Dergalis ASSOCIATES

Group Enrollment Processing

In order to ensure proper processing of your applications, please read the following instructions carefully.

1) Once you have selected the plan(s) in which you wish to enroll, print and complete the corresponding application(s).

2) Make sure you have signed and completed the application(s) in their entirety. Check them for any errors or missing information.

3) Review, complete and sign the **Automatic Deduction Agreement** form.

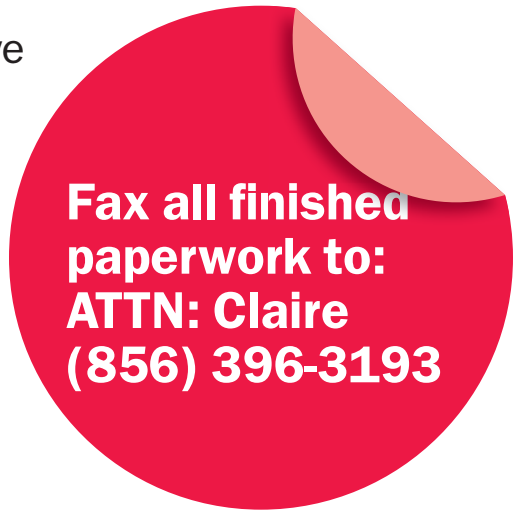
4) Make a **photocopy** of your **voided check** for the account from which you would like the premium deduction to take place and include it with your forms. Remember, all bank account deductions will take place on the 1st business day of each month. If we are unable to draft your account on this day, you may be subject to fees as outlined in the Automatic Deduction Agreement.

5) **Fax** your application with the Automatic Deduction Agreement and the voided check to the Insurance Department fax number shown below. **We MUST have all applications by the posted due date or coverage cannot become effective!**

Please call us with any questions you have during the enrollment process.

Claire Rightler
Benefits Administrator

P: (888) 564-0300, toll free
P: (856) 751-2691, direct
F: (856) 396-3193
E: claire@agentbenefits.net



Dergalis ASSOCIATES

Frequently Asked Questions

Q: Must I take all of the benefits?

A: No, each benefit can be purchased individually.

Q: Will I get another opportunity to enroll if I decline to take coverage now?

A: Once a year, the Group Dental and Vision plans will have an Open Enrollment period. However, the Group Disability and Life Insurance will NEVER be offered again on a Guaranteed-Issue basis. While you can apply at a later date, limited medical underwriting will be required and the carrier will have the right to decline you coverage based on the results.

Q: I currently have other coverage for Dental and Vision. If I lose that coverage, could I participate in your program?

A: Yes, you will have the opportunity to enroll in the Dental or Vision plan within 30 days of a qualifying life event such as birth, death, divorce or loss of coverage. For more information on what constitutes a qualifying life event, please contact our office.

Q: Is the Automatic Deduction from my checking account the only way to pay?

A: Please contact our office at (888) 564-0300 for more information. Additionally, you can use a savings account as long as you provide a deposit slip imprinted with your name, bank account number and bank routing number. Please note, we are not set up for individual billing and cannot accept a check as payment.

Q: When and how will I receive confirmation of my coverage?

A: You should receive an email from our office within three weeks. Please make sure to check your junk mail folder if you haven't received the email.

Q: What if I have an emergency before I receive proof of coverage?

A: In the event of an emergency situation, you should contact Claire Rightler at (888) 564-0300. Claire will help you in the transition period.

Q: Why am I not receiving email communication from Claire?

A: Claire's email address (claire@agentbenefits.net) may be filtered out by some e-mail providers as "SPAM". Please ensure to update your email address and communication preferences.

Life Insurance Information

Coverage Underwritten by Lincoln Financial Group, 8801 Indian Hills Drive, Omaha, NE 68114

Voluntary Life Insurance

Sales Associate

- Excellent opportunity to purchase group term life insurance.
- You Choose The Protection You Want!
- $5,000 increments up to $250,000
- $100,000 Guarantee Issue for Realtors under age 60
- $10,000 Guarantee Issue for Realtors age 60-64
  $6500 Guarantee Issue for Realtors age 65-69
- No Guarantee Issue for Realtors age 70 and over – maximum coverage is $50,000. Subject to Evidence of Insurability and underwriting requirements

Your Benefits Will Reduce

- 35% upon the attainment of age 65
- An additional 15% of the original amount at age 70
- An additional 20% of the original amount at age 75
- Benefits will terminate upon retirement

