The Lincoln Long-term Disability Insurance Premier Plan:

- Provides a cash benefit after you are out of work for 120 days or more due to injury, illness, or surgery
- Features group rates for The University of Tennessee employees
- Includes EmployeeConnect™ services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance

<table>
<thead>
<tr>
<th>Long-term Disability</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly benefit amount</td>
<td>66.67% of your monthly salary, limited to $8,000 per month</td>
</tr>
<tr>
<td>Elimination period</td>
<td>120 days</td>
</tr>
<tr>
<td>Coverage period for your occupation</td>
<td>36 months</td>
</tr>
<tr>
<td>Maximum coverage period</td>
<td>Up to age 65 or Social Security Normal Retirement Age (SSNRA), whichever is later</td>
</tr>
</tbody>
</table>

**Elimination Period**

- This is the number of days you must be disabled before you can collect disability benefits.
- The 120-day elimination period can be met through either total disability (out of work entirely) or partial disability (working with a reduced schedule or performing different types of duties).

**Coverage Period for Your Occupation**

- This is the coverage period for the trade or profession in which you were employed at the time of your disability (also known as your own occupation).
- You may be eligible to continue receiving benefits if your disability prohibits you from any employment for which you are reasonably suited through your training, education, and experience. In this case, your benefits are extended through the end of your maximum coverage period (benefit duration).

**Maximum Coverage Period**

- This is the total amount of time you can collect disability benefits (also known as the benefit duration).
- Benefits are limited to 24 months for mental illness; 24 months for substance abuse.

**Pre-existing Condition**

- If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.
**Benefit Exclusions & Reductions**

Like any insurance, this long-term disability insurance policy does have some exclusions. You will not receive benefits if:

- Your disability is the result of a self-inflicted injury or act of war
- You are not under the regular care of a doctor when you request disability benefits
- Your disability occurs while you are committing a felony or participating in a riot
- Your disability occurs while you are imprisoned for committing a felony
- Your disability occurs while you are residing outside of the United States or Canada for more than 12 consecutive months for a purpose other than work

Your benefits may be reduced if you are eligible to receive benefits from:

- A state disability plan or similar compulsory benefit act or law
- A retirement plan
- Social Security
- Any form of employment
- Workers’ Compensation
- Salary continuance
- Sick leave

A complete list of benefit exclusions and reductions is included in the policy. State restrictions may apply to this plan.

**Voluntary Long Term Disability Insurance**

*Here’s how little you pay with group rates.*

Your estimated monthly premium is determined by multiplying your monthly salary amount (up to $11,999) by the premium rate: 0.00191. If your monthly salary exceeds $11,999, multiply $11,999 by 0.00191.

\[
\text{monthly salary} \times 0.00191 = \text{monthly premium}
\]

**Questions? Call 800-423-2765 and mention Group ID: UOFTENN2.**

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. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

EmployeeConnect® services are provided by ComPsych® Corporation, Chicago, IL. ComPsych® and GuidanceResources® are registered trademarks of ComPsych® Corporation. ComPsych® is not a Lincoln Financial Group® company. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations.

Insurance products (policy series GL3001) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply.

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**Voluntary Long-term Disability Insurance At-A-Glance | Premier Plan**

LTD-ENRO-BRC001-TN
Here is your Enrollment Form.

Group ID: UOFTENN2

1. Your Personal Information

<table>
<thead>
<tr>
<th>Group/Employer/Participating Organization Name</th>
<th>County</th>
<th>Zip</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>The University of Tennessee</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your First Name</th>
<th>Middle Name/MI</th>
<th>Last Name</th>
<th>Social Security No.</th>
<th>Employee ID No.</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address (Include Apt. or Suite No.)</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Cell Phone</th>
<th>Work Phone</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>(          ) - (          ) - (          ) -</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Gender: [ ] Male [ ] Female  Marital Status: [ ] Married [ ] Single

Employer Completes this Section.

Billing Division or Location: ____________________________

Sort Group/Code: ____________________________  Payroll Cycle: ____________________________

Policy #(s): ____________________________

Average Hours Worked Per Week: ____________________________  [ ] Full-time  [ ] Part-time  Occupation: ____________________________

Earnings: [ ] Hourly  [ ] Weekly  [ ] Monthly  [ ] Yearly  $__________________________  Date of Employment: ____________________________

Actively at Work? [ ] Yes [ ] No  Date of Rehire: ____________________________

2. Benefit Selection — Choose your benefits.

Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions stated in the policy and certificate.

<table>
<thead>
<tr>
<th>Class</th>
<th>Effective Date</th>
<th>Type of Insurance</th>
<th>Amount of Insurance</th>
<th>Total Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ / /</td>
<td>Long Term Disability (LTD)</td>
<td></td>
<td>$_____________</td>
</tr>
</tbody>
</table>

*By selecting “No,” enrolling for insurance at a later date may require further medical information and/or a physical exam, which will be at your own expense.

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

4. Confirm Enrollment

ENROLL 18
This group insurance has been offered to me and after careful consideration of the benefits, I have decided to:

☐ ENROLL FOR INSURANCE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company, or its insurance partners. If contributions are required, I authorize my Employer to deduct premium from my pay.

☐ NOT ENROLL myself in the group insurance offered. I understand if I enroll for insurance 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 group insurance offered. I understand if I enroll my dependents for insurance at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

Fraud Warning/State Disclosure(s)

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.

5. Sign and Return

I understand the group insurance requested will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners. A delayed effective date will apply if you are not Actively at Work/an Active Member. A delayed effective date may apply to your dependent, if he or she is confined in a hospital or health care facility or is in a period of limited activity on the date insurance would otherwise take effect.

I understand the information provided is for enrollment in group insurance as offered by my Employer and will not be used for underwriting purposes.

The information provided is complete, true, and accurate to the best of my knowledge.

Your Full Name (Print): __________________________________________________________

Your Signature: X_________________________________________________________ Date _____/_____/_____

Complete and return this form.
(Be sure to sign and date the form to start your insurance.)

Questions? Call 800-423-2765