OF ALL LETTERS SENT TO OUR EMPLOYEES, SUCH AS INITIAL CLAIM LETTERS, APPROVALS, DENIALS, AND EXTENSION LETTERS?
Yes, you will receive copies of all letters. However, the program is subject to Graham-Leach-Bliley privacy regulations requiring Private Health Information be removed from letters copied to the employer.

HOW FREQUENTLY WILL WE RECEIVE ASO REPORTS?
We provide a monthly report via mail. The same information is also available real-time on our website (www.jpfic.com) on a 24/7 basis.

WHAT TURNAROUND TIME IS EXPECTED OF OUR SERVICE REPRESENTATIVES RESPONDING TO EMPLOYEE OR EMPLOYER INQUIRIES?
Messages left before 3:00 pm CST must be returned the same day; if left after 3:00 pm CST, we will return the call by noon the next day. This is one of our Employee Care Center's ten "Non-Negotiables" that employees must perform to be a part of our organization. Regular audits are performed to ensure compliance.

FROM START TO FINISH WITH AN STD CLAIM, IF EVERYTHING RUNS SMOOTHLY, WHAT IS THE LENGTH OF TIME IN BUSINESS DAYS ONCE A CLAIM IS PHONED IN, THAT IT IS APPROVED? COULD YOU WALK US THROUGH THE PROCESS AGAIN?
We pay, pend, or deny all claims within five business days of receipt. Please see the attached flowchart in this packet.

WHAT FUNCTIONS ARE AVAILABLE ONLINE?
Our industry-leading website is aimed at making our customer's lives easier. Our customers enjoy real-time access to claim reports, evidence of insurability status, claim status, certificates, claim forms, and our administrative guide, 24/7.

CAN WE REVIEW THE IVR?

Integrated Voice Response is available to claimants and policyholders for a wide variety of issues, including claim status, payment dates, amounts, reporting return-to-work and maternity delivery dates. Claimants and Policyholders always have the option to talk to a CSR or Benefit Specialist.

WHAT SOCIAL SECURITY ASSISTANCE IS PROVIDED?

We employ former Social Security Administration experts to assist claimants throughout the initial application and the appeal process. We will pay the cost of attorney fees for appeal representation. Additionally, claimants who sign our indemnity agreement and show evidence that they've applied for SSDI will receive full benefit until an award is received. Claimants not expected to qualify for Social Security are not required to go through the application process; in fact, these claims are often recommended as return-to-work or case management candidates.

WHAT ARE THE GUIDELINES FOR DURATION OF DISABILITY?

We use Medical Disability Advisor, published online by Presley Reed, the industry-leading program for determining disability duration. It incorporates diagnosis, age, and strength demand of the job and type of treatment, to establish an optimum return to work date. Duration guidelines serve as benchmarks or starting points, for determining what is reasonable; they are not rigid rules. Many claims are not "typical", and in such cases, we gather additional medical information to substantiate or refute additional days of disability beyond what the duration guidelines suggest.

HOW DO REGISTERED NURSES PARTICIPATE IN THE CASE MANAGEMENT PROCESS?

Our RN staff is an integral part of the claims team, and available to our Benefit Specialists for "walk-in" visits (short discussions regarding medical information), or more extensive formal medical reviews of entire files. They participate in Return-to-Work Roundtables and will call physicians to discuss detailed medical information. Our RN's are experienced in a variety of specialties, including mental health issues.

IN THE EVENT OF COMPLICATED OR CONFLICTING MEDICAL INFORMATION WHO MAKES THE CLAIM DETERMINATION, AND WHAT IS THE PROCESS?

Your assigned Benefit Specialist retains ultimate decision-making authority for claims. However, the Benefit Specialist has a wide array of resources available to assist in making the best decision possible. We have an R.N. team with various specialties available for "walk-in" medical reviews, or more formal written medical reviews. These RNs may also contact a physician to discuss or clarify medical information. Other resources include Peer Reviews (an independent specialist reviews medical information in the claim file), Independent Medical Exams, and Functional Capacity Assessments -- where safe working tolerances are established based on the claimant's functional limitations. More complicated claims are typically reviewed by Senior Benefit Specialists and Managers in addition to reviews conducted by clinical staff.

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toll free (800) 423-2765
www.LincolnFinancial.com

LIFE CLAIM ADMINISTRATION GUIDELINES

GENERAL QUESTIONS

HOW DO I FILE A LIFE CLAIM?

As the Policyholder, you need to complete the Employer or Plan Administrator portion of the Life Claim Form (GLC-01253*).

- A certified death certificate must accompany all life claims. A copy of a certified death certificate can be accepted.
- If the death resulted from anything other than natural causes (e.g. accident, homicide), a copy of the official investigative report (e.g. police, accident, fire, FAA, OSHA) must accompany or follow the claim. AD&D benefits cannot be paid on any claim without an investigative report regarding the insured person's/dependent's death. If your group contract contains an alcohol/drug exclusion, a toxicology report will be required.
- Groups that are self-administered should include the enrollment form, copies of any beneficiary changes, absolute assignments or funeral assignments when submitting a claim.
- Depending on the claim situation, we may need to verify premium or salary verification in order to make payment.

WHAT IF THE PRIMARY BENEFICIARY HAS DIED?

If the Primary Beneficiary is no longer living, a certified death certificate must accompany the claim before payment can be made to the Contingent (secondary) Beneficiary. If the Contingent (secondary) Beneficiary is also deceased, a certified death certificate will also be required in order to pay certain relatives or the Estate.

IF THERE IS NO BENEFICIARY…

Payment may be made to certain relatives or the Insured Person's estate, as provided in the Policy.

IF PAYMENT IS TO BE MADE TO AN ESTATE…

Court documents of appointment must be forwarded to our company before payment can be made to the Estate. The documents of appointment must name the Personal Representative of the Estate (also called the Executor, Executrix, Administrator or other similar title) to whom benefits can be paid.

IF PAYMENT IS MADE TO A TRUST…

A copy of the Trust Document must be provided with the claim. Such documents must designate the Trustee to whom proceeds will be paid.

IF THE BENEFICIARY IS A MINOR CHILD…

According to state law, a minor lacks capacity to sign a binding release of an insurance contract. Only the lawfully appointed representative of a minor may give release for the payment to a minor. Life insurance benefits, therefore, cannot be paid to anyone who has not reached the age of majority. If guardianship documents are not secured, the proceeds will be held until the beneficiary reaches the age of majority,unless state statutes (e.g. the Uniform Gifts/Transfer to Minors Act) in the appropriate jurisdiction allow for other payment provisions to be used.

* This form is available on the Lincoln Financial Group Web site at www.LincolnFinancial.com. Choose Products & Performance/Group Insurance/ Group Insurance Forms.

CAN THE BENEFICIARY MAKE A FUNERAL HOME ASSIGNMENT?

Yes, the beneficiary can assign the proceeds to a funeral home.

- A funeral home assignment is the beneficiary assigning the policy benefits to a funeral home in order to cover funeral expenses.
- The form required is obtained from the funeral home.
- The form must be signed by all named beneficiaries. If only one beneficiary signs the form, proceeds will be deducted from the portion allotted for that beneficiary only.
- The form must indicate the amount of the benefit being assigned.
- The funeral home assignment cannot be:
  - Signed by a minor (to assign benefits, the beneficiary must be of legal age).
- Collateral assignments (we do not accept collateral assignments – use of life insurance as collateral).

WHAT IS *LIFEKEYS*℠?

LifeKeys is a service provided to all employees and their dependents covered by the Life/AD&D policy. These services include online access to information, resources and tools on a broad range of topics, including identity theft and online access to prepare a valid will and testament. This is offered at no cost to you or your employees.

To access the new online services, employees and their dependents can visit www.Lincoln4Benefits.com and select the *LifeKeys* services link. During the log in process, the Web ID is LifeKeys.

ARE THERE OTHER SERVICES OFFERED UNDER *LIFEKEYS* SERVICES?

The *LifeKeys* program includes services designed to help beneficiaries deal with difficult issues after the death of a loved one and for an Insured filing an Accelerated Death Benefit claim. The program includes grief, legal and financial services with unlimited phone sessions and a combined total of six in-person sessions or equivalent working time. In addition, unlimited phone access to a variety of resources including, but not limited to, memorial and funeral planning information, child/elder care referrals, and other resource information based on individual need.

To access *LifeKeys* service, the beneficiary or claimant can call 855-891-3684 or access the website at www.Lincoln4Benefits.com and select the *LifeKeys* services link. During the log in process, the Web ID is LifeKeys.

WHAT IS THE FILING LIMITATION FOR SUBMITTING A LIFE CLAIM?

Claim filing will be reviewed based on the contract wording.

WHAT IF A BENEFICIARY NEEDS A 712 FORM?

A 712 form can be sent on request. This is a government form required from some beneficiaries for income tax returns. The form includes the amount of money paid on a life claim without interest.

WHAT IS TRAVEL ASSISTANCE?

Your employee benefits package includes travel assistance as part of your group life insurance coverage. Travel assistance includes your immediate family members. When you travel 100 miles or more from home, services available to you include: lost luggage service; replacement assistance for lost or stolen travel documents; emergency funds transfer; emergency pet housing and return; medical, dental, vision, and pharmaceutical referrals; translation services; emergency medical evacuation and transportation; emergency security evacuation; and many more.

To utilize this service, please call our Travel Assistance provider, United Healthcare Global, at 1-800-527-0218.

WHAT IS THE ACCELERATED DEATH BENEFIT?

The Accelerated Death Benefit is also called the Living Benefit. This benefit allows advance payment of part (based on contract language) of the Insured Person's personal life insurance. It may be paid to a terminally ill insured person in a lump sum, once during his or her lifetime.