Spouse Benefit Amount

- You choose the protection you want!
- $2,500 increments up to a maximum of $50,000
- $25,000 Guarantee Issue for a spouse up to realtor's age 59!
- No Guarantee Issue for spouses age 60 and over.
- Agent must elect coverage in order for your spouse to be eligible
- Subject to a maximum of 50% of the agent's elected life benefit

Your Spouse's Benefit Will Reduce

- 35% upon the attainment of the Realtor's age 65
- Benefits will terminate at Realtor's age 70

Dependent Children Benefit Amount

- You must elect coverage for yourself in order to be eligible for this benefit.
- You Choose: $5,000 or $10,000 for children age 6 months to 19 years (up to 25 years if unmarried and a full-time student)
- $250 for children age 14 days to 6 months; newborn children to age 14 days are not eligible for a benefit

Other Benefits Include

- Waiver of Premium
- Accelerated Death Benefit
- Portable after 12 months
- Conversion

Program Eligibility

All Sales Associates. You must be a licensed Real Estate Sales Associate with your realty company who:

1) is currently in business of listing and selling real estate for your realty company or through one of its affiliated real estate companies;
2) has met the minimum eligibility requirements set by your realty company;
3) has a Real Estate license current with the State;
4) is a member in good standing with the Local Board of Realtors, and;
5) is current on the Release of Liability Plan with the Policyholder.

Sales Associates must be actively at work on the day coverage takes effect. Dependents must not be in a period of limited activity on the day coverage takes effect.

This is only a summary and is subject to the terms and conditions of the contract. If there is a discrepancy between this summary and the contract, the contract is considered correct.

Short-Term Disability Insurance Information

Coverage Underwritten by Lincoln Financial Group, 8801 Indian Hills Drive, Omaha, NE 68114

Sales Associate

- Excellent opportunity to purchase group short term disability insurance on an automatic deduction basis.
- 60% of your salary, rounded to the nearest dollar, up to $500.
- $500 Guarantee Issue

Elimination Period

- This is the number of continuous days you must be totally disabled before benefit payments start.
- 31st Day Accident / 31st Day Sickness

Maximum Benefit Duration

- This is the longest period of time that benefits will continue to be paid to you during a period of disability.
- 26 Weeks (Benefit is reduced by 50% at age 70, and terminates at retirement)

Pre-Existing Exclusion

- "Pre-existing condition" means any sickness or injury for which you have received medical treatment, consultation, care or services (including diagnostic measures or the taking of prescribed drugs or medicines) during the 12 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 duties as a realtor for 12 months following the coverage effective date.

Other Benefits Included

- Pregnancy, Alcoholism, Drug Addiction and Mental and Nervous conditions are treated the same as any other sickness.
- Partial Disability Benefits

Program Eligibility

- All Sales Associates.* Sales Associates must be actively at work on the day coverage takes effect.

*see definitions page.

- All Late Entrants are required to complete satisfactory Evidence of Insurability information.

Short-Term Disability Insurance Information

continued

ELIGIBILITY

All Sales Associates. You must be a licensed Real Estate Sales Associate with your realty company who:

1) is currently in business of listing and selling real estate for your realty company or through one of its affiliated real estate companies;
2) has met the minimum eligibility requirements set by your realty company;
3) has a Real Estate license current with the State;
4) is a member in good standing with the Local Board of Realtors, and;
5) is current on the Release of Liability Plan with the Policyholder.

Sales Associates must be actively at work on the day coverage takes effect. Dependents must not be in a period of limited activity on the day coverage takes effect. A delayed effective date will apply if the Realtor is not actively at work on the date that the insurance would otherwise take effect, or for a dependent who is confined to a health care facility or in a period of limited activity.

WEEKLY BENEFIT

If you are Totally Disabled beyond the elimination period due to a covered injury or sickness, you will be eligible to receive a weekly benefit of 60% of your basic weekly income to a maximum benefit of $500. This coverage is optional.

DEFINITION OF TOTAL DISABILITY

Total Disability means you are unable to perform each of the main duties of a realtor on a full-time or part-time basis due to an injury or sickness.

ELIMINATION PERIOD

Elimination Period is the number of continuous days you must be totally disabled before benefit payments start.

BENEFIT DURATION

Maximum Benefit Duration is the longest period of time that benefits will continue to be paid to you during a period of disability**.**

GUARANTEE ISSUE

This coverage is extended to you without requiring evidence of insurability as long as you meet eligibility requirements and enroll during your eligibility period. If you do no apply for this coverage when you are initially eligible and you choose to apply at a later date, you will be responsible for any expenses associated with obtaining further medical information.

