Lincoln Financial Group®

Voluntary Life Insurance

SUMMARY OF BENEFITS

Sponsored by: **NYSARC, Inc. Nassau County Chapter**

Life Benefit	**Employee**	**Spouse**	**Dependent**
	Employee must elect coverage for Spouse or dependents to be eligible.		
Amount	Choice of $50,000 increments	Choice of $5,000 increments	Age 1 Day to 6 months: $1,000 6 months to age 20 (to age 25 if full-time student): $2,500
Minimum Amount	$50,000	$5,000	$2,500
Maximum Amount	$500,000, limited to 5 times your annual salary	$250,000, limited to 100% of employee amount	$2,500
Guarantee Issue for Newly Eligible Employee	$200,000	$45,000	

Benefit Reduction	**Employee**	**Spouse**
Benefits will reduce:	40% at age 76; Additional 20% of original amount at age 80; Additional 15% of original amount at age 85; Additional 10% of original amount at age 90; Additional 5% of original amount at age 95; Benefits terminate at retirement	Benefits terminate at Spouse Age 75

Eligibility	**Employee**	**Spouse and Dependents**
	All employees in an eligible class.	Cannot be in a period of limited activity on the day coverage takes effect.

Additional Benefits

See Definition:	Accelerated Death Benefit
See Definition:	Portability
See Definition:	Conversion

Definitions

Accelerated Death Benefit	Accelerated Death Benefit provides an option to withdraw a percentage of your life insurance coverage when diagnosed as terminally ill (as defined in the policy). The death benefit will be reduced by the amount withdrawn. To qualify, you have satisfied the Active Work rule and have been covered under this policy for the required amount of time as defined by the policy. Check with your tax advisor or attorney before exercising this option.
Conversion	If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination.
Guarantee Issue	For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance, and it will be provided at your own expense.
Limited Activity	A period when a Spouse or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex.
Portability	If coverage has been in force for at least 12 months, you may continue coverage for a specified period of time after your employment by paying the required premium. Portability is available if you cease employment for a reason other than total disability or retirement at Social Security Normal Retirement Age. A written application must be made within 31 days of your termination.
Term Life	Benefit provided to the designated beneficiary upon the death of the insured. The benefit is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product.
Exclusion: Suicide	Benefits will not be paid if the death results from suicide within 1 year after coverage is effective. May apply if employee contributes toward the premium.
Additional Benefits	
***LifeKeys*℠**	Online will & testament preparation service, identity theft resources and beneficiary assistance support for all employees and eligible dependents covered under the Group Term Life and/or AD&D policy.
***TravelConnect*℠**	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.

For assistance or additional information Contact Lincoln Financial Group at	
(800) 423-2765; reference ID: **AHRCNASSA**	www.LincolnFinancial.com

NOTE: This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

Monthly Employee Premium
Life Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.
Refer to Program Specifications for your maximum benefit amounts.
Benefits and premium amounts reflect age reductions.

