Lincoln Life & Annuity Company of New York
A Stock Company Home Office Location: 120 Madison Street, Suite 1310, Syracuse, NY 13202
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066
(800) 423-2765 Online: www.LincolnFinancial.com

CERTIFIES THAT Group Policy No. 000010290238 has been issued to

Friends Academy
(The Group Policyholder)

The issue date of the Policy is July 1, 2025.

The insurance is effective only if the Employee is eligible for insurance and becomes and remains insured as provided in the Group Policy.

Certificate of Insurance for Class 1

You are entitled to the benefits described in this Certificate if you are eligible for insurance under the provisions of the Policy. This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. Nothing in the Policy invalidates or impairs any rights granted to you in this Certificate. If the provisions of this Certificate and the Policy do not agree, the provisions more favorable to you will apply.

IMPORTANT NOTICE(S): The Policy is issued and delivered in the State of New York. It is governed by the laws of that State. Nothing in the Policy invalidates or impairs any rights granted to you by New York insurance law. The Company's state of domicile is New York. The address of the Company's Group Insurance Service Office is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

This Certificate does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York State Insurance Department.

Ellen Cooper
PRESIDENT

CERTIFICATE OF GROUP TERM LIFE INSURANCE

Friends Academy
000010290238
SCHEDULE OF INSURANCE

ELIGIBLE CLASS

Class 1 All Full-Time Employees

Persons first employed in an eligible class after this Policy takes effect may be enrolled in accord with the terms of this Policy. (See the Eligibility and Effective Dates sections.)

Friends Academy
000010290238
SCHEDULE OF INSURANCE
For
Class 1 - All Full-Time Employees

MINIMUM HOURS: 30 hours per week

WAITING PERIOD: (For date insurance begins, refer to "Effective Dates of Coverages" section)
None

EXCEPTION: If you are working as an ineligible employee for the Employer and then become a regular Full-Time Employee of the Employer, any time incurred with the Employer as an ineligible Employee will be applied toward the Waiting Period.

Basic Annual Earnings means your annual base salary or annualized hourly pay from the Employer before taxes on the Determination Date. The **"Determination Date"** is the last day worked just prior to the loss.

It does **not** include commissions, bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Employer. It will not exceed the amount shown in the Employer's financial records or the amount for which premium has been paid; whichever is less.

LIFE INSURANCE

	Benefit Amount
Personal Life Insurance	One times Basic Annual Earnings, rounded to the next higher $1,000; subject to a maximum of $200,000.

Personal Life Insurance will be reduced as follows:
- At age 70, benefits will reduce by 35% of the original amount;
- At age 75, benefits will reduce an additional 20% of the original amount;
- At age 80, benefits will reduce an additional 15% of the original amount.
Benefits will terminate when you retire.

If you first enroll for Personal Life Insurance at age 70 or older, the above age reductions will apply to:
- Any Guarantee Issue Amount available without evidence of insurability; and
- The maximum amount of insurance for which you are eligible.

Friends Academy
000010290238
SCHEDULE OF INSURANCE
For
Class 1 - All Full-Time Employees

AD&D INSURANCE

	Benefit Amount
AD&D Insurance Principal Sum	One times Basic Annual Earnings, rounded to the next higher $1,000; subject to a maximum of $200,000.

AD&D Insurance will be reduced as follows:
- At age 70, benefits will reduce by 35% of the original amount;
- At age 75, benefits will reduce an additional 20% of the original amount;
- At age 80, benefits will reduce an additional 15% of the original amount.
Benefits will terminate when you retire.

If you first enroll for AD&D Insurance at age 70 or older, the above age reductions will apply to:
- Any Guarantee Issue Amount available without evidence of insurability; and
- The maximum amount of insurance for which you are eligible.