To qualify, the insured person must:

1. satisfy the actively at work requirement under the policy.
2. have a minimum amount of personal life insurance under the policy on the date the living benefit is paid
3. be insured under the policy on the date the living benefit is to be paid.
   (See your specific contract for details.)

HOW DOES THE INSURED PERSON APPLY FOR AN ACCELERATED DEATH BENEFIT?

The Insured Person (or his or her legal representative) must apply for the benefit by:

1. completing a Request for Living Benefit claim form.
2. providing satisfactory proof that the Insured Person is terminally ill, including a Physician's written statement indicating the approximate life expectancy.

For example, the amount may be withdrawn in $1,000 increments subject to minimums and maximums as defined in your contract.

1. A minimum of $50,000 or 25%, whichever is less.
2. A maximum of $250,000 or 75%, whichever is less.

Terminally ill means the Insured Person has a medical condition which is expected to result in death within 12 months, despite appropriate medical treatment.

HOW DO I FILE A DISMEMBERMENT CLAIM?

As the policyholder, you will need to complete the employer portion of the Dismemberment Claim form (GLC-01249*).

The insured person will need to:

- complete the employee portion of the claim form;
- have his/her physician complete the attending physician statement of the claim form;
- provide a copy of the accident report; and
- provide a copy of the toxicology report (if one was done)

POLICY QUESTIONS

WHAT IS EXTENSION OF DEATH BENEFIT?

The Extension of Death Benefit is commonly referred to as Waiver of Premium. This is a benefit allowing the employee/employer to forego premium payment on life insurance during a qualifying period of Permanent Total Disability. The employee is required to provide proof of continued total disability as required by our company. Please refer to your contract for the specific reason Waiver of Premium would terminate.

HOW DO WE APPLY FOR EXTENSION OF DEATH BENEFIT (WAIVER OF PREMIUM)?

For life waiver of premium, there is a specific form, which must be completed to make application for these benefits. This form is the Extension of Death Benefits form. The employee must be Totally Disabled as defined by the contract from any occupation for at least six months and be under the age 60 at the time of disability (see the specific contract for plan details as age and waiting period may vary).

IS LIFE WAIVER OFFERED WITH EVERY LIFE CONTRACT?

No. Not every Life contract includes Extension of Death Benefit.

IF WE HAVE LIFE AND LTD COVERAGE, DO WE HAVE TO FILE TWO CLAIMS?

No. As indicated in the "LINKS" section, if the employee supplies claim information for LTD benefits, then we will use that same information as an initial first step to begin the Life Extension of Death Benefit claim. It will not be necessary for the insured to file a separate claim form for the Extension of Death benefit.

Note: Acceptance of LTD or STD benefits does not guarantee acceptance under Life Waiver of premium.

IS THE DEFINITION OF TOTAL DISABILITY THE SAME BETWEEN LTD AND LIFE WAIVER?

No. The definition for Permanent Total Disability on the Extension of Death Benefit is an any occupation definition (requires the employee to be Totally Disabled from any occupation). LTD language generally requires the employee to be totally disabled from his/her own occupation initially for a period of time and then from any occupation at the change in definition.

* This form is available on the Lincoln Financial Group Web site at www.LincolnFinancial.com. Choose Products & Performance/Group Insurance/ Group Insurance Forms.

WHAT PREMIUM ARE YOU WAIVING?

Our standard contract provides waiver of premium for Life, Dependent Life and Optional Life. The AD&D contract premium cannot be waived. Under Voluntary, only the Life premium for employees may be waived. Please refer to your specific contract for verification.

HOW WILL MY PREMIUMS BE ADJUSTED?

For list billed groups, our administration area will be notified of the waiver and will make the adjustment to the bill.

For self billed groups, the plan administrator must make the adjustment upon receipt of the copy of the approval letter and use the effective date indicated on the correspondence. The employer should not make the adjustment until they are notified that the claim has been approved for waiver of premium.

DO I CONTINUE PAYING PREMIUM ON AN EMPLOYEE WHO HAS FILED FOR THE EXTENSION OF DEATH BENEFIT?

Yes, the employer should continue to pay the premium for the employee during the waiting period.

WHAT IS AN ABSOLUTE ASSIGNMENT?

An Absolute Assignment form is used for the purpose of changing ownership of a policy and must be signed by the current owner of the policy. The new owner will have the right to change the beneficiary designation. Ownership is usually transferred for tax purposes.

To request an Absolute Assignment form or if you have further questions, please contact a Client Management Representative at 1-800-423-2765 or visit our Web site at www.LincolnFinancial.com.

HOW DOES AN EMPLOYEE MAKE WRITTEN REQUEST FOR CONTINUED COVERAGE?

Your plan may include a Continuation of Coverage (Portability) provision. Please refer to your Policy to determine if your plan contains this provision. Continuation of Coverage is available if the insured ceases employment for reasons other than sickness, injury or retirement, and coverage had been inforce for at least 12 months. You may obtain a Continuation of Coverage form either by accessing our Web site at www.LincolnFinancial.com, in the Group Forms Section, or contacting a Client Service Representative at 1-800-423-2765.

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MINNESOTA LIFE CONTINUATION GUIDELINES

These guidelines will assist you in the administration of your group insurance program.
For assistance, please contact a Client Management Representative at *1-800-423-2765*.

If an Employer is located in Minnesota or in another state but has Minnesota Employees, the residents of Minnesota have to be offered the opportunity to continue their life coverage.

The only exceptions are if all of the following are true:

- The policyholder or certificate holder exists primarily for purposes other than to obtain insurance.
- The policyholder or certificate holder is not a Minnesota corporation and does not have its principal office in Minnesota.
- The policyholder or certificate holder covers fewer than 25 persons who are residents of Minnesota and the Minnesota residents represent less than 25% of all covered persons; and on request of the commissioner, the issuer files with the commissioner a copy of the policy and a copy of each form of certificate.

A Notice of Continuation Privilege form (GLA-01279*) needs to be completed within **60 days** from the date of termination or the date the Employee is notified of the continuation privilege. The form must be completed, signed, dated and submitted to our company. AD&D is not continued.

Mail the completed Notice of Continuation Privilege form to:

Lincoln Life & Annuity Company of New York
P.O. Box 2616, Omaha, NE 68103-2616

*This form is available through Lincoln Financial Group's Web site, at www.LincolnFinancial.com. Choose Products & Performance/ Group Insurance/Group Insurance Forms.

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LIFE CONVERSION PRIVILEGE GUIDELINES

These guidelines will assist you in the administration of your group insurance program.
For assistance, please contact a Client Management Representative at *1-800-423-2765*.

WHO IS ELIGIBLE TO PURCHASE A CONVERSION POLICY?

- All employees are eligible if all or part of the insured person's life insurance provided by their policy terminates because of:
    1. Insured person's termination of employment or membership in an eligible class;
    2. Reduction in amount of coverage due to age; change in class; or amendment of the policy; or
    3. Termination of the policy.

- A Conversion policy will also cover any dependents whose coverage was terminated or reduced due to one of the above events. In addition, a conversion policy will also be available to dependents who insurance is terminated or reduced due to:
    1. Death of the insured person, divorce or annulment; or
    2. Dependent child ceasing to be an eligible dependent.

WHAT IS THE CONVERSION POLICY?

- An individual life policy, known as a conversion policy, may be purchased from Lincoln Life & Annuity Company of New York without evidence of insurability. The first premium payment, made payable to Lincoln Life & Annuity Company of New York, must be submitted within 31 days after the life insurance is terminated. Any policy issued under the Conversion Privilege will:
    - ⇛ be for an amount not to exceed the amount of the life insurance which was terminated, or by which life insurance was reduced, less any replacement coverage.
    - ⇛ be on any form then issued by the Company at the age and amount for which application is made.
    - ⇛ be issued without disability or other supplement benefits.
    - ⇛ require premiums based on the class of risk to which the person belongs and the form and amount of the policy at his or her attained age.

WHAT IF THE INSURED JUST WANTS A QUOTE?

- The insured can call a Client Management Representative at **1-800-423-2765** and get it by giving the policy number, age, sex, amount requested and last day worked or termination date.

WHAT ARE THE NOTICE REQUIREMENTS TO THE INSURED?

- When the insured person's personal insurance terminates, written notice of the right to convert must be given personally to the insured person or mailed by your company to the insured person at his last known address. Please contact our office for a conversion form or obtain the form from our Web site – **www.LincolnFinancial.com**. Please check your specific contract for details.

WHAT HAPPENS IF NOTICE OF THE CONVERSION PRIVILEGE IS GIVEN LATE?

- An additional period in which to convert will be granted if this written notice is not given to the insured person at least fifteen (15) days before or after the termination or reduction of coverage. The 31-day conversion period will be extended as follows:
    1. If written notice is given more than 15 days, but less than 90 days after the termination or reduction, the conversion period will extend to the 45th day following the date of notice.
    2. If written notice is not given within 90 days after the termination or reduction, the conversion period will end of the 90th day following the termination or reduction.

HOW DO WE SEND IN THE APPLICATION FOR CONVERSION AND WHEN WILL IT BE EFFECTIVE?

- The form should be sent to the employee and upon completion mailed to:

Lincoln Life & Annuity Company of New York
Service Office Address:
P. O. Box 2616
Omaha, NE 68103-2616

- Information regarding the conversion will be sent to the applicant so premium can be determined and premium submitted. The coverage provided by a conversion policy issued will be effective on the later of:
  - ⇛ Its date of issue; or
  - ⇛ Thirty-one (31) days after the date on which the person's life insurance terminated.

WHAT IF SOMEONE DIES DURING THE CONVERSION PERIOD?

