ONLY AVAILABLE TO 30+ HOURS/WK EMPLOYEES

Lincoln Financial Group®

Voluntary Long-Term Disability Insurance

SUMMARY OF BENEFITS

Sponsored by: Town of Hadley

Long-term disability is intended to protect your income for a long duration after you have depleted short-term disability or any sick leave your company may offer.

Eligibility	All full-time active employees working 30 or more hours per week in an eligible class are eligible for coverage.
Maximum Monthly Benefit	50% of salary up to $6,000 per month
Maximum Benefit Duration	To Age 65/Reduced Benefit Duration
Own Occupation Period	24 Months
Elimination Period	90 days The number of days you must be disabled prior to collecting disability benefits.
Accumulation of Elimination Days	You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability. If you are working on a partial basis, you will have 2x the elimination period days to satisfy the total of 90 days.
Pre-Existing Condition	You may not be eligible for benefits if you have received treatment for a condition within the past 12 months until you have been covered under this plan for 24 months, or if you remain treatment free for a period of 12 consecutive months.
Enrollment (Newly Eligible)	You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again, or may be responsible for the cost of required examinations.
Waiver of Premium	You will not be required to pay premium during any time of approved total or partial disability.
Survivor Income Benefit	A survivor benefit may be paid to your beneficiary if you should die while receiving qualifying disability payments.
***EmployeeConnect*SM**	Access to an employee assistance program for the employee or an immediate household family member who may be experiencing personal or workplace issues.
Benefit Limitations	Mental Illness: 24 months Substance Abuse: No Limit Specified Illness: No Limit
Portability	If your employment is terminated for any reason other than retirement, disability, or a leave of absence, you can keep your current LTD coverage at the same rate for up to 12 months. Your current coverage must have been in force for at least 12 months.

(Please see other side)

Understanding Your Benefits

Own Occupation	The occupation trade or profession you were employed in prior to your disability as defined by the US DOL Dictionary of Occupational Titles.
Total Disability	You are considered totally disabled if, due to an injury or illness, you are unable to perform each of the main duties of your own occupation. Your "own" occupation is covered for a specific period of time. Following this, the definition of total disability becomes the inability to perform any occupation for which you are reasonably suited based on your experience, education, or training.
Partial Disability	You are considered partially disabled if you are unable, due to an injury or illness, to perform the main duties of your regular occupation on a full-time basis. Partial Disability benefits may be payable if you are earning at least 20% of the income you earned prior to becoming disabled, but not more than 99%. Partial disability benefits allow you to work and earn income from your employer as well as continue to receive benefits, which may enable you to receive 100% of your income during your time of disability.
Continuation of Disability	If you return to work full-time but become disabled from the same disability within 6 months of returning to work, you will begin receiving benefits again immediately.
Benefit Duration Reduction	Your benefit duration may be reduced if you become disabled after age 65.
Pre-Existing Condition	Any sickness or injury for which you have received medical treatment, consultation, care, or services (including diagnostic measures or the taking of prescribed medications) during the specified months prior to the coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for the specified months following the coverage effective date, unless no treatment was received for the specified consecutive months after the coverage effective date.
Benefit Exclusions	You will not receive benefits in the following circumstances: • Your disability is the result of a self-inflicted injury. • You are not under the regular care of a doctor when requesting disability benefits. • You were involved in a felony commission, act of war, or participation in a riot. • You were residing outside of the United States or Canada for more than 12 consecutive months for purposes other than employment with your Employer.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources: • Any compulsory benefit act or law (such as state disability plans); • Any governmental retirement system earned as a result of working for the current policyholder; • Any disability or retirement benefit received under a retirement plan; • Any Social Security, or similar plan or act, benefits; • Earnings the insured earns or receives from any form of employment; • Workers compensation; • Salary continuance or employer contributions to an employer sponsored retirement plan.
Benefit Termination	This coverage will terminate when you terminate employment with this policyholder, or at your retirement.

For assistance or additional information
Contact Lincoln Financial Group at (800) 423-2765 or log on to www.LincolnFinancial.com

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

Lincoln Financial Group℠

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ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: **TOFHADLEY**	GROUP POLICY #: 000400003002-01043	Billing Division or Location: 190913

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) **Town of Hadley**			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)

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

TYPE OF COVERAGE	AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Long Term Disability ☐Yes ☐No*	**Monthly Benefit Amount $**_____	$

*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. Request for Coverages

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

- ☐ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby 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.

NOTE: A PERSON MAY BE COMMITING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name:_____ Employee Signature:_____ Date:_____

Monthly Premium Calculation

		Example: Sample Employee, Age 35
List your monthly earnings (*Maximum covered payroll is $12,000 Monthly)	$ _____	$2,500
Multiply by your premium factor (see table below)	_____	0.003000
Your Estimated Monthly Premium**	$ _____	$7.50

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

Attained Age	Premium Factors
<30	0.001600
30 – 34	0.002000
35 – 39	0.003000
40 – 44	0.004200
45 – 49	0.007600
50 – 54	0.010100
55 – 59	0.013900
60 – 64	0.012500
65 – 69	0.007600
70 – 74	0.004900
75 – 99	0.005300