PARTIAL DISABILITY BENEFITS

Partial Disability means that due to a non-work-related sickness or injury, you are unable to perform one or more of the main duties of your regular occupation or are unable to perform such duties on a full-time basis. You must be totally disabled prior to receiving partial benefits. To qualify for the benefit you must satisfy the elimination period and be earning less than 80% of your pre-disability salary. Partial disability benefits are reduced by earnings from any form of employment and end on the earliest of the date you cease to be partially disabled, the date your earnings exceed 85% of your pre-disability income or the date the maximum benefit duration ends.

PRE-EXISTING CONDITION

Pre-Existing Condition means any sickness or injury for which you have received medical treatment, consultation, care or services (including diagnostic measures or the taking of prescribed drugs or medicines) during the 12 months prior to the coverage effective date. A disability arising from any such injury or sickness will be covered only if it begins after you have been insured for 12 consecutive months.

PREGNANCY

Pregnancy is treated as an illness. The definition of disability must be satisfied and the elimination period completed before benefits would begin. The pre-existing condition exclusion applies as for any illness.

EXCLUSIONS

Benefits are not payable while you are not under the regular care of a physician; if disability is due to intentional, self-inflicted injury; if disability is due to an injury or sickness covered by Workers' Compensation or resulting from employment for wage and profit; or while you receive payment under a salary continuance or retirement plan sponsored by your employer.

BENEFIT REDUCTION The Short-Term Disability benefit duration will reduce by 50% at age 70 and will terminate at retirement.

This is only a summary of coverage and 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.

Coverage Underwritten by Lincoln Financial Group
8801 Indian Hills Drive, Omaha, NE 68114

Berkshire Hathaway HomeServices Fox and Roach Realtors
Group Insurance Rates

Lincoln Financial Group
Life Insurance

Monthly Rates*	
$100,000 Benefit Amount	
Age	Rate
< 30	$7.28
30-34	$9.36
35-39	$12.48
40-44	$17.68
45-49	$30.16
50-54	$52.00
55-59	$78.00
Dependent Child Life $5,000	$1.04
Amounts over $100,000	
• Require Evidence of Insurability Paperwork	
• Are subject to underwriting requirements and you may be denied.	
Spousal rates are based on the agent's date of birth.	

Lincoln Financial Group
Short-Term Disability

Monthly Rates Per	
$500 Weekly Benefit Amount	
Age	Rate
< 30	$27.56
30-34	$24.96
35-39	$23.40
40-44	$23.40
45-49	$24.96
50-54	$27.56
55-59	$32.76
60-64	$39.00
65-69	$44.20
70-74	$48.88
75-99	$53.04

Lincoln Financial Group
Life Insurance Over Age 60

Monthly Rates	
$10,000 Guarantee Issue Amount	
Age	Rates
60-64*	$11.96
Monthly Rates	
$6,500 Guarantee Issue Amount	
65-69**	$15.21
Amounts over $10,000	
• Require Evidence of Insurability Paperwork	
• Are subject to underwriting requirements and you may be denied.	
Spousal rates are based on the agent's date of birth	
*Max benefit of $250,000 **Max benefit of $162,500	

MetLife
Comprehensive Dental Coverage

Basic Plan Monthly Rates	
Single	$41.65
Two or More	$112.30
Comprehensive Plan Monthly Rates	
Single	$61.25
Two or More	$161.30
Freedom Plan Monthly Rates	
Single	$50.72
Two or More	$129.18
Rates are effective 1/1/2017 to 12/31/2017	

****These rates include a 4% administrative fee. These rates are for illustrative purposes and are subject to change without notice. For more specific information refer to the highlight sheets.**

***These rates include a 6% administrative fee.**

Revised 10/21/2015

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: **PRUFOXROA**	GROUP POLICY #:	Billing Division or Location:

Employee Information (Completed by Employee for ALL Enrollments)

Employer Name/Company Name (Please Print) **Prudential Fox & Roach Realtors**			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 ( )	Occupation	

Must Be Completed

Annual Earnings: $_____	Date of Full-Time Employment:	Rehire Date:

Product Selection (Completed by Employee 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 Employee Life Insurance **Evidence of Insurability Required Coverage Amounts Over $100,000.	☐**Yes**	☐**No**	☐ **$ 25,000** ☐ **$ 50,000** ☐ **$ 75,000** ☐ **$100,000** ☐ **Other: _____**	$
Voluntary Spouse Life Insurance **Evidence of Insurability Required Coverage Amounts Over $25,000.	☐**Yes**	☐**No**	☐ **$ 5,000** ☐ **$15,000** ☐ **$25,000** ☐ **Other:_____**	$
Voluntary Dependent Child Benefit	☐**Yes**	☐**No**	☐ **$5,000** ☐ **$10,000**	$
Voluntary **Short** Term Disability	☐**Yes**	☐**No**	**Weekly Benefit Amount $_____** **$500 maximum Benefit**	$

Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)				
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.