- Lincoln Life & Annuity Company of New York will pay a death benefit under the policy equal to the amount of the Life Insurance which could have been converted, provided:
  - ⇛ The person was entitled to purchase a conversion policy; and
  - ⇛ The person dies within the 31, 45 or 90-day conversion period as outlined in the policy.

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SHORT-TERM DISABILITY CLAIM ADMINISTRATION GUIDELINES

GENERAL QUESTIONS

HOW DO I FILE A CLAIM FOR DISABILITY?

Submit the STD Claim form (GLC-01363*). This form consists of the Employer's portion, the Employee's portion and the Physician's portion. All 3 pages must be submitted.

With the Group Protection On-line Services, administrators can administer Group and Voluntary employee benefits in real time. This includes submission of STD claims! To register for On-line Services, call Lincoln Financial Group at 1-800-423-2765 or visit our Web site at http://www.jpfic.com.

A claim may also be submitted through our One Call Claims service. This allows an employer to call Lincoln Financial Group to initiate a claim. The only other information that may be necessary when using our telephonic claim submission service is an Attending Physician's Statement. Our Telephonic Benefit Specialists can be reached at 1-866-STD CALL (1-866-783-2255).

WILL YOU ACCEPT A FAX CLAIM FORM? DO YOU NEED THE ORIGINAL? WHAT IS THE FAX NUMBER?

Yes. You may fax claim forms to our office at 877-843-3950. We do not need the original.

DO ALL QUESTIONS REGARDING OTHER INCOME NEED TO BE ANSWERED?

Yes. To avoid a delay in the processing of a claim, all questions on the claim form should be fully answered, including a signed authorization.

HOW SOON CAN I EXPECT TO HEAR SOMETHING REGARDING THE CLAIM FILED FOR SHORT TERM DISABILITY BENEFITS?

Within 5 working days after the Claims Department receives a claim, they will review the claim and make an initial decision. This initial decision will either approve benefits and issue a check to the claimant, pend the claim for additional information, or deny the claim if the claim is not eligible for payment.

IF ADDITIONAL INFORMATION IS REQUESTED, HOW MUCH LONGER WILL IT TAKE TO REVIEW A CLAIM?

Periodically, information may be needed from the Attending Physician, Employer or Claimant. Since we are waiting on information from an outside source, the decision time will depend on when the information is submitted. Once the requested documentation is submitted, the Claims Department will review the information within 5 working days.

WHY IS ADDITIONAL INFORMATION NEEDED PRIOR TO CLAIM APPROVAL?

To be eligible for benefits a person must be found to be totally disabled according to our contract. Objective documentation such as office and treatment records may be required to support the inability to perform one's occupation.

WHAT ARE OFFICE AND TREATMENT RECORDS?

Office and treatment records are the records a physician creates following each visit. They include test results and x-rays. These are considered to be objective information.

IF MY DOCTOR INDICATES ON THE CLAIM FORM I AM TOTALLY DISABLED, AM I GUARANTEED BENEFITS?

No. The medical documentation submitted must support the contract definition of totally disabled. Total disability means the employee is unable to perform the material duties of his/her occupation. Supporting documentation, including office and treatment notes, must be submitted to support the statement.

ARE BENEFITS GUARANTEED ONCE A CLAIM IS FILED?

No. Each claim must be reviewed to determine if it is payable. Benefits are paid based on evidence submitted that support a total disability status and not simply just on a physician's opinion.

WHAT ARE NATIONAL DURATION GUIDELINES?

A set of guidelines followed by the disability staff to help outline the length of disability for a specific diagnosis or procedure. Several factors are taken into account when applying the guidelines such as occupation, age, and variability with a diagnosis.

ARE BENEFITS PAYABLE ON A MATERNITY CLAIM?

Benefits are considered for up to 6 weeks after the delivery of a child, subject to the elimination period. Benefits may be approved prior to delivery if documentation is submitted which supports a total disability status. Pregnancy in itself is not disabling until after delivery. It may be necessary for additional documentation to be submitted and reviewed to determine if benefits are payable prior to delivery.

MY EMPLOYEE'S SALARY HAS CHANGED AND THE CHECK DOES NOT REFLECT THIS. HOW CAN I GET THIS CORRECTED?

If the claim was incurred prior to the date of increase, the increase would not be reflected in the benefit. If the increase was effective prior to the date of disability and meets contract requirements for reporting salary increase, you must provide the amount and date of the increase and pay back premium on the increased amount.

After receipt of the premium for the increased amount, the adjustment to the benefit will be made, and any retroactive benefits due would be paid to the employee.

HOW DO I PROVIDE YOU WITH PART TIME EARNINGS FOR THIS EMPLOYEE WHO IS CURRENTLY RECEIVING DISABILITY BENEFITS?

You must submit information indicating the number of hours the employee works each day & the rate of pay. This may be provided on a weekly or monthly basis. You may also provide this on your own form or in the form of a letter along with copies of payroll records. The partial benefit cannot be calculated or paid until this information is submitted.

WHERE ARE DISABILITY CHECKS MAILED?

Unless otherwise indicated, all claim checks are mailed directly to the employee's home.

HOW OFTEN ARE SHORT-TERM DISABILITY BENEFIT CHECKS ISSUED?

Our standard procedure is to issue Short-Term Disability checks every other week.

HOW DO I NOTIFY YOU OF A RETURN TO WORK?

We prefer to take this information over the phone as we could expedite the final payment. The group may also provide a **Return to Work Notification** or the employee may provide a doctor's release form. If the information is being given over the phone, the following information is required regarding the return to work:

- Date the employee returned to work?
- Did the employee return to the same occupation?
- Did the employee return to work full or part time?

WHAT IS REQUIRED TO APPEAL A DENIED CLAIM?

In most instances a written appeal must be received within 180 days from the date of denial to reconsider a denied claim. A written response will be completed within 45 days advising the claimant if additional information is needed or if a decision has been reached.

Send a written appeal to:

Risk Services - Employee Care Center
Lincoln Life & Annuity Company of New York
P. O. Box 2337
Omaha, Nebraska 68103

Risk Services fax number (402) 361-1460

The letter should indicate the reason the claim should be reconsidered. If the denial was due to a waiting period or effective date issue, proof will be required to support employee position such as enrollment form or copies of payroll deductions.

For disability, employee should also provide any additional information to support the appeal.
Examples are:

- Medical records
- Test results
- Payroll records

POLICY QUESTIONS

WHAT IS AN ELIMINATION PERIOD?
An Elimination Period is a time period in which benefits are not payable but the employee must satisfy before becoming eligible for benefits.

CAN WE PROVIDE SALARY CONTINUANCE TO OUR EMPLOYEE DURING THE ELIMINATION PERIOD?
Yes. The employees may receive salary continuance during the elimination period.

WHAT IS SALARY CONTINUANCE?
Any money paid by the employer to the employee excluding vacation time or any money earned by the employee.

ARE WE ABLE TO PROVIDE ADDITIONAL MONIES TO OUR EMPLOYEE TO MAKE UP THE DIFFERENCE BETWEEN THE STD BENEFIT AND THEIR NORMAL SALARY?
No. Since salary continuance is an exclusion under the Standard Short-Term Disability Contract, any monies deemed as salary continuance provided to that employee would make them ineligible for benefits.

WHAT IS PARTIAL DISABILITY?
Partial Disability provides benefits to an employee who returns to work on a part-time basis. The Partial Language States: The amount of the Weekly Partial Disability Benefit equals the lesser of:

(1) The Insured Person's Basic Weekly Earnings multiplied by the benefit percentage (limited to the Maximum Weekly Benefit); or
(2) The Insured Person's Basic Weekly earnings minus earnings received from any form of employment for that period of disability.

The Benefit Percentage, Maximum Weekly Benefit and Definition of Basic Weekly Earnings are shown in the Schedule of Benefits.

Example 1:
Pre-Disability Earnings $300.00 Benefit Percentage 60%
Maximum $150.00 Part-time Earnings $220.00
1. $300.00 X .60 = $180.00
2. $300.00 - $220.00 = $80.00
The lesser is #2, $80.00. This is the amount the claimant would receive.

Example 2:
Pre-Disability Earnings $200.00 Benefit Percentage 66 2/3%
Maximum $90.00 Part-time Earnings $150.00
1. $200.00 x .6667 = 133.34 (MAXIMUM IS $90.00) = $90.00
2. $200 - 150.00 = $50.00
The lesser is #2, $50.00. This is the amount the claimant would receive.

OUR POLICY HAS A PRE-EXISTING CONDITION CLAUSE. HOW IS THIS APPLIED? WHAT DOES THIS MEAN?
This provision stipulates that disabilities caused by, or contributed to, a pre-existing condition are excluded from coverage under the contract unless certain conditions have been met. A pre-existing condition applies to a sickness or injury from which the employee received medical treatment, consultation, care or services including diagnostic measures or prescribed drugs or medicines during a specific period of time prior to the employee's effective date.

If a Pre-Existing provision is included in your policy, an investigation based on the Pre-Existing language will be conducted, if applicable.

Example: A 12/12 pre-existing clause means that any disabling condition which the Insured received treatment during the 12 months immediately prior to the effective date of coverage is excluded. Once the Insured has been covered for 12 months the pre-existing clause no longer applies.

WHAT IS PRIOR INSURANCE CREDIT?

The intent of the prior insurance credit provision is that employees covered under a policy will not lose coverage due to a change in carriers. Prior insurance credit applies two of the more traditional contract provisions: The Active at Work Requirement and the pre-existing Condition Exclusion.

In order to provide prior insurance credit, Lincoln Life & Annuity Company of New York must have a copy of the prior carrier's contract, certificate of insurance or plan booklet. If prior insurance credit is a state mandated regulation, a copy of the prior contract, etc., **must** be received before issuing the policy.