Monthly RATE	AGE	$ 50,000	$ 100,000	$ 150,000	$ 200,000	$ 250,000	$ 300,000	$ 350,000	$ 400,000	$ 450,000	$ 500,000
0.0560	<25	$2.80	$5.60	$8.40	$11.20	$14.00	$16.80	$19.60	$22.40	$25.20	$28.00
0.0560	25-29	$2.80	$5.60	$8.40	$11.20	$14.00	$16.80	$19.60	$22.40	$25.20	$28.00
0.0560	30-34	$2.80	$5.60	$8.40	$11.20	$14.00	$16.80	$19.60	$22.40	$25.20	$28.00
0.0840	35-39	$4.20	$8.40	$12.60	$16.80	$21.00	$25.20	$29.40	$33.60	$37.80	$42.00
0.1410	40-44	$7.05	$14.10	$21.15	$28.20	$35.25	$42.30	$49.35	$56.40	$63.45	$70.50
0.2430	45-49	$12.15	$24.30	$36.45	$48.60	$60.75	$72.90	$85.05	$97.20	$109.35	$121.50
0.4060	50-54	$20.30	$40.60	$60.90	$81.20	$101.50	$121.80	$142.10	$162.40	$182.70	$203.00
0.7040	55-59	$35.20	$70.40	$105.60	$140.80	$176.00	$211.20	$246.40	$281.60	$316.80	$352.00
0.8270	60-64	$41.35	$82.70	$124.05	$165.40	$206.75	$248.10	$289.45	$330.80	$372.15	$413.50
1.2130	65-69	$27.99	$55.98	$83.97	$111.96	$139.95	$167.94	$195.93	$223.92	$251.91	$279.90
2.2150	70-75	$51.12	$102.23	$153.35	$204.46	$255.58	$306.69	$357.81	$408.92	$460.04	$511.15
2.2150	76-79	***$30,000***	***$60,000***	***$90,000***	***$120,000***	***$150,000***	***$180,000***	***$210,000***	***$240,000***	***$270,000***	***$300,000***
		$66.45	*$132.90*	*$199.35*	*$265.80*	*$332.25*	*$398.70*	*$465.15*	*$531.60*	*$598.05*	*$664.50*
2.2150	80-84	***$20,000***	***$40,000***	***$60,000***	***$80,000***	***$100,000***	***$120,000***	***$140,000***	***$160,000***	***$180,000***	***$200,000***
		$44.30	*$88.60*	*$132.90*	*$177.20*	*$221.50*	*$265.80*	*$310.10*	*$354.40*	*$398.70*	*$443.00*
2.2150	85-89	***$12,500***	***$25,000***	***$37,500***	***$50,000***	***$62,500***	***$75,000***	***$87,500***	***$100,000***	***$112,500***	***$125,000***
		$27.69	*$55.38*	*$83.06*	*$110.75*	*$138.44*	*$166.13*	*$193.81*	*$221.50*	*$249.19*	*$276.88*
2.2150	90-94	***$7,500***	***$15,000***	***$22,500***	***$30,000***	***$37,500***	***$45,000***	***$52,500***	***$60,000***	***$67,500***	***$75,000***
		$16.61	*$33.23*	*$49.84*	*$66.45*	*$83.06*	*$99.68*	*$116.29*	*$132.90*	*$149.51*	*$166.13*
2.2150	95+	***$5,000***	***$10,000***	***$15,000***	***$20,000***	***$25,000***	***$30,000***	***$35,000***	***$40,000***	***$45,000***	***$50,000***
		$11.08	*$22.15*	*$33.23*	*$44.30*	*$55.38*	*$66.45*	*$77.53*	*$88.60*	*$99.68*	*$110.75*

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

Dependent Children Benefit	$ 2,500
Monthly Rate:	$ 1.00

Premium covers all dependent children regardless of the number of children.

Monthly Spouse Premium
Life Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.
Spouse premiums will be calculated based on the Spouse Age
Refer to Program Specifications for your maximum benefit amounts.
Benefits and premium amounts reflect age reductions.