TABLE OF CONTENTS

Amount of Insurance....3

Definitions....3

General Provisions....5

Eligibility....6

Effective Dates of Coverages....6

Termination of Coverage....7

Continuation of Coverage For Life Insurance....8

Continuation of Coverage for AD&D Insurance....10

Death Benefit....11

Beneficiary....12

Extension of Death Benefit....13

Accelerated Death Benefit....15

Conversion Privilege....18

Accidental Death and Dismemberment Insurance....21

Safe Driver Benefit....27

Claims Procedures for Life Benefits....28

Claims Procedures for Accidental Death and Dismemberment Benefits....31

Notice to Certificate Holders....34

Notice to Certificate Holders Insured for AD&D....35

AMOUNT OF INSURANCE

The amount of your insurance is determined by the Schedule of Insurance in the Policy. The initial amount of coverage is the amount which applies to your class on the day your coverage takes effect. You may become eligible for increases in the amount of insurance in accord with the Schedule of Insurance. Any such increase will take effect on the latest of:

(1) the date on which you become eligible for the increase, provided you are Actively at Work on that day;
(2) the day you resume Active Work, if you are not Actively at Work on the day the increase would otherwise take effect; or
(3) the day any required evidence of insurability is approved by the Company.

Any decrease will take effect on the first day of the Insurance Month which coincides with or follows the day of the change, whether or not you are Actively at Work.

DEFINITIONS

ACTIVE WORK or **ACTIVELY AT WORK** means an employee's full-time performance of all customary duties of his or her occupation at:

(1) the EMPLOYER'S place of business; or
(2) any other business location where the employee is required to travel.

Unless disabled on the prior workday or on the day of absence, an employee will be considered Actively at Work on the following days:

(1) a Saturday, Sunday or holiday which is not a scheduled workday;
(2) a paid vacation day, or other scheduled or unscheduled non-workday; or
(3) an non-medical leave of absence of 12 weeks or less, whether taken with the Employer's prior approval or on an emergency basis.

This includes a Military Leave or an approved Family or Medical Leave that is **not** due to the employee's own health condition.

COMPANY means Lincoln Life & Annuity Company of New York, a New York corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DAY or **DATE** means at 12:01 A.M., Standard Time, at the Group Policyholder's place of business, when used with regard to eligibility dates and effective dates. It means 12:00 midnight, Standard Time, at the same place, when used with regard to termination dates.

EMPLOYEE or **FULL-TIME EMPLOYEE** means an employee of the EMPLOYER:

(1) whose employment with the EMPLOYER is the employee's principal occupation;
(2) whose employment is for regular wage or salary;
(3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance;
(4) who is a member of a class which is eligible for coverage under the Policy;
(5) who is not a temporary or seasonal employee; and
(6) who legally works in the United States.

EVIDENCE OF INSURABILITY means a statement of proof of your or your Dependents' medical history. The Company uses this to determine your or your Dependents' acceptance for insurance or an increased amount of insurance. Such proof will be provided at your own expense.

EMPLOYER means the Group Policyholder. It includes any division, subsidiary or affiliated company named in the Application or Participation Agreement.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:
(1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
(2) is taken in accord with the Employer's leave policy and the law which applies; and
(3) does not exceed the period approved by the Employer and required by that law.

Under the federal FMLA law, such leaves are permitted for up to 12 weeks in a 12-month period as defined by the Employer. The 12 weeks:
(1) may consist of consecutive or intermittent work days; or
(2) may be granted on a part-time equivalency basis.

If an Employee is entitled to a leave under both the federal FMLA law and a similar state law, he or she may elect the more favorable leave (but not both). If an Employee is on an FMLA leave due to his or her own health condition on the date Policy coverage takes effect, he or she is not considered Actively at Work.

INSURANCE MONTH means that period of time:
(1) beginning at 12:01 A.M. Standard Time, at the GROUP POLICYHOLDER'S place of business on the first day of any calendar month; and
(2) ending at 12:00 midnight on the last day of the same calendar month.

MILITARY LEAVE means a leave of absence that:
(1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
(2) is taken in accord with the Employer's leave policy and the federal USERRA law; and
(3) does not exceed the period required by that law.

PERSONAL INSURANCE means the insurance provided by the Policy on Insured Persons.