ARE WORK RELATED DISABILITIES COVERED?

The standard contract excludes any work-related conditions. A claim filed for any condition, which is work-related, would, therefore, be denied. If the employee's Worker's Compensation claim is denied, the employee will need to provide a copy of the Worker's Compensation denial in order for Lincoln Life & Annuity Company of New York to reconsider the claim.

DOES LINCOLN FINANCIAL GROUP INTEGRATE WITH STATE DISABILITY PLANS?

Yes, in California, Hawaii, New Jersey, New York, Puerto Rico and Rhode Island, most employers are required to provide state-mandated disability income coverage (the state TDI plan) for both full-time and part-time employees. The amount received through the State plan would be deducted from the claimant's benefit.

* This form is available on the Lincoln Financial Group Web site at www.LincolnFinancial.com. Choose Products & Performance/Group Insurance/Group Insurance Forms.

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ADMINISTRATION GUIDELINES FOR TAX INFORMATION

Please be aware that Lincoln Life & Annuity Company of New York is not a tax advisor and the following information is only to assist you with some general tax questions. Any specific or detailed questions should be addressed with your own tax consultant. Thank you.

CAN YOU EXPLAIN TAXABILITY OF DISABILITY BENEFITS (OR) THIRD PARTY SICK PAY?

TAXABILITY OF DISABILITY BENEFITS (OR) THIRD PARTY SICK PAY

Short-Term and Long-Term disability benefits may or may not be considered taxable income. The taxability of these benefits is determined by who pays the premium and how the premium is paid. Following are a few examples of when a disability benefit may or may not be considered as taxable income:

• The Employer pays 100% of the cost of the Premium	100% Taxable Benefit
• The Employer pays 50% of the cost of the premium and the Employee pays the remainder of the premium on a post-tax basis.	50% Taxable Benefit
• The Employer pays 50% of the cost of the premium and the Employee pays the remainder of the premium on a pre-tax basis.	100% Taxable Benefit
• The Employee pays the entire cost of the premium on a pre-tax basis.	100% Taxable Benefit
• The Employee pays the entire cost of the premium on a post-tax basis.	0% Taxable Benefit

As you will note, if the Employee pays any portion of the premium on a post-tax basis, this portion of the benefit is not taxable and if any portion of the premium is paid on a pre-tax basis, this portion of the benefit is taxable. Pre-tax contributions are deemed to be "Employer contributions" and, therefore, result in taxable benefits.

ALL disability payments, regardless of their taxability must be reported to the government on a W-2. If the disability benefit is taxable, this amount should be recorded in box 1 under wages, tips, and other compensation. If the disability benefit is non-taxable, this amount should be recorded on the W-2 in box 12A, with a code J. Box 13 should be checked as Third Party Sick Pay.

THE EFFECTS OF A TAXABLE DISABILITY BENEFIT

When a disability benefit is considered taxable, these benefits may become subject to additional withholdings. These withholdings include FICA (Social Security and Medicare tax), and FIT (Federal Income Tax). FICA & FIT are based upon the amount of the disability benefit that is actually taxable. For example, if only 50% of the disability payment is taxable, then FICA & FIT only apply to that portion of the benefit. FIT is only withheld upon election of the claimant. Example is as follows:

EXAMPLES

1. The Employer pays 50% of the premium & the Employee pays the remainder of the premium on a post-tax basis = 50% taxable benefit. Example is as follows:

The disability benefit is $250.00. $250.00 @ 50%= $125.00 should be reported as taxable income and FICA & FIT only apply to this portion of the payment. FICA amount = $9.56 ($125.00 x 7.65% = $9.56). The FIT amount will vary dependent upon the employee's whole dollar election, but only $125.00 is taxable.

Lincoln Life & Annuity Company of New York is required by law to withhold FICA for the first six months of any applicable disability period on "taxable" amounts. FICA tax is required to be withheld until the first of the month following six (6) full calendar months of disability, provided that our payment is made within the six-month period.

Example is as follows:

2. Disability date is 1/15/— - 1st of the month following is 2/1/— (+) 6 months = 8/1/—. For any payments made before 8/1/—, FICA applies. For any payments made on or after 8/1/—, FICA does not apply.

The current FICA rate is 7.65%. (6.20% = Social Security Tax 1.45% = Medicare Tax). The FICA rate is subject to change annually.

Federal Income Tax withholding is voluntary rather than mandated by Federal law. The Long-Term disability claim form allows the employee to elect the amount to be withheld when they initially file the claim. However, if they elect to change their FIT withholding at a later date, a form W4-S should be provided. This form can be obtained from their local post office. The Short-Term Disability claim form does not allow an option for FIT withholding; therefore, the employee must provide their request in writing.

GENERAL 'FICA' QUESTIONS

CAN WE REQUEST LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK TO MATCH THE EMPLOYER PORTION OF THE FICA FOR OUR EMPLOYEES?

For Long-Term Disability (LTD) coverage, Lincoln Life & Annuity Company of New York automatically includes our FICA match service.

For Short-Term Disability (STD) coverage, the employer has the option to retain responsibility for matching FICA, or request Lincoln Life & Annuity Company of New York match FICA. FICA Match service for STD will result in an additional cost, and must be part of or added to the policy.

HOW DOES LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK REPORT ALL WITHHOLDINGS (I.E., FICA & FIT)?

All FICA & FIT withheld on disability payments is sent through the Federal Reserve System. This is sent in one lump sum, at least twice weekly, under Lincoln Life & Annuity Company of New York's applicable Employer Identification Number.

CAN YOU REQUEST MONTHLY OR ANNUAL FICA REPORTS?

Yes. LTD & STD FICA reports may be obtained by accessing the Lincoln Life & Annuity Company of New York Web site (www.JPFIC.com), through IVR or calling Client Services at 1-800-423-2765.

WHAT PROCEDURES SHOULD BE FOLLOWED IF THE EMPLOYER HAS NOT MATCHED FICA?

This question should be answered by your tax advisor. Unless FICA Match service is requested for STD, our Company has only withheld and submitted the Employee's portion of FICA as reflected in the reports provided to your office.

DOES EVERYONE GET A FICA REPORT?

No. Only groups that had employees on disability in that month and STD groups that do not have the FICA Match service, will receive the monthly report. Every group will receive a report at the end of the year if disability benefits have been paid.

LTD groups do not receive a monthly FICA report, however, Lincoln Life & Annuity Company of New York will provide a yearly report of all claims paid.

WHEN ARE THE DISABILITY FICA REPORTS SENT?

The monthly FICA reports are sent the first full week following the 1st of the month. Annual statements are sent in the first two weeks following the end of the year.

WHO IS RESPONSIBLE FOR THE FEDERAL AND APPLICABLE STATE UNEMPLOYMENT TAX FOR DISABILITY PAYMENTS?

The employer will be responsible for FUTA and SUTA taxes on both Short-Term and Long-Term disability payments, if applicable. Please refer to IRS Publication 15-A, under the section regarding Sick Pay Reporting, for details on instances in which the payments may be exempt from FUTA.

GENERAL 'W-2' QUESTIONS

WILL LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK GENERATE W-2'S?

Lincoln Life & Annuity Company of New York will generate and report W-2's for all LTD groups who have claims.

For all STD Groups that have opted for the FICA Match service, W-2's will be provided and reported. For STD Groups that have elected to retain responsibility for matching FICA, a W-2 "printing" service may be requested. With the "printing" service, your W-2's are printed under your company's name and Tax ID number.

IF THE EMPLOYEE IS NO LONGER EMPLOYED WITH THE EMPLOYER GROUP, WHAT ARE THE TAX REPORTING REQUIREMENTS? IF THE EMPLOYER GROUP IS TERMINATED WITH LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK, WHO REPORTS W-2 / FICA TO THE GOVERNMENT?

If the employer group is terminated with Lincoln Life & Annuity Company of New York, the W-2 / FICA reporting obligations still remains the same.

IF THE BENEFIT PROVIDED BY LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK IS NON-TAXABLE, IS A W-2 REQUIRED?

Yes. A W-2 is still required and should be reported as Third Party Sick Pay.

IS THE EMPLOYER REQUIRED TO ISSUE A SEPARATE W-2 FOR THIRD PARTY SICK PAY?

No. The employer can either include the Third Party Sick Pay with the taxable wages received during active employment with the employer, or they may choose to issue a separate W-2.

WHOSE TAX ID NUMBER IS LISTED ON THE W-2?

We will use the Lincoln Life & Annuity Company of New York Tax ID number for all generated LTD claims W-2's and STD W-2's if Lincoln Life & Annuity Company of New York is providing the FICA match service. If you have requested that Lincoln Life & Annuity Company of New York print your W-2's without the FICA match service, your company's tax identification will be used.

WHY DOES LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK WITHHOLD FICA FROM DISABILITY CHECKS?

Federal law requires withholding of FICA from Third Party Sick Pay on the percentage of benefit attributed to the premium paid for by the employer or with pre-tax employee dollars.

GENERAL 'FORM 941' QUESTIONS

Please refer to IRS Publication 15-A - Employer's Supplemental Tax Guide, the section on Sick Pay Reporting.

GENERAL "1099" QUESTIONS

DOES LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK ISSUE 1099'S?

1099's are not issued for Third Party Sick Pay. Third Party Sick Pay must be reported on Form W-2.

WILL A BENEFICIARY RECEIVE A 1099-INT FROM LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK AT THE END OF THE YEAR?

Any interest received from a life claim that is over $600.00 will be considered income and they will receive a 1099-INT.

GENERAL "FEDERAL AND STATE TAX" QUESTIONS

WHOSE TAX ID NUMBER DOES LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK USE IN REPORTING THE FICA & FIT WITHHELD FROM DISABILITY PAYMENTS WHEN FILING OUR 941?

