Lincoln Financial Group®

Group Short-Term Disability Insurance Voluntary

SUMMARY OF BENEFITS

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

All Full-Time and Regular Part-Time Employees excluding Brookville Center for Children's Services Employees
All Full-Time and Regular Part-Time Brookville Center for Children's Services Employees with less than 3 Years of Service
All Full-Time and Regular Part-Time Brookville Center for Children's Services Employees with 3 or more Years of Service

Short-term disability is intended to protect your income for a short duration in case you become ill or injured.

STD Benefit

Weekly Benefit	Elimination Period	Maximum Duration
60% of weekly salary up to $750 per week	Benefits begin on: Accident: 15th day Illness: 15th day Hospitalization: 1st day	26 weeks

Pre-Existing Condition You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under this policy until you have been covered under the policy for 6 months.

Integration of Benefits The total of all benefits received from this policy, state disability plans, worker's compensation programs and your employer's sick pay plan may not exceed 80% of your income prior to disability.

Waiver of Premium You will not be required to pay premium during any time of approved total or partial disability.

Additional Benefits

Portability
Rehab Assistance - 5%
Survivor Income - 3 Weeks
C-Section Benefit - 8 weeks
See your Schedule of Benefits on your Certificate for more information

Enrolling for Coverage

Eligibility: All employees in an eligible class.
You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again until your annual open enrollment.

Monthly Premium Calculation**

		EXAMPLE
List your weekly earnings (Maximum covered payroll is $1,250 weekly)	$_____	$610
Multiply by the premium factor	0.02220	0.02220
Your Estimated Monthly Premium	$_____	$13.54

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

Composite Rate Factor:
0.02220

Understanding Your Benefits

Total Disability	Due to an injury or illness, you are unable to perform each of the main duties of your regular occupation.
Partial Disability	Due to an injury or illness, you are unable to perform one or more of 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 2 weeks of returning to work, you will begin receiving benefits again immediately.
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 your 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.
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. • Your disability is covered under a worker's compensation plan and/or is due to a job-related sickness or injury.
Benefit Reductions	Your benefits may be reduced if you are receiving benefits from any of the following sources: • 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; • Disability income benefits received under state disability benefit laws.
Rehabilitation Assistance Benefit	Employees who participate in an approved rehabilitation program are eligible to receive an additional percent of benefit. Additionally, approved program costs may be reimbursed.
Survivor Income	A benefit may be paid to your survivor for additional months if you should die while you were eligible to receive benefits under this policy.
Coverage 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; 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 detail. Should there be a difference between this summary and the policy, the policy will govern.

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		
		Short Term Disability ☐ Yes ☐ No*		

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.

*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:_____