PHYSICIAN means a licensed medical doctor, or other duly licensed practitioner of the healing arts who:
(1) is deemed by the state to be the same as a physician; and
(2) is acting within the scope of his or her license.

Physician does **not** include you or your relative. Relatives include:
(1) your spouse, siblings, parents, children and grandparents; and
(2) your spouse's relatives of the same degree.

POLICY means the Group Insurance Policy issued by the Company to the Group Policyholder. A copy of the Policy may be examined upon request at the home office of the Group Policyholder.

SECTION 125 PLAN means a Cafeteria Plan or other flexible benefits plan, which:
(1) qualifies for favorable tax treatment under Section 125 of the U.S. Internal Revenue Code; and
(2) allows the payroll deduction of employee contributions for certain group insurance plans to be done on a pre-tax basis.

WAITING PERIOD means the period of time you must be employed in an eligible class with the Employer, before you become eligible to enroll for coverage under the Policy. The period of service must be continuous, except as explained in the Eligibility provision captioned Prior Service Credit Towards Waiting Period.

GENERAL PROVISIONS

ENTIRE CONTRACT. The rights of the Group Policyholder, or of any Insured Person or Beneficiary under it, shall not be affected by any provision other than one contained in:

(1) the Policy or any riders or endorsements on it;
(2) any amendments to it signed by the Group Policyholder and the Company;
(3) the copy of the Group Policyholder's application attached to the Policy; or
(4) any individual statements signed by the Insured Persons and submitted in connection with the Policy.

INCONTESTABILITY. Except for the non-payment of premiums, the Company may not contest the validity of the Policy as to any Insured Person after it has been in force for two years during his or her lifetime.

All statements made by the Group Policyholder and by Insured Persons are representations and not warranties. No statement made by an Insured Person relating to his or her insurability will be used to contest the coverage provided by the Policy or to reduce benefits, unless:

(1) it is contained in a written statement signed by that Insured Person; and
(2) a copy of the statement is furnished to the Insured Person or Beneficiary.

TERM INSURANCE. The Policy will not provide paid-up insurance, or any loan or cash values, at any time.

MISSTATEMENT OF AGE. If an Insured Person's age has been misstated, premiums will be subject to an equitable adjustment. It will be retroactive and based upon the person's correct age. If the amount of benefit depends upon age, the benefit will be that which would have been payable, based upon the person's correct age.

WORKER'S COMPENSATION AND STATE DISABILITY BENEFITS. The Policy is not to be construed to provide benefits required by Worker's Compensation laws, the New York Disability Benefits Law, or any other state disability benefits law.

ELIGIBILITY

If you are a member of a class shown in the Schedule of Insurance; then you will become eligible for the coverage provided by the Policy on the later of:

(1) the Policy's date of issue; or
(2) the date the Waiting Period is completed.

WAITING PERIOD. (See Schedule of Insurance).

EFFECTIVE DATES OF COVERAGES

Your insurance is effective on the latest of:

(1) the day you become eligible for the coverage;
(2) the day you resume Active Work, if you are not Actively at Work on the day you become eligible;
(3) the day you make written application for coverage; and sign:
    (a) a payroll deduction order, if you pay any part of the premium; or
    (b) an order to pay premiums from your Section 125 Plan account, if Employer contributions are paid through a Section 125 Plan (defined in the Definitions section); or
(4) the day the Company approves your coverage, if evidence of insurability is required.

Evidence of Insurability. Evidence of insurability is required if:

(1) you apply for coverage more than 31 days after you become eligible; or
(2) you make written application to re-enroll for coverage after you have requested:
    (a) to cancel your coverage;
    (b) to stop payroll deductions for the coverage; or
    (c) to stop premium payments from your Section 125 Plan account.