Lincoln Life & Annuity Company of New York will report FICA & FIT withheld under Lincoln Life & Annuity Company of New York applicable EIN.

DOES THE EMPLOYER REPORT FIT WITHHOLDINGS THAT LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK MADE?

No, other than the FIT amount should be included on any applicable NON-FICA Matched STD W-2 prepared by the employer. Lincoln Life & Annuity Company of New York will report the FIT amount on their 941 and no further reporting is required by the Employer.

IF THE DISABILITY BENEFITS ARE TAXABLE, WOULD FEDERAL & STATE TAXES STILL APPLY AFTER THE 6-MONTH FICA RULE?

Yes, Federal, as well as any applicable state income taxes, are still applicable for the duration of the claim.

CAN LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK WITHHOLD FEDERAL & STATE TAXES?

Lincoln Life & Annuity Company of New York will withhold Federal taxes per the claimant's request. There is a minimum of $88.00 per month that must be withheld in Federal Income Tax (FIT) if the employee is requesting this be withheld. Under most state income tax regulations regarding Third Party Sick Pay, we do not have an obligation or the capability to withhold state income taxes at this time.

Lincoln Financial Group®

Lincoln Life & Annuity Company of New York
Service Office Address: PO Box 2616, Omaha, NE 68103-2616
Home Office: Syracuse, NY
toll free (800) 423-2765
www.LincolnFinancial.com

ADMINISTRATION GUIDELINES FOR "LINKS" INTEGRATED DISABILITY CLAIMS MANAGEMENT

WHAT IS "LINKS"?

LINKS provides early intervention with the disabled insured to ensure a smooth transition from Short-Term Disability to Long-Term Disability without claim filing, while assisting the employee to return to work in the most efficient and effective manner possible. In addition, if the employee has life insurance coverage as well, this program will coordinate disability coverage with Life Waiver coverage to ensure there is no protection loss.

HOW IS A CLAIM MANAGED?

The LINKS program is a team approach to claims management. A team of Disability Benefit Specialists work closely together with a Certified Case Manager (R.N.) to provide a "three point contact" with the employee, employer and treating physician. The ultimate goal is for either a successful return to work or to establish a smooth transition into LTD without a delay in benefit payments.

HOW DOES THE PROGRAM WORK?

Our Integrated Claim Representatives work closely together to continually manage the claim and monitor the progress of the disability to the benefit of the employer and employee. LINKS blends technology with the personal touch.

DOES MY EMPLOYEE HAVE TO FILE A CLAIM FORM FOR EACH PRODUCT?

No. Part of the effectiveness of the LINKS program is to offer true integration without the need for duplicate form completion. Only the Links Disability Claim Form (GLC-01418) needs to be completed. Limited additional information may be necessary at the time the claim is being considered for LTD benefits.

WHAT HAPPENS IF WE HAVE LTD AND LIFE INSURANCE AND I ONLY FILE A LTD CLAIM BUT NOT A LIFE WAIVER CLAIM?

We understand that when you lose an employee to a disability, there is a lot of paper work to be completed. To eliminate some of that hassle, we will ensure that the information received from the LTD claim is provided to the Life Claims area so we can make a determination on eligibility without the need for the completion of another claim form.

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Lincoln Life & Annuity Company of New York
Service Office Address: PO Box 2616, Omaha, NE 68103-2616
Home Office: Syracuse, NY
toll free (800) 423-2765
www.LincolnFinancial.com

LONG-TERM DISABILITY CLAIM ADMINISTRATION GUIDELINES

GENERAL QUESTIONS

HOW DO I FILE A CLAIM? WHAT DO I NEED TO SUBMIT?

Submit the LTD Claim Form (GLC-01252*). The LTD Claim Form includes the Employer's portion which includes a Physical Requirements Form, Employee's portion, Physician's portion, Educational Background Form & Authorization. The LTD Claim Form requests the employee's job description will be provided as well.

With the Group Protection On-line Services, administrators can administer Group and Voluntary employee benefits in real time. This includes submission of LTD claims! To register for On-line Services, call Lincoln Financial Group at 1-800-423-2765 or visit our Web site at http://www.jpfic.com.

WHEN IS THE BEST TIME TO SUBMIT A LTD CLAIM?

We suggest that the claim is submitted at least 45-60 days prior to the end of the elimination period to ensure a decision is made before the first payment is due (if the claim is payable).

HOW SOON CAN I EXPECT TO HEAR SOMETHING REGARDING THE CLAIM FILED FOR LONG TERM DISABILITY BENEFITS?

Within 4 working days after the complete claim is received, it will be reviewed and an initial decision will be made. This initial decision will either approve benefits and issue a check, pend the claim for additional information or deny the claim if the claim is not eligible for payment. An initial phone call to the employee and employer will be made during this same time.

WHEN ARE THE INITIAL DISABILITY CHECKS MAILED?

The initial payment is usually made when a decision is rendered on a claim, when appropriate. If the period for payment has passed, payment is released to a current date. After meeting the elimination period, LTD payments are made in arrears which means they are paid at the end of the period for which they are due.

> For Example: If the elimination period is from 09/01/— to 10/01/—, payment is made for the period from 10/1/— to 11/1/—. This payment will usually be sent out by mail approximately 7 days prior to November 1. If the payment is sent out via direct deposit it will usually be send out approximately 3 days prior to November 1.

Payment will not be made beyond the date the physician has released the employee, without supporting documentation. Therefore, if a claim is submitted indicating a release date prior to the current date, payment will not be made beyond that date.

CAN YOU SEND THE CHECK DIRECTLY TO MY EMPLOYEE?

Normally, the checks are sent directly to the employee, unless otherwise requested in writing by the group policyholder.

HOW DID YOU FIGURE MY EMPLOYEE'S BENEFIT?

The contract dictates the % of benefit. The benefit amount or % is indicated in the Schedule of Benefits page in the contract. The benefit is calculated by multiplying the pre-disability income of the employee times this %. Some contracts provide for a flat benefit amount which the employee is entitled to receive. The policy also contains a minimum and maximum amount available under the contract.

Some common reasons for differences in amount paid versus amount expected on disability claims are:

- Unreported salary increase
- Payment period
- Taxes
- Integration of other income

WHAT IS INTEGRATION OF OTHER INCOME?

Our contracts allow for integration of other income the employee receives due to the disability. This means that the benefit amount will be reduced by the income received up to the minimum benefit. Some examples of other income are:

- Social Security (both employee and family)
- Short-term disability
- Workers' compensation
- State disability benefits
- Qualified Employer Retirement Plan

MY EMPLOYEE'S SALARY HAS CHANGED AND THE CHECK DOES NOT REFLECT THIS. HOW CAN I GET THIS CORRECTED?

If the claim was incurred prior to the date of increase, the increase would not be reflected in the benefit. If the increase was effective prior to the date of disability and meets contract requirements for reporting salary increase, you must provide the amount and date of the increase and pay back premium on the increased amount.

After receipt of the premium for the increased amount, the adjustment to the benefit will be made, and any retroactive benefits due would be paid to the employee.

HOW DO I PROVIDE YOU WITH PART TIME EARNINGS FOR THIS EMPLOYEE WHO IS CURRENTLY RECEIVING DISABILITY BENEFITS?

You must submit information indicating the number of hours the employee works each day & the rate of pay. This may be provided on a weekly or monthly basis. You may also provide this on your own form or in the form of a letter along with copies of payroll records. The partial benefit cannot be calculated or paid until this information is submitted.

HOW DO I APPLY FOR WAIVER OF PREMIUM FOR DISABILITY?

For Long Term Disability waiver of premium is automatic when the claim is approved provided the disability extends beyond the period required to qualify. The employee & employer will receive a notification from the claims area indicating, "Your waiver of premium is effective _____." The waiver effective date is the first of the month following the LTD benefit commencement date.

HOW WILL MY PREMIUMS BE ADJUSTED FOR WAIVER OF PREMIUM?

For list billed groups, the waiver will automatically be adjusted on the bill. *For self billed groups*, the plan administrator must make the adjustment upon receipt of the copy of the approval letter and use the effective date indicated on the correspondence. The employer should not make the adjustment until they are notified that the claim has been approved for waiver of premium.

HOW DO I NOTIFY YOU OF A RETURN TO WORK?

We prefer to take this information over the phone as we could expedite the final payment. The group may also provide a **Return to Work Notification** or the employee may provide a doctor's release form. If the information is being given over the phone, the following information is required regarding the return to work:

- Date the employee returned to work?
- Did the employee return to the same occupation?
- Did the employee return to work full or part time?

HOW LONG DO YOU PAY BENEFITS FOR MATERNITY LEAVE?

The usual and customary benefit consideration period is six weeks from the date of delivery for either a vaginal delivery or a c-section. The elimination period (if applicable) will be taken into account for this period. For a complication which may cause disability prior to or following the six weeks, the employee must provide objective medical information, such as office and treatment notes, to support continued disability. **Benefits will not be paid beyond the date the doctor released the patient, if that date is sooner.**

WHAT IS REQUIRED TO APPEAL A DENIED CLAIM?

In most instances a written appeal must be received within 180 days from the date of denial to reconsider a denied claim. A written response will be completed within 45 days advising the claimant if additional information is needed or if a decision has been reached.

Send a written appeal to:

Risk Services - Employee Care Center
Lincoln Life & Annuity Company of New York
P. O. Box 2337
Omaha, Nebraska 68103

Risk Services fax number (402) 361-1460

The letter should indicate the reason the claim should be reconsidered. If the denial was due to a waiting period or effective date issue, proof will be required to support employee position such as enrollment form or copies of payroll deductions.

