

LINCOLN FINANCIAL GROUP
SUMMARY OF GROUP LONG-TERM DISABILITY INSURANCE

City of Fargo North Dakota

EFFECTIVE DATE	January 1, 2008																								
ELIGIBILITY	All full-time active employees hired prior to January 1, 2008 and working 20 or more hours per week are eligible for Long-Term Disability (LTD) coverage on the effective date of this policy. A delayed effective date will apply if the employee is not actively at work on the date the insurance would otherwise take effect.																								
MONTHLY BENEFIT	If you are totally disabled beyond the Elimination Period due to a covered injury or sickness, you will be eligible to receive a monthly benefit equal to 60% of your basic monthly income, up to a maximum benefit of \$6,000.																								
BENEFIT REDUCTIONS FROM OTHER INCOME	<p>LTD benefits will be reduced by disability or retirement benefits from the following sources:</p> <ol style="list-style-type: none">1) Social Security benefits (Primary and Family Social Security Integration), the Canada Pension Plan, the Quebec Pension Plan or any similar plan or act.2) Disability benefits for which the employee is eligible under: worker's compensation, occupational disease or similar law; state disability plans or any compulsory benefit act or law; any other group plan, sick leave or salary continuance plan of the employer.3) Disability or retirement benefits under the employer's retirement plan or a government retirement plan.4) Any form of employment (full or part-time). <p>LTD benefits are not reduced by:</p> <ol style="list-style-type: none">1) Distributions from profit sharing, 401k, IRA, TSA or stock ownership plans.2) Non-qualified deferred compensation plans.																								
DEFINITION OF TOTAL DISABILITY	Total Disability is defined as the inability to perform each of the main duties of your own occupation, due to injury and sickness. The "own occupation" definition applies to the first 24 months of your disability. Following this, the definition of disability becomes the inability to perform any occupation for which you are reasonably fitted, based on your experience, education or training.																								
ELIMINATION PERIOD	You need to satisfy a 180 day Elimination Period before benefits would begin. This Elimination Period can be satisfied with days of partial disability, total disability or a combination of both. The Elimination Period may be met by days of disability built up over an Accumulation Period of 360 days, so there is no penalty for briefly attempting to return to work during this Elimination Period.																								
MAXIMUM BENEFIT DURATION	<p>The Maximum Benefit Period is the longest period of time that benefits will continue to be paid as long as you are disabled in accordance with the contract. The benefit period starts reducing depending on the age at disability, as outlined below:</p> <table border="0" style="margin-left: auto; margin-right: auto;"><thead><tr><th style="text-align: center;"><u>AGE</u></th><th style="text-align: center;"><u>MAXIMUM BENEFIT PERIOD</u></th></tr></thead><tbody><tr><td style="text-align: center;">up to 60</td><td style="text-align: center;">age 65</td></tr><tr><td style="text-align: center;">60</td><td style="text-align: center;">60 months</td></tr><tr><td style="text-align: center;">61</td><td style="text-align: center;">48 months</td></tr><tr><td style="text-align: center;">62</td><td style="text-align: center;">42 months</td></tr><tr><td style="text-align: center;">63</td><td style="text-align: center;">36 months</td></tr><tr><td style="text-align: center;">64</td><td style="text-align: center;">30 months</td></tr><tr><td style="text-align: center;">65</td><td style="text-align: center;">24 months</td></tr><tr><td style="text-align: center;">66</td><td style="text-align: center;">21 months</td></tr><tr><td style="text-align: center;">67</td><td style="text-align: center;">18 months</td></tr><tr><td style="text-align: center;">68</td><td style="text-align: center;">15 months</td></tr><tr><td style="text-align: center;">69 and over</td><td style="text-align: center;">12 months</td></tr></tbody></table>	<u>AGE</u>	<u>MAXIMUM BENEFIT PERIOD</u>	up to 60	age 65	60	60 months	61	48 months	62	42 months	63	36 months	64	30 months	65	24 months	66	21 months	67	18 months	68	15 months	69 and over	12 months
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LTD PRE-EXISTING CONDITION	Benefits will not be paid for any disability for which you received medical treatment, care or consultation, including diagnostic measures or took prescribed drugs or medications during the 3 months preceding your effective date under this policy, unless you are covered under this policy (or a prior policy) for 12 consecutive months before disability begins.																								

**PROGRESSIVE
PARTIAL DISABILITY
BENEFIT**

Your plan includes our Progressive Partial Disability Benefit. The partial disability benefit will not be reduced by earnings from any employer until those earnings, plus the policy benefit and other income benefits from other sources listed in your certificate (such as Social Security or worker's compensation), exceeds 100% of covered pre-disability earnings.

Partial disability benefits are payable until the earliest of the date you:

- Reach the later of age 65, Social Security Normal Retirement Age or your maximum benefit period;
- Are no longer partially disabled or earn more than the earning cap shown in your certificate:
 - 99% of your basic monthly earnings during the first 24 months of policy benefits; or
 - 85% of your basic monthly earnings after the first 24 months of policy benefits;
- are able to engage partial disability employment or work full-time, but chose not to;
- fail to take a medical exam or supply additional proof requested by Lincoln Financial.

PREGNANCY

Pregnancy is treated as any other disability. The definition of disability must be met and the Elimination Period completed before benefits would begin.

CONVERSION

If you have been covered under the LTD contract for 12 consecutive months and you terminate your employment for any reason except retirement, you are eligible to convert this coverage to a group trust contract. You must elect conversion within 31 days of your date of termination.

EXCLUSIONS

Lincoln Financial does not pay LTD benefits when a disability is:

- not under the regular care of a doctor;
- due to active participation in a riot or in the commission of a felony;
- due to war, declared or undeclared, or any act of armed aggression;
- the result of any intentional, self-inflicted injury or attempted suicide; or
- due to a preexisting condition, except as described in the policy.

When a disability is due to mental illness, the Lincoln Financial standard contract considers benefits payable for up to a maximum period of 24 months. However, if the insured employee is hospital-confined at the end of the 24-month period, benefits may continue to be payable.

When considering LTD plan options, it's important to understand the difference in benefits and how they impact a disability claim. Your Lincoln Financial representative can advise you on the appropriate choice for your situation.

This is only a summary of coverage and is not a binding contract. A certificate of coverage will be made available to you shortly, which describes the benefits in greater detail. Should there be differences between this summary and the contract, the contract will govern.

Group insurance is issued and underwritten by The Lincoln National Life Insurance Company, a Lincoln Financial Group company. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

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
 Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: FARGOND	GROUP POLICY #:	Billing Division or Location:
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A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) City of Fargo North Dakota		County	Employer ZIP	State
Employee 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:

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	Amount of Coverage	Total Premium
		Long Term Disability <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$	Employer Paid

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 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.

NOTE: A PERSON COMMITS 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, 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 a dependent is in a period of limited activity on the date insurance would otherwise take effect.

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