TERMINATION OF COVERAGE

Your coverage terminates on the earliest of:

(1) the day the Policy terminates (but without prejudice to any claim incurred prior to termination);
(2) the day your Class is no longer eligible for insurance;
(3) the date you cease to be in a class of employees which is eligible for coverage under the Policy or die;
(4) the last day of the Insurance Month in which you request termination;
(5) the last day of the last Insurance Month for which premium payment is made on your behalf;
(6) the end of the period for which the last required premium has been paid;
(7) with respect to any particular insurance benefit, the date the portion of the Policy providing that benefit terminates;
(8) the day your employment with the Employer terminates; or
(9) the day you enter the armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. If you send proof of military service, the Company will refund any unearned premium.

Exception – Continuation Rights. Ceasing Active Work terminates your eligibility. However, you may continue coverage as follows:

(1) If you are disabled due to illness or injury, then coverage may be continued:
    (a) until you are no longer disabled; or, for life insurance, until qualified for the Extension of Death Benefit under the Policy;
    (b) provided premium payments are made on your behalf.
    Throughout the period of continued coverage, you will be required to pay the Employer the premium which you would have been required to pay as an Active Employee.
(2) If you cease work due to a temporary lay off, an approved leave of absence, or a military leave; then coverage may be continued:
    (a) for three Insurance Months after the lay off or leave begins;
    (b) provided premium payments are made on your behalf.

If Personal Life Insurance ceases for any reason **except** nonpayment of premium, it may be possible to purchase an individual life policy. See the Conversion Privilege section of this Certificate.

CONTINUATION OF COVERAGE
(Life Insurance)

This section applies to any Basic Personal Life Insurance provided by the Policy. Such insurance may be continued until you attain age 80, by paying the required premiums, when your employment with the Employer ends for a reason other than retirement (normal retirement); provided

(1) the insurance has been in force for at least 12 months in a row just prior to the date employment ends; and
(2) you are not continuing coverage under an Extension of Death Benefit provision or under any other continuation allowed by the Policy.

Continuation of insurance under this provision will follow any state required continuation or other continuation allowed under the Continuation Rights section of this Certificate.

To continue insurance, written application and the first premium payment must be made to the Company, within 31 days of the date insurance would otherwise end.

The Continuation of Coverage is not available when Policy coverage terminates solely because:

(1) your Employer ceases to be a Participating Employer; or
(2) the Policy terminates.

For life insurance that terminates under the Policy due to your termination of membership in an eligible class; see the Conversion Privilege section of this Certificate.

AMOUNT OF COVERAGE. The amount of continued insurance may not exceed the amount in force when employment ends. During the continuation period the amount of insurance may not be increased. Continued insurance will be subject to any reduction on account of age, as shown in the Schedule of Insurance.

You may decrease the amount of continued insurance at any time, by completing a request form supplied by the Company. The decrease will take effect on the first day of the Insurance Month after the Company receives the request.

PAYMENT OF PREMIUM. Timely payment of premium must be made directly to the Company, throughout the period of continued insurance. Premiums will be based on attained age as shown in the premium information provided with the application. A direct billing fee will be added to the premium based on the frequency chosen. The premium frequency may be changed by sending the Company advance written request on forms supplied by the Company. Such request may be sent at any time while continued insurance is in force, except during a Grace Period.

TERMINATION OF COVERAGE. Continued insurance will end on the earliest of:

(1) the date the Policy terminates;
(2) the last day of the Insurance Month in which termination is requested;
(3) the last day of the Insurance Month for which premium is paid;
(4) the date you are reinstated for coverage in an eligible class under the Policy;
(5) the date you attain age 80, or die; or
(6) the date insurance would otherwise end had you remained an Active Employee.

NOTICE OF CONTINUATION. Written notice is to be given within 15 days before or after your insurance ends. If the written notice is not given on time, the 31-day period in which to elect to continue insurance will be extended as follows.

(1) If the written notice is given more than 15 days before or after insurance terminates but less than 90 days after termination, the period in which to elect to continue insurance will be extended to the 45th day following the date of the notice.
(2) If the written notice is not given within 90 days after insurance terminates, the period in which to elect to continue insurance will end on the 90th day following the termination of employment.