Monthly RATE	AGE	$ 5,000	$ 10,000	$ 15,000	$ 20,000	$ 25,000	$ 30,000	$ 35,000	$ 40,000	$ 45,000	$ 50,000
0.0560	<25	$0.28	$0.56	$0.84	$1.12	$1.40	$1.68	$1.96	$2.24	$2.52	$2.80
0.0560	25-29	$0.28	$0.56	$0.84	$1.12	$1.40	$1.68	$1.96	$2.24	$2.52	$2.80
0.0560	30-34	$0.28	$0.56	$0.84	$1.12	$1.40	$1.68	$1.96	$2.24	$2.52	$2.80
0.0840	35-39	$0.42	$0.84	$1.26	$1.68	$2.10	$2.52	$2.94	$3.36	$3.78	$4.20
0.1410	40-44	$0.71	$1.41	$2.12	$2.82	$3.53	$4.23	$4.94	$5.64	$6.35	$7.05
0.2430	45-49	$1.22	$2.43	$3.65	$4.86	$6.08	$7.29	$8.51	$9.72	$10.94	$12.15
0.4060	50-54	$2.03	$4.06	$6.09	$8.12	$10.15	$12.18	$14.21	$16.24	$18.27	$20.30
0.7040	55-59	$3.52	$7.04	$10.56	$14.08	$17.60	$21.12	$24.64	$28.16	$31.68	$35.20
0.8270	60-64	$4.14	$8.27	$12.41	$16.54	$20.68	$24.81	$28.95	$33.08	$37.22	$41.35
1.2130	65-69	$2.80	$5.60	$8.40	$11.20	$14.00	$16.79	$19.59	$22.39	$25.19	$27.99
2.2150	70-74	$5.11	$10.22	$15.33	$20.45	$25.56	$30.67	$35.78	$40.89	$46.00	$51.12

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

Example:
Use this formula to calculate premium for benefit amounts over $ 50,000

	Age	Monthly Rate Per $1,000	X	Benefit In $1,000's	=	Monthly Cost
Example:	35	0.0840	X	75	=	$ 6.30
			X		=	

Dependent Children Benefit $ 2,500
Monthly Rate: $ 1.00

Premium covers all dependent children regardless of the number of children.

LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK

Home Office: 100 Madison St., Ste 1860, Syracuse, NY 13202
All Group Insurance questions and correspondence send to:
Group Insurance Service Office
8801 Indian Hills Drive
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type

GROUP ID:	GROUP POLICY #:	Billing Division or Location:
AHRCNASSA	000010176704, 000010198175, 000400198174	☐ 1497726 - AHRC Nassau ☐ 1497944 - Brookville Center for Children's Service ☐ 1497945 - Advantage Care ☐ 1497946 - Citizens, Inc. ☐ 1497947 - AHRC Foundation

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) **NYSARC, Inc. Nassau County Chapter**			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single		Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly $_____	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage		

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

TYPE OF COVERAGE			AMOUNT OF COVERAGE	
Voluntary Employee Life Insurance	☐ Yes	☐ No*	$	$
Voluntary Spouse Life Insurance	☐ Yes	☐ No*	$	$
Voluntary Dependent Child Benefit	☐ Yes	☐ No*	$2,500	$

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

C. Beneficiary Information (Complete ONLY for Life/AD&D)

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

Accelerated Death Benefit Information: This benefit is included with your Life insurance, at no additional premium charge. The Death Benefit payable to your Beneficiary upon your death will be reduced by any Accelerated Death Benefits received plus an interest charge. Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs and may be taxable. For this reason, you should consult your personal tax advisor before claiming this benefit.

E. Request for Coverages

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

- ☐ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by Lincoln Life & Annuity Company of New York.** I hereby enroll for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
- ☐ **NOT ENROLL myself in the Program.** I understand that if I enroll for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
- ☐ **NOT ENROLL my dependents in the Program.** I understand that if I enroll for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

ACCIDENT & HEALTH INSURANCE FRAUD: Any person who knowingly and with intent to defraud any insurance company or other person:

(1) files an application for insurance or a statement of claim containing any materially false information; or

(2) conceals, for the purpose of misleading, information concerning any fact material thereto;

commits a fraudulent insurance act, which is a crime. Such person shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation.

THIS WARNING DOES NOT APPLY TO APPLICATION FOR LIFE INSURANCE.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of Lincoln Life & Annuity Company of New York, or its insurance partners, and the initial premium is paid to Lincoln Life & Annuity Company of New York. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect. **By signing below, you agree that all statements made above are to the best of your knowledge and belief.**

Employee Full Name:_____ Employee Signature:_____

Date:_____