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 Financial Life Insurance Company.** I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
- ❑ **NOT ENROLL myself in the Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
- ❑ **NOT ENROLL my dependents in the Program.** I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

The insurance requested on this enrollment form will not be effective until approved by the Home Office of Lincoln Financial Life Insurance Company, and the initial premium is paid to Lincoln Financial Life Insurance Company. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

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

Automatic Deduction and Notification Agreement

PLEASE READ CAREFULLY. BY SIGNING BELOW, YOU AGREE TO HAVING READ AND UNDERSTOOD THE FOLLOWING:

I hereby authorize **Realty Benefit Services**, **an affiliate of Dergalis Associates**, to access my account for the purpose of paying premiums for the insurance benefits that I select. The deductions could include health, dental, vision, life, and / or disability insurance premiums. I understand that these deductions will be made periodically and I realize that changes in premiums may result in higher or lower deductions. I further understand that I shall incur additional charges in the event this debit is returned for any reason. In the event that **Realty Benefits Services** is unable to collect my premiums on the first business day of the month, I will be charged $25.00. I understand there is no monthly paper billing from **Realty Benefit Services**, **an affiliate of Dergalis Associates** and I cannot pay by check.

Notifications

I agree to provide signed written notice at least two weeks in advance in the event I wish to cancel, change or amend my current policies. I further agree to indemnify and hold harmless **Realty Benefit Services**, **an affiliate of Dergalis Associates**, for charges assessed on my account from my lending institution due to debits for services rendered. I agree to notify **Realty Benefit Services**, **an affiliate of Dergalis Associates**, in writing of any changes to my bank account. This notice will be at least two weeks in advance of any scheduled payment debits. (**You can fax or email your notice to Dergalis Associates at (856) 396-3193, ATTN: Claire Rightler or email to claire@agentbenefits.net).**

I understand that these services are being provided solely through arrangements with **Realty Benefit Services**, **an affiliate of Dergalis Associates**, my real estate firm and the insurance carrier. I am aware that I must notify **Dergalis Associates** in writing if I no longer work as a licensed Realtor or become a referral realtor with my current Real Estate firm. This notification is my responsibility. If I do NOT notify **Dergalis Associates** within 30 days of my termination, I realize I may continue to get billed for services and benefits that I am no longer eligible to receive and I may forfeit any benefits received or premiums I paid for these benefits beyond my termination date. **NO REFUNDS WILL BE PROVIDED FOR MY FAILURE TO NOTIFY DERGALIS ASSOCIATES OF TERMINATION OR SEPARATION FROM MY REAL ESTATE COMPANY**. I understand that any changes to or termination of my coverage will also affect the coverage I have elected for my dependents.

By signing, I acknowledge that I have read and accept the terms of the above notification agreement.

SIGNATURE REQUIRED

SIGNATURE *of insured* _____ DATE _____

WERE YOU HELPED BY A DERGALIS REPRESENTATIVE? (please check) ☐ YES ☐ NO

IF YES, WHO: _____

NAME OF INSURED _____

REALTY COMPANY _____ OFFICE LOCATION _____

SOCIAL SECURITY # _____ EMAIL _____

HOME PHONE _____ CELL PHONE _____

HOME ADDRESS _____

CITY *STATE* *ZIP*

SIGNATURE REQUIRED

SIGNATURE *of account owner** _____ DATE _____

*Note: Signature should be that of the owner of the checking account whose name appears on the check used for deductions.

Revised 4/04/2016

Dergalis ASSOCIATES

Attach Voided Check

Attach Your Business Card

Dergalis ASSOCIATES

Evidence of Insurability Form

You only need to fill out the Evidence of Insurability form if you're purchasing **MORE THAN** the Guaranteed-Issue amount of **LIFE INSURANCE**.

Fill out the form:

— If you are a realtor under age 60 purchasing a Life Insurance policy over $100,000

— If you are a realtor age 60 or over purchasing a Life Insurance policy over $10,000

— If you are purchasing a Life Insurance policy for your spouse* over $25,000

spouse must be under age 60

STOP **ONLY FILL OUT IF YOU'RE PURCHASING *MORE THAN* THE GUARANTEED-ISSUE AMOUNT OF LIFE INSURANCE**

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066

EVIDENCE OF INSURABILITY INFORMATION

Attach this form with your enrollment card and submit to The Lincoln National Life Insurance Company (herein referred to as "the Company"). Please complete a form for each applicant. No coverage will be effective until approved in writing by the Company. **Complete all blanks in ink and print clearly.** Incomplete forms will cause coverage to be delayed.

Applicant Information:

Name_____ State of Birth_____ Date of Birth____ ____ ____ Male ☐ Female ☐ Height_____ Weight_____

Relationship to employee_____ Amount Applied For $_____ Total Benefit Amount $_____

Address_____
(Street) (City) (State) (Zip)

Phone Number Home ____ ____ _____ Work ____ ____ _____ Best Time to call_____ Home ☐ Work ☐

Beneficiary (for Life or AD&D Insurance)_____ Relationship_____

Plan Applied for:

Life ☐	Optional Employee Life ☐	Voluntary Employee Life ☐
Dependent Life ☐	Optional Employee AD&D ☐	Voluntary Employee AD&D ☐
STD ☐	Optional STD ☐	Voluntary Spouse Life ☐
LTD ☐	Optional LTD ☐	Voluntary Spouse AD&D ☐
Critical Illness ☐	Optional Spouse Life ☐	Voluntary STD ☐
	Optional Spouse AD&D ☐	Voluntary LTD ☐

Employee Information:

Group Name_____

Name_____ Group Policy Number_____ Group ID_____

Employee Social Security Number_____ Annual Earnings $_____ Date of Hire/Rehire_____

STATEMENT OF HEALTH

	YES	NO
1. In the past 12 months, have you smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?	☐	☐
2. Within the past 7 years, have you ever (a) had, or (b) been told by a physician that you had, or (c) received treatment for a condition listed below? **CIRCLE CONDITIONS ANSWERED YES AND PROVIDE DETAILS BELOW.**		
A. Heart or artery disorder, heart attack, tuberculosis, liver disorder, kidney trouble, lung or other respiratory disorder?	☐	☐
B. High blood pressure? If YES, please note last two readings and date of reading: Date_____ Reading_____ Date_____ Reading_____	☐	☐
C. Diabetes? If YES, please note age of onset, and treatment prescribed? Age at onset:_____ Type of treatment:_____	☐	☐
D. Cancer, leukemia, malignant growth or any form of tumor?	☐	☐
E. Epilepsy or any mental/nervous disorder?	☐	☐
3. Have you been medically treated for alcoholism, drug use or dependency?	☐	☐
4. Within the past 7 years, have you been diagnosed as having, or been treated for:		
A. Any disorder of the immune system, including AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-Related Complex), or tested positive for antibodies to HIV (Human Immunodeficiency Virus)?	☐	☐
B. Hepatitis or any sexually transmitted disease?	☐	☐
5. Have you had any physical examinations in the last 5 years? If YES, provide details below and note reason for exam, symptoms, treatment or medication and results.	☐	☐
6. Within the past 5 years, have you had any physical disorder not listed above?	☐	☐

If you answered YES to questions 2-6, please give complete details below:

Item No.	Condition, injury, or findings of exam. If surgery performed, state type.	Date of Onset	Date Last Treated	Results/Degree of Recovery	Name & Address of Attending Physician

Item No.	Condition, injury, or findings of exam. If surgery performed, state type.	Date of Onset	Date Last Treated	Results/Degree of Recovery	Name & Address of Attending Physician

	YES	NO
7. Are you:		
A. Under observation or receiving treatment?	☐	☐
B. Taking medication?	☐	☐

If you answered YES to questions 7A or 7B, please provide details below:

Condition	Date of Onset	Name of Medication	Dosage and Frequency	Name and Address of Attending Physician

NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containi ng any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

CONTINUED ON NEXT PAGE

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066

I HEREBY:

1. request the coverage for which I am (or may become) eligible under group policies issued by The Lincoln National Life Insurance Company (the Company);
2. authorize any required deductions from my earnings;
3. name the above beneficiary to receive any benefits payable in the event of my death;
4. represent to the best of my knowledge and belief that the above Statement of Health is true and complete, and that each item answered yes is fully disclosed.

I understand that for continued eligibility I must remain an active employee working at least the minimum hours as outlined in the contract **and that my coverage will not be effective until the date this application is approved by the Company.**

AUTHORIZATION: I (the undersigned) authorize any physician, medical professional, medical facility, pharmacy benefit manager, insurer, reinsurer, consumer reporting agency or the Medical Information Bureau (MIB) to release information from the records of:

1. Applicant/Patient Name:_____
(Last) (First) (Middle)

Date of Birth:_____ Social Security Number:_____

This Authorization covers any periods of medical treatment during the last seven years.

2. Information to be released: My complete medical records including:
   - information about the diagnosis, treatment or prognosis of my medical condition (including referral documents from other facilities); and
   - prescription drug records and related information maintained by physicians, pharmacy benefit managers, and other sources.

3. Information is to be released to: EMSI (Examination Management Services Incorporated), The Lincoln National Life Insurance Company (the Company) or its reinsurers.

4. I understand that the purpose of disclosing this information is to evaluate my application for insurance. The Company will use the information obtained with this Authorization to determine eligibility for insurance; and will only release such information:
   - to reinsurance companies, the MIB or providers of a business or legal service concerned with my application; and
   - as otherwise may be required by law or may be further authorized by me.

I further understand that refusal to sign this Authorization may result in denial of eligibility for this insurance coverage.

5. I understand the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law, however, the Company contractually requires the recipient to protect the information.

6. I understand that I may revoke this Authorization in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my coverage with the Company. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signing. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.

7. A photocopy of this Authorization is to be considered as valid as the original.

8. I acknowledge that I have received the attached Notice of Information Practices.

9. I understand that I am entitled to receive a copy of this Authorization.

Signature of Applicant:_____ **Date:**_____

Group Insurance Service Office Use: ☐ Self Bill ☐ List Bill

Approved_____ Declined_____

EFFECTIVE DATE:_____

NOTICE OF INSURANCE INFORMATION PRACTICES

COLLECTION OF INFORMATION
This NOTICE is provided in compliance with your state's Insurance Information and Privacy Protection Act.

In order to provide insurance coverage on a fair and equitable basis, we must collect information about you and others for whom coverage may be provided. This information may include age, occupation, physical condition, health history, prescription drug records, general reputation, mode of living and other personal characteristics.

You will provide much of the information. We may collect or verify information by personal interviews and by otherwise contacting Medical professionals and institutions, pharmacy benefit managers, employers, business associates, friends, neighbors and other insurance companies. We may ask insurance support organizations to collect information and submit an investigative consumer report. That organization may disclose the contents of the report to others for which it performs such services. You may request a copy of the report or a personal interview in connection with it.

DISCLOSURE OF INFORMATION
The law allows disclosure of certain information without your authorization in response to a valid administration or judicial order, as permitted or required by law, or to:

1. Persons or organizations performing professional, business or insurance functions for us;
2. Our agents, insurance support organizations or consumer reporting agencies;
3. Medical professionals and medical-care institutions;
4. Persons or organizations conducting bonafide actuarial or scientific research studies, audits or evaluations;
5. Insurance regulatory, law enforcement or other governmental authorities;
6. Persons or organizations involved in any sale, transfer, merger or consolidation of our business; and
7. Group Policyholders, certificate holders, professional peer review organizations, or persons having legal or beneficial interest in a policy of insurance.

We do NOT disclose to our affiliates any information we receive about you from a consumer reporting agency. We do NOT disclose your nonpublic personal information to third parties except as necessary to provide you our products and services.

MEDICAL INFORMATION BUREAU
Information regarding your insurability will be treated as confidential. We, or our reinsurers, may make a brief report to the MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact the MIB at 866 692-6901 (TTY 866 346-3642 for hearing impaired). If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is P. O. Box 105, Essex Station, Boston, MA 02112.

We, or our reinsurers, may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

PERSONAL DISCLOSURE
Also, you have a right to access personal information about you in our files. You may request that we correct, amend or delete information you believe is inaccurate or irrelevant. A description of the appropriate procedures will be sent to you upon written request.

TELEPHONE PERSONAL HISTORY REVIEW
After your application has been received in the Group Insurance Service Office, you may receive a telephone call from a specially trained Group Insurance Service Office Interviewer who will ask you some questions to obtain verification or additional information.

If you have questions about the terms discussed in the NOTICE, please write to:
The Lincoln National Life Insurance Company
Group Insurance Service Office
P. O. Box 2616
Omaha, Nebraska 68103-2616

DETACH THIS COPY AND KEEP FOR YOUR RECORDS