For disability, employee should also provide any additional information to support the appeal.
Examples are:

- Medical records
- Test results
- Payroll records

POLICY QUESTIONS

WHAT IS A WAITING PERIOD?

The eligibility waiting period is a specified period of time an employee must be actively at work before being eligible for insurance, and is a standard contract feature.

For example, assuming a 30-day eligibility waiting period, an employee who starts work on 9/15/— would be covered under the LTD plan effective 10/15/—. (See your contract for the specific waiting period.)

WHAT IS ACCUMULATION OF THE ELIMINATION PERIOD?

The elimination period is the time during which the employee is disabled before benefits become payable. Accumulation of elimination period wording allows for the temporary recovery during the elimination period and is designed to reward an insured employee's attempt to return to work.

The standard accumulation of elimination period wording under your contract is two times the elimination period. It ensures that disabled employees are not penalized for trying to go back to work during the elimination period. The days the employee is not disabled will not count toward satisfying the elimination period. The days an employee is not disabled may be consecutive or intermittent. All or part of the elimination period can be completed while working if the insured employee is considered disabled under the terms of our contract during the period of work activity.

CAN YOU EXPLAIN "ZERO DAY" RESIDUAL? DOES IT APPLY TO LONG-TERM DISABILITY?

Our standard type of disability is residual, or "zero day" residual as it is sometimes called in the industry. For Long-Term Disability this means that the employee may be partially disabled during the elimination period and still may be eligible for benefits once the elimination period is satisfied. No period of total disability is required.

WHAT IS A PRE-EXISTING CONDITION EXCLUSION?

This provision stipulates that disabilities caused by, or contributed to, a pre-existing condition are excluded from coverage under the contract unless certain conditions have been met. A pre-existing condition applies to a sickness or injury from which the employee received medical treatment, consultation, care or services including diagnostic measures or prescribed drugs or medicines during a specific period of time prior to the employee's effective date.

If a Pre-Existing provision is included in your policy, an investigation based on the Pre-Existing language will be conducted, if applicable.

> Example: A 3/12 pre-existing clause means that any disabling condition which the Insured received treatment during the 3 months immediately prior to the effective date of coverage is excluded. Once the Insured has been covered for 12 months the pre-existing clause no longer applies.

WHAT IS PRIOR INSURANCE CREDIT?

The intent of the prior insurance credit provision is that employees covered under a policy will not lose coverage due to a change in carriers. Prior insurance credit applies two of the more traditional contract provisions: The Active at Work Requirement and the pre-existing Condition Exclusion.

In order to provide prior insurance credit, Lincoln Life & Annuity Company of New York must have a copy of the prior carrier's contract, certificate of insurance or plan booklet. If prior insurance credit is a state mandated regulation, a copy of the prior contract, etc., **must** be received before issuing the policy.

HOW IS A RECURRENT DISABILITY HANDLED?

The employee who has attempted to return to work **(FULL-TIME)** for six months or less will be considered the same claim, **PROVIDED** it is for the same disabling condition as the first period of disability. An employee who has returned to work for more than six months must file a new claim and meet another elimination period. If the employee returns to work and becomes disabled with a new disabling condition, this will be handled as a new claim.

HOW DOES THE PARTIAL DISABILITY PROVISION WORK?

Partial disability or partially disabled means as a result of sickness or injury which caused disability, the insured employee is:

1. Able to perform one or more, but not all of the main duties of his or her own occupation or any occupation on a full-time or a part-time basis; or
2. Able to perform all of the main duties of his or her own occupation or any other occupation, but only on a part-time basis.

If earnings are less than 20%, the insured employee usually will be considered totally disabled.

After 24 months of partial disability benefit payments (the Return to Work Incentive period), an earnings test is applied. Our partial disability benefit will cease if the employee is earning over **85%** (or **60%** depending on the coverage purchased) of pre-disability earnings.

Progressive is our standard method of calculating partial disability benefits, and it is the best in the industry! It provides a better benefit than the proportionate loss or 50% offset methods because a disabled employee may be eligible to receive up to 100% of his or her pre-disability earnings in total income from all sources (Social Security and all other income sources). The progressive approach is also a more simplified calculation than the proportionate loss method.

Under the progressive method of calculating partial disability benefits, the benefit payable will be the lessor of:

1. The scheduled benefit percentage multiplied by the insured employee's Pre-disability earnings less other income benefits (excluding partial earnings).
2. One hundred percent of the insured employee's pre-disability earnings less other income benefits, including earnings from partial employment.
3. The scheduled benefit maximum.

Partial disability benefits are payable to the end of the benefit duration: until the disabled employee's current earnings exceed 85% (or 60%) of pre-disability earnings; until death; or until recovery.

Example:

Assumptions:

Pre-disability Earnings:	$5,000
Benefit Percentage:	60%
Maximum Monthly Benefit:	$5,000
Partial Employment Earnings:	$2,200
Income from Other Sources:	$0

Progressive:

The partial disability benefit payable is the lesser of:

A) 60% Of Pre-Disability Earnings:	$5,000
Less Other Income Benefits:	x 60%
	$3,000
B) Pre-Disability Earnings:	$5,000
Less Partial Employment Earnings and Other Income Benefits:	-$2,200
	$2,800
C) Maximum Monthly Benefit:	$5,000
Partial Disability Benefit Payable:	**$2,800**

IF A CLAIMANT IS BEING PAID A DISABILITY BENEFIT, AND HAS A COURT ORDER FOR GARNISHMENT, WILL WE HONOR THIS GARNISHMENT?

Yes. We will accept a written request from the employer with a copy of the court order for garnishment of disability benefits. We will also accept a copy of the court order if it is sent directly from the court or from any other entity. The request must be made in writing and submitted to the benefit specialist handling the claim.

WHAT IS THE DIFFERENCE BETWEEN LTD MAXIMUM BENEFIT PERIODS SSNRA AND RBD?

Reducing Benefit Duration:
This approach provides a graded benefit period for disabilities commencing on or after age 60. Also referred to as "To Age 65" or ADEA Option 1, RBD is one of the most common maximum benefit periods. ***The RBD schedule reads as follows:***

Age at Disability	**Maximum Benefit Period**
Less than age 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Social Security Normal Retirement Age Duration Schedule:
The SSNRA benefit period schedule is usually used with the RBD schedule by including a simple statement incorporating the Social Security normal retirement age. The employee will be eligible for the greater of the two benefit periods. ***The SSNRA schedule reads as follows:***

Year of Birth	**Maximum Benefit Period**
Before 1938	age 65
1938	age 65 and 2 months
1939	age 65 and 4 months
1940	age 65 and 6 months
1941	age 65 and 8 months
1942	age 65 and 10 months
1943 through 1954	age 66
1955	age 66 and 2 months
1956	age 66 and 4 months
1957	age 66 and 6 months
1958	age 66 and 8 months
1959	age 66 and 10 months
After 1959	age 67

ARE WORK RELATED DISABILITIES COVERED?

Yes, however, our standard contract integrates with Workers' Compensation benefits. An example of integration: If the employee's benefit is $1,000 per month and he/she receives $300 per month from Workers' Compensation, we will deduct the $300 from the $1,000 for a net benefit of $700.

THE EMPLOYEE WAS RECEIVING DISABILITY BENEFITS AND NOW HAS DIED. WHAT INFORMATION DO YOU NEED TO PROCESS THE FINAL BENEFIT?

Upon notification of a death, the survivor benefit will be typically paid to the surviving spouse or child/children less than 25 years of age when benefits have been paid and the disability has lasted greater than 180 days.

* This form is available, in fillable format on the Lincoln Financial Group Web site at www.LincolnFinancial.com. Choose Products & Performance/Group Insurance/Group Insurance Forms.

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Lincoln Life & Annuity Company of New York
Service Office Address: PO Box 2616, Omaha, NE 68103-2616
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toll free (800) 423-2765
www.LincolnFinancial.com

ADMINISTRATION GUIDELINES FOR REHABILITATION SERVICES

GENERAL QUESTIONS

WHAT IS YOUR REHABILITATION PROGRAM, INCLUDING THE CRITERIA USED IN DETERMINING POTENTIAL REHABILITATION CANDIDATES?

Rehabilitation candidates are selected by using criteria that indicates that the person will benefit from Rehabilitation Services.

This criteria includes:

- Motivated and interested in rehabilitation services;
- In need of retraining or hands on assistance;
- Physical condition is stable and would not prevent work in other occupations;
- Liability over the life of the claim outweighs cost of services (if person is at a minimum monthly benefit it would be too costly to provide rehabilitation services).

When providing rehabilitation, we contract with local independent agencies. We are able to provide at our cost, Professional Masters prepared Vocational Counselors and Registered Nurse Case Managers to assist the claimant in returning to their own employment work site or seek alternative employment work sites. These professionals are all certified and experienced in the management of Long-Term and Short-Term disability cases. A Rehab example is as follows:

A truck driver has a back condition and is unable to return to work in his own profession. He is paid benefits for the period he is recovering until his condition is stabilized and released to return to employment by his physician with lifting restrictions that will not allow him to return to his own occupation. Rehabilitation services were initiated. A Vocational Counselor met with him over a few months. She spoke with the physician, claimant, tested the claimant, explored the community resources, assisted with writing the resume, practiced the job interview and facilitated the job search. The claimant was placed in a full time job where he is very satisfied. LTD claim closed.

HOW DO YOU WORK WITH THE EMPLOYER OR ADMINISTRATOR AND TREATING PHYSICIAN TO FACILITATE AN EMPLOYEE'S EARLY RETURN TO WORK? DOES YOUR PLAN INCLUDE PAYMENT OF PARTIAL BENEFITS FOR EMPLOYEES RETURNING TO WORK PART-TIME?

Contact is made with the employer to communicate a release to return to work and the restrictions that have been assigned by the physician. We have on staff Registered Nurse Case Managers and Vocational Coordinators who coordinate "Return to Work" efforts between the claimant, employer and the physician.

Our company does have excellent partial benefits available to facilitate a return to work. Accommodation funds are also available if the claimant should need special equipment or accommodation. Contact is made with the employer to communicate a release to return to work and the restrictions that have been assigned by the physician.

DO YOU USE OUTSIDE VENDORS FOR REHABILITATION SERVICES? IF SO, HOW ARE THEY SELECTED? HOW ARE THEIR CHARGES BILLED?

We are able to provide this service at our cost and are billed directly by the rehabilitation service. Vendors are selected by contacting nation wide companies who are experienced in this business and also through local contacts that have performed excellent high quality services in the past.

WHAT RESOURCES WOULD BE USED IN MANAGING LTD CLAIMS WITH REHABILITATION?

Coordination with state Department of Vocational Rehabilitation offices, local employment offices, national level resources and networks and other employment related agencies are utilized.

WHAT ARE THE RESPONSIBILITIES OF YOUR MEDICAL DEPARTMENT IN MANAGING AN INTEGRATED DISABILITY PROGRAM?

All STD claims and many new claims are reviewed by the Registered Nurse and many new claims are reviewed by a Registered Nurse and options regarding case direction are identified. This provides immediate assessment for Rehabilitation, Social Security Assistance, early back to work efforts and identifying questionable claims that are inconsistent with meeting contract provisions and national guideline standards. Cases are referred out for Physician Review when warranted.

DO YOU USE DISABILITY DURATION GUIDELINES TO MANAGE DISABILITY CLAIMS? IF SO, HOW ARE THEY DEVELOPED, UPDATED AND USED IN THE CLAIMS MANAGEMENT PROCESS?

We use The Medical Disability Advisor by Presley Reed, M.D. We also refer to Governmental guidelines through the Agency for Health Care Policy and Research (AHCPR), we also use the AMA Guide to the Evaluation of Permanent Impairment and various other guides and expert research criteria also certified.

WHAT IS YOUR CREDENTIALING PROCESS FOR DISABILITY MANAGEMENT PHYSICIANS?

All physicians performing Independent Medical Evaluations and file reviews are board certified in their specialty areas. We utilize a network of IME providers and appointment services that have screened their associated physicians and maintain applications and background information in their files regarding credentials and other pertinent information.

Lincoln Financial Group®

EMPLOYEECONNECT℠ SERVICES

Lincoln Financial Group long-term disability coverage includes *EmployeeConnect* program at no additional cost. Your employees and their dependents automatically have access to our *EmployeeConnect* services. This includes practical help for life's challenges, no matter what the issue. *EmployeeConnect* services are available 24 hours a day, seven days a week, 365 days a year, for support, guidance, and resources.

***EmployeeConnect* Services Include:**

- **Assistance for employees and his/her dependents**
- **In-person sessions for short-term problem resolution**
- **24 x 7 x 365 telephone and Web access**
- **Unlimited telephonic support with an attorney for legal information and referrals to a network attorney when requested, one free 30 minute consultation and a 25% discount for ongoing legal representation.**
- **Unlimited telephonic support with a financial expert and referrals to a network specialist when requested.**
- **Unlimited telephonic support for work life services including resource information on topics such as:**
  - **Child / Elder care search**
  - **Wedding planning**
  - **Vacation planning**
  - **Parenting and childcare**
  - **Wellness and weight management**

You can obtain a pdf of the *EmployeeConnect* flier by visiting www.Lincoln4Benefits.com under Forms, then clicking on the Administrative link.

If you have purchased the *EmployeeConnect* Plus program, employer kits, including brochures, promotional material and a program guide will be provided to you. The *EmployeeConnect* Plus program includes the services listed above as well as management support, crisis response, reporting and consultation. For further information regarding this program contact your Lincoln representative.

Lincoln Life & Annuity Company of New York
Service Office Address: PO Box 2616, Omaha, NE 68103-2616
Home Office: Syracuse, NY
toll free (800) 423-2765
www.LincolnFinancial.com

DENTAL CLAIM ADMINISTRATION GUIDELINES

GENERAL QUESTIONS

HOW DO I FILE A CLAIM?

1) Complete the patient & subscriber sections of the Dental Claim Form in full. An incomplete form may cause delay in the processing of the claims for benefits.
2) Have the dentist complete the remaining portions of the Dental Claim Form or attach the dentist's itemized billing statement to this claim form.
3) Sign the authorization section of the claim form.
4) Send the completed forms and bills to our Dental Claims Input Center. (Address listed below)
5) Claims should be submitted within 90 days from the date of services and no later than 1 year from such time.

WHEN CAN I EXPECT TO RECEIVE DOCUMENTATION REGARDING THE HANDLING OF MY DENTAL CLAIM?

Our standard turnaround time is 6 working days after the claim is received. The employee and dentist will be notified if the claim has been paid, denied or if additional information is needed to process the claim.

WHEN THE CLAIM IS PAID, DOES THE BENEFIT CHECK GO TO THE EMPLOYEE OR THE DENTIST?

If the employee has assigned benefits, the payment is made to the dentist. If not, the employee will receive the benefit check.

WHERE DO I SUBMIT MY CLAIM?

Dental claims can be directed to:

Lincoln Life & Annuity Company of New York
Dental Claims Input Center
P.O. Box 2640
Omaha, NE 68103-2640

Claims can be sent electronically or can be faxed to 877-843-3945
Claim inquiries: 1-800-423-2765

DO I HAVE ACCESS TO DENTAL HEALTH INFORMATION?

Lincoln DentalConnect[SM] is an online information tool that is automatically added to your group Dental plan. You are required to have Dental coverage to enter the Web site. Simply log on to www.jpfic.com and select "My Benefits". Under the "Coverages" section click the *Lincoln DentalConnect* hyperlink and you will be connected to the site.

WHAT ARE BENEFIT WAITING PERIODS AND HOW DO THEY AFFECT MY EMPLOYEES?

A benefit waiting period is a period of time a person must be covered by the plan before certain dental procedures are covered. This time period can vary from 3 to 24 months depending upon the policy provisions. Time covered by the employer's prior policy may be applied toward the benefit waiting period.

WHAT IS PRIOR CARRIER CREDIT?

To ensure continuity of coverage for plan participants during a change in carriers, Lincoln Financial Group offers 'prior insurance credit' for employees and dependents who were covered by the prior carrier's policy on its termination date. Except in Florida, Idaho and New Jersey, the employer's dental plan must have been inforce with the prior insurance company for at least 12 months in order to qualify for this credit.

The Prior Carrier Credit Provision provides covered persons with 'credit' toward:

- covered charges applied to the prior policy's deductible during the same calendar year.
- benefit waiting periods, if included in this policy, for each covered person's continuous months of coverage under the prior policy just before it terminated. (The 'credit' applies only if the prior policy included the type(s) of coverage that are subject to the new policy's benefit waiting periods.)

The provision also extends coverage for replacement of natural teeth lost while covered under the prior policy and allows Lincoln Financial Group to deduct previously paid benefits from participants' annual and lifetime maximums.

WHEN SHOULD A PRE-DETERMINATION OF BENEFITS BE REQUESTED?

If your employee or their dentist anticipates the cost of treatment for dental expense will exceed $300.00, a pre-determination is recommended. This allows the employee and dentist to find out before the work is done how the charges will be covered by the plan.

WHAT IS THE ALTERNATE BENEFIT PROVISION?

When there are two or more methods of treating a dental condition the amount of covered expense will be based on the charge for the least costly procedure that Lincoln Financial Group determines to be appropriate and adequate. This determination is based on current professional dental standards.

WHAT IS REQUIRED TO APPEAL A DENIED CLAIM?

In most instances a written appeal must be received within 180 days from the date of denial to reconsider a denied claim and must be submitted by the employee or dentist.

Send a written appeal to: **Lincoln Life & Annuity Company of New York**
Dental Appeals
P.O. Box 2337
Omaha, NE 68103-2337

The appeal letter should indicate the reason the claim should be reconsidered and include:

- Employee's & patient's name
- Employee's social security number
- Dentist's name
- Date(s) of service
- Supporting documentation, i.e., x-rays, narrative, charting, when appropriate

WHAT IF AN EMPLOYEE LOSES HIS/HER DENTAL INSURANCE ID CARD?

If an employee loses his/her dental insurance ID card, contact our Client Management area at **1-800-423-2765** and a new card will be issued.

WHERE DO I GO FOR PREMIUM, BILLING OR CERTIFICATE QUESTIONS?

All questions about premium, billing and certificates can be directed to:

Lincoln Life & Annuity Company of New York
P.O. Box 2616
Omaha, NE 68103-2616
1-800-423-2765

PPO DENTIST DIRECTORIES - ON LINE

1. Log on to www.LincolnFinancial.com
2. Select **Find a Dentist**, listed under **Quick Links located on the right side of the screen**.
3. From the navigation menu in the left column, click on **Provider Directory**.
4. Click on the **Create a Provider Directory** link (password protected) to access the directory information.

The **Dental Provider Directory** section provides a directory that can be personalized to meet the needs of each individual group. A user ID and password are required to access the directory. The user ID and password are only to be used by authorized Lincoln Financial Group representatives, licensed brokers, and group administrators. The user ID and password are not designed, and should not be distributed or published, for the general public.

User ID: lincoln (case sensitive)

Password: 4ppolist (case sensitive)

Once logged in, you can view (and print) a directory by:

- METROPOLITAN AREA - Select a state and the metropolitan area within the state.
- COUNTY - Select a state and up to four counties within the state.
- Three-digit ZIP CODE - You can display up to three Zip codes per directory.

If your search does not locate the dentist you prefer, you can nominate your dentist.

- On the "Find A Network Dentist" results page, click on the **Nomination a Dentist** link located at the top right hand corner.
- Complete the form online. The information will be automatically sent to Lincoln Financial.
- You may also complete the form, print it and mail it to:
  Lincoln Financial Group
  8801 Indian Hills Drive
  Omaha, NE 68114

If you have questions, please contact Lincoln Financial customer service at (800) 423-2765.

Lincoln Financial Group®

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COBRA GUIDELINES

These guidelines will assist you in the administration of your group dental insurance program with Lincoln Life & Annuity Company of New York. These COBRA guidelines do not apply to any other coverages.
For assistance, please contact a Client Management Representative at *1-800-423-2765*.

HOW DOES AN EMPLOYEE APPLY FOR COBRA?

- The Employee needs to complete the Dental COBRA Election Form (GLA-01359*) within **60 days** of the date of termination or qualifying event. The form **must be** completed, signed, dated and submitted to our company by the Employer.
- Fax all completed COBRA forms to: **1-877-573-6177**
  Or mail the completed COBRA form to: **Lincoln Life & Annuity Company of New York**
  Service Office Address: P. O. Box 2616, Omaha, NE 68103-2616
- **Do not** mail COBRA forms with your premium payment.
- **Do not** mail the originals if you have faxed in COBRA forms.
- **Note:** Incomplete forms may be returned, therefore causing a delay in processing.

WHAT IS CONSIDERED A "QUALIFYING EVENT" AS IT APPLIES TO A COVERED EMPLOYEE?

- A Qualifying event for a Covered Employee is one of the following events that would otherwise result in a loss of coverage:
  - ⇛ The Covered Employee's termination of employment;
  - ⇛ The Covered Employee's hours reductions; or
  - ⇛ The Covered Employee's retirement.

WHAT IS CONSIDERED A "QUALIFYING EVENT" AS IT APPLIES TO A COVERED DEPENDENT?

- A Qualifying event for a Covered Employee is one of the following events that would otherwise result in a loss of coverage:
  - ⇛ The Covered Employee's termination of employment, retirement or hours reduction.
  - ⇛ The Covered Employee's death, divorce or legal separation.
  - ⇛ The Covered Employee becomes entitled to Medicare benefits.
  - ⇛ A child ceasing to be an eligible dependent, under the terms of the policy.

WHO IS CONSIDERED A QUALIFIED BENEFICIARY?

- A Qualified Beneficiary, who can be either the Employee or dependent and who is **covered at the time of the event**, can make the election to continue coverage when a Qualifying Event occurs.
- A Qualified Beneficiary would also be a dependent child born to or adopted by one of the original Qualified Beneficiaries during the COBRA continuation.
- An insured person's new spouse, stepchild or foster child acquired during the continuation period **is not** considered a Qualified Beneficiary.
- A notice delivered in person to the Employee or as payroll mailer is considered adequate notice to the Employee and any children in the Employee's custody.
- A separate notice is to be sent to spouse's or adult child's last known address.
- Domestic Partners - for dental policies that include Domestic Partner coverage:
  - ⇛ COBRA is not mandated for domestic partners. Therefore, a domestic partner cannot be a Qualified Beneficiary.
  - ⇛ The terminating employee can continue dental coverage for himself or herself. If the employee elects COBRA, on an extracontractual basis, Lincoln Finanical Group will allow the employee to cover the Domestic Partner in the same manner as a spouse, for the duration of the continuation period, if the Domestic Partner was covered by the dental policy on the day the employee's coverage would have ended. The domestic partner does not have any of the continuation rights usually given to a Qualified Beneficiary during or after the continuation period.
  - ⇛ If the employee acquires a Domestic Partner during the COBRA continuation period, the Domestic Partner can be added to the employee's COBRA coverage, but only for the remainder of the employee's continued coverage.
  - ⇛ The employee may add the Domestic Partner to his or her coverage during the annual enrollment period, if included in the policy, in the same manner as an active employee would be able to. The COBRA continuation for the employee and the extracontractual continuation for the Domestic Partner would terminate at the end of the employee's continuation period.

- Children of Domestic Partners - for dental policies that include Domestic Partner coverage.
    - ⇛ If a child of a Domestic Partner is covered by the dental plan as an eligible dependent on the date the employee's coverage terminates, because of his/her dependent status, he or she should be treated as a Qualified Beneficiary, with the rights given to Qualified Beneficiaries by COBRA.
    - ⇛ If the child of a Domestic Partner is covered by the dental plan as an eligible dependent on the date he/ she reach the plan's maximum age or other Qualifying Event, he or she should be treated as a Qualified Beneficiary.

WHEN SHOULD AN EMPLOYER GIVE NOTICE TO THEIR EMPLOYEES?

- If an Employer sends a COBRA notice by the date insurance ends, a Qualified Beneficiary has an election period of 60 days after the date coverage under the plan is lost.
- If an Employer does not give COBRA notice by the date insurance ends, then election deadline is extended to the **60th day** after notice is sent.
- The Employee has 60 days to notify the Employer of a divorce, legal separation, or child's ceasing to be eligible (due to marriage, leaving school, accepting employment, entering military, etc.).
- If the Employer never sends COBRA notice, a Qualified Beneficiary could be entitled to enroll and submit claims 18 to 36 months retroactively, provided:
    - ⇛ The Employer knew of the qualifying event such as the Employee's death, termination of employment, Medicare eligibility or
    - ⇛ The Employer was notified within 60 days of a divorce, legal separation or child's ceasing to be eligible.

MUST A QUALIFIED BENEFICIARY GIVE THE EMPLOYER OR INSURER ANY NOTICE?

- A Qualified Beneficiary must notify the Employer within **60 days** after:
    - ⇛ the date of a divorce; legal separation; or a child's ceasing to be an eligible dependent, as defined under the policy; or
    - ⇛ the date coverage would end as a result of one of these events.
- A Qualified Beneficiary must notify the Employer within **60 days** of the Social Security Administrations' finding that a Covered Employee or Covered Dependent was disabled within 60 days after the Covered Employee's termination of employment.
- To continue Dental Insurance, the Covered Employee or Covered Dependent must notify the Employer of such election no later than 60 days from:
    - ⇛ the date of the Qualifying Event; or
    - ⇛ the date coverage would otherwise end due to the Qualifying Event; or
    - ⇛ the date the Employer sends notice of the right to continue.

WHAT IS THE MAXIMUM ADMINISTRATIVE FEE THAT AN EMPLOYER MAY CHARGE AN EMPLOYEE FOR THE ADMINISTRATION OF COBRA?

- The maximum administrative fee that an Employer can charge an Employee for the administration of COBRA is 2%.

WHEN DOES COBRA COVERAGE TERMINATE?

- The contract states that "continued coverage will end on the earliest of the following dates":
    - ⇛ The end of the maximum benefit period of continued coverage.
    - ⇛ The date on which the Employer ceases to provide any group dental plan to any Employee.
    - ⇛ If the Employee or dependent fails to make a premium payment when due; the last day of the period of coverage for which payments have been paid.
    - ⇛ The date on which the Insured Person or dependent becomes covered under any other group dental plan or becomes eligible for benefits under Medicare.

WHAT HAPPENS WHEN A COVERED EMPLOYEE IS ENTITLED TO MEDICARE?

- If the Covered Employee's eligibility ends due to a Qualifying Event and he or she becomes entitled to Medicare after electing COBRA continuation coverage, then coverage may not be continued for the Covered Employee but coverage may be continued for any Covered Dependents for up to:
    - ⇛ 36 months from the date of the first Qualifying Event.
- If the Covered Employee's eligibility under the policy continues beyond Medicare entitlement, but later ends due to a Qualifying Event, any Covered Dependents may continue coverage for up to:
    - ⇛ 36 months from the Covered Employee's Medicare entitlement date, or
    - ⇛ 18 months from the date the first qualifying Event (whichever is later).

  Coverage may not be continued beyond 36 months from the date of the first Qualifying Event.

CAN A MEMBER ADD DEPENDENTS TO THE COBRA COVERAGE, THAT WERE NOT ORIGINALLY COVERED BY THIS MEMBER BEFORE GOING ON COBRA?

- According to COBRA laws, the same rights provided to active Employees must be provide to members on COBRA. There are two exceptions to this:
  - ⇛ The same late entrant limitations apply to "later added" dependents if they are added outside the 31 day eligibility period.
  - ⇛ A dependent added after the COBRA coverage has begun does not have the right to continue coverage on their own if they lose those benefits under the member.
- Any other dependents acquired during the COBRA continuation can be added as dependents, but they do not have their own "COBRA rights."
- If an "employee-qualified beneficiary" marries during the continuation period and adds his spouse to his COBRA coverage, then divorces during the continuation period, that spouse does not have any additional continuation rights.

IF APPLICABLE, HOW DOES AN EMPLOYEE APPLY FOR CAL-COBRA?

- The Employee completes the Cal-COBRA or Senior Cal-COBRA Dental Election Form (GLA-01547) to apply.
- Send the Employee one of the following:
  - ⇛ The Notice of Group Dental Continuation Rights Under Federal and California law (COBRA) and Cal-COBRA).
  - ⇛ The Notice of Group Dental Continuation Rights For Certain Retirees Under California Law (Senior Cal-COBRA).
- The Employer must complete a form to transfer the responsibility to provide COBRA to the Employee, to our company.

* This form is available on the Lincoln Financial Group Web Site, at www.LincolnFinancial.com. Choose Products & Performance/ Group Insurance/Group Insurance Forms.