CONVERSION. In accord with the Policy's Conversion Privilege, you may be entitled to purchase an individual life policy:

(1) at any time during the period of continued insurance;
(2) when continued insurance is terminated; or
(3) when continued insurance is reduced due to:
    (a) age;
    (b) a change in class; or
    (c) a Policy amendment that takes effect immediately or at any later date.

Written notice of the right to convert is to be given within 15 days before or after the event qualifying you to convert. See the Notice of Conversion Privilege under the Conversion Privilege section of this Certificate for details.

Any Life Insurance that takes effect as a result of exercising the rights under the Conversion Privilege section of this Certificate will reduce the amount of continued insurance that remains in effect.

CONTINUATION OF COVERAGE
(Accidental Death and Dismemberment Insurance)

This section applies to any Basic Accidental Death and Dismemberment Insurance provided by the Policy. Such insurance may be continued until you attain age 80, by paying the required premiums, when your employment with the Employer ends for a reason other than retirement (normal retirement); provided:

(1) the insurance has been in force for at least 12 months in a row just prior to the date employment ends; and
(2) you are not continuing coverage under any other continuation allowed by the Policy.

Continuation of insurance under this provision will follow any state required continuation or other continuation allowed under the Continuation Rights section of the Policy.

To continue insurance, written application and the first premium payment must be made to the Company, within 31 days of the date insurance would otherwise end.

The Continuation of Coverage is not available when Policy coverage terminates solely because:

(1) your Employer ceases to be a Participating Employer; or
(2) the Policy terminates.

AMOUNT OF COVERAGE. The amount of continued insurance may not exceed the amount in force when employment ends. During the continuation period the amount of insurance may not be increased. Continued insurance will be subject to any reduction on account of age, as shown in the Schedule of Insurance.

You may decrease the amount of continued insurance at any time, by completing a request form supplied by the Company. The decrease will take effect on the first day of the Insurance Month after the Company receives the request.

PAYMENT OF PREMIUM. Timely payment of premium must be made directly to the Company, throughout the period of continued insurance. Premiums will be based on attained age as shown in the premium information provided with the application. A direct billing fee will be added to the premium based on the frequency chosen. The premium frequency may be changed by sending the Company advance written request on forms supplied by the Company. Such request may be sent at any time while continued insurance is in force, except during a Grace Period.

TERMINATION OF COVERAGE. Continued insurance will end on the earliest of:

(1) the date the Policy terminates;
(2) the last day of the Insurance Month in which termination is requested;
(3) the last day of the Insurance Month for which premium is paid;
(4) the date you are reinstated for coverage in an eligible class under the Policy;
(5) the date you attain age 80, or die; or
(6) the date insurance would otherwise end had you remained an Active Employee.

NOTICE OF CONTINUATION. Written notice is to be given within 15 days before or after your insurance terminates. If the written notice is not given on time, the 31-day period in which to elect to continue insurance will be extended as follows.

(1) If the written notice is given more than 15 days before or after insurance terminates but less than 90 days after termination, the period in which to elect to continue insurance will be extended to the 45th day following the date of the notice.
(2) If the written notice is not given within 90 days after insurance terminates, the period in which to elect to continue insurance will end on the 90th day following the termination of employment.

DEATH BENEFIT

AMOUNT PAYABLE ON DEATH. Upon receipt of satisfactory proof of your death, the Company will pay a death benefit equal to the amount of Personal Life Insurance in effect on the date of your death. The benefit will be paid in accord with the Beneficiary section. Arrangements may be made to have this death benefit paid in installments.

FACILITY OF PAYMENT. Policy benefits may become payable to your estate. In that event, the Company has the option to pay one or more of the following: your surviving spouse, parent(s), child or children, brother(s) or sister(s). No payment made under this section may exceed $500. Any remaining amount of benefit will be paid as shown in the Beneficiary section.

SETTLEMENT OPTIONS. All or part of the Death Benefit may be received in installments. A written election to the Company may be made:

(1) by you, while living; or
(2) by your Beneficiary, if no such direction is in effect at the time of your death.

The election must comply with the Company's practices at the time it is made. It must provide for at least $2,000 to be paid in installments of at least $20 per month.

ASSIGNMENT. The Company will accept the absolute assignment of your Personal Life Insurance to a third party, as a gift or a viatical settlement. Such an assignment transfers all rights under the Policy, including the rights to:

(1) name and change the Beneficiary, unless an irrevocable Beneficiary has been named; and
(2) obtain an individual policy, by exercising the Conversion Privilege under this Policy.

However, the Company will not accept:

(1) a collateral assignment in connection with a debt; or
(2) an assignment of any Dependents Life Insurance under the Policy.

To be binding upon the Company, an assignment must be in a form acceptable to the Company; be filed at the Company's Group Insurance Service Office (or other office designated by the Company); and be accepted in writing by the Company.

The assignment:

(1) will take effect as of the date it was signed, even if you are not alive when it is received; and
(2) will not apply to any payment the Company makes before receiving your notice of the assignment.

The Company assumes no obligation as to the validity of any assignment.

BENEFICIARY

PAYMENT TO BENEFICIARY. Your Beneficiary is the person or persons named on your enrollment card. There may be more than one surviving Beneficiary when you die. In that event, they will share equally, unless your Beneficiary designation states otherwise.

NO BENEFICIARY AT DEATH. If you have not named a Beneficiary, or if no named Beneficiary is living when you die; then the death benefit will be paid to your:

(1) surviving spouse; or, if none
(2) surviving child or children in equal shares; or, if none
(3) surviving parent or parents in equal shares; or, if none
(4) surviving brothers and sisters in equal shares; or, if none
(5) estate, or in accord with the Facility of Payment section of the Policy.

The amount payable to anyone shown above will be reduced by any amount paid in accord with the Facility of Payment section of the Policy.

In determining who is to receive payment, the Company may rely upon an affidavit by a member of the class of relatives to receive payment. The Company will make payment based upon the affidavit it has, unless it receives notice of a valid claim by some other person:

(1) at its Group Insurance Service Office;
(2) before paying the proceeds.

Such payment will release the Company from any further obligation for your life insurance benefit.

If your Beneficiary dies:

(1) within 15 days of your death; and
(2) before the Company receives satisfactory proof of your death;

then payment will be made as if you had survived that Beneficiary, unless other provisions have been made.

CHANGING THE BENEFICIARY. Only you or your assignee may change the Beneficiary. Your Beneficiary's consent is not required, unless an irrevocable Beneficiary has been named. You may do so by filing a written notice with the Company, on a form it approves, at its Group Insurance Service Office. The change:

(1) will take effect as of the date it was signed, even if you are not alive when it is received; and
(2) will not apply to any payment the Company makes before receiving your notice of the change.

When applying for a conversion policy under the Conversion Privilege section, you must name a Beneficiary. It may be someone other than the person named under the group Policy. In that event, the application for the conversion policy will be treated as a written notice of change of Beneficiary.

EXTENSION OF DEATH BENEFIT

BENEFIT. Your life insurance will be continued, without payment of premiums, if:
(1) you incur a Permanent Total Disability while insured and before reaching age 60;
(2) you send the Company written notice during the period of disability, while living; and
(3) you submit satisfactory proof of Permanent Total Disability:
    (a) within the 7th through 12th months of disability; or:
    (b) as soon as reasonably possible after that.

Failure to give notice or submit proof by the end of the 12th month of such disability will not invalidate or reduce a claim, if proof is furnished:
(1) as soon as reasonably possible; and
(2) not later than the end of the 24th month of disability (unless you lacked legal capacity).

"Permanent Total Disability" means that, due to a sickness or injury, you:
(1) are unable to engage in any employment or occupation for which you are or become qualified by reason of education, training or experience;
(2) remain continuously unable to do so for at least 6 months in a row; and
(3) do not engage in any gainful employment or occupation during that period.

PREMIUM PAYMENT. Premium payments must continue until you are approved for this benefit, or the Policy terminates, if earlier. Upon receipt of satisfactory