



The Lincoln National Life Insurance Company
 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: UOFTENN2	GROUP POLICY #: 102329850000	Billing Division or Location: N/A
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A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) The University of Tennessee		County	Employer ZIP 37996	State TN
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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	Home Phone ()	Work Phone ()	

Completed By Employer

Average Hours Worked Per Week:	Occupation:
Earnings: <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly	Date of Full-Time Employment:
\$ _____	Rehire Date:

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 <input type="checkbox"/> Yes <input type="checkbox"/> 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--

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 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.

NOTE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

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.

I understand that the vision care insurance benefit plan I have selected provides reimbursement for certain vision costs which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my provider or me for vision care expenses which I have incurred may not be covered by my vision care insurance benefit plan.

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



Group Long-Term Disability Insurance Specialty Worksite

SUMMARY OF BENEFITS

Sponsored by: **University of Tennessee**

All Full-Time Employees

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.

LTD Benefit				
	Monthly Benefit	Maximum Benefit Duration	Own Occupation Period	Elimination Period
Employee Paid Plan	66.67% of monthly salary up to \$8,000 per month	Later of Age 65 or Social Security Normal Retirement Age	36 Months	120 Days
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 12 months.			
Waiver of Premium	You will not be required to pay premium during any time of approved total or partial disability.			
Benefit Limitations	Mental Illness: 24 Months Substance Abuse: 24 Months Specified Illness: No Limit			

Enrolling for Coverage	
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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 monthly earnings (*Maximum covered payroll is \$11,999 Monthly)	\$ _____	\$2,643
Multiply by your premium factor	_____ 0.00191	0.00191
Your Estimated Monthly Premium**	\$ _____	\$5.05
**This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.		

Composite Rate Factor:
0.00191

Understanding Your Benefits

Elimination Period	The number of days you must be disabled prior to collecting disability 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	Due to an injury or illness, you are unable to perform each of the main duties of your own occupation on a full-time basis. 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. See Certificate of Coverage for details.
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 and continue to receive benefits, which may enable you to receive 100% of your income during your time of disability. See Certificate of Coverage for details.
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 with no new Elimination Period.
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 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: <ul style="list-style-type: none">• 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: <ul style="list-style-type: none">• 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 from any form of employment;• Workers compensation;• Salary continuance or employer contributions to an employer sponsored retirement plan.
Coverage Termination	Coverage will terminate when you terminate employment with this policyholder, or at your retirement.

Additional Benefits

Progressive Income Benefit, Family Care Expense Benefit, Survivor Income Benefit, EmployeeConnect - Employee Assistance Program, Waiver of Premium, Portability and Cost of Living Increase

See your Schedule of Benefits on your Certificate for more information

For assistance or additional information Contact Lincoln Financial Group at

(800) 423-2765; reference ID: UOFTENN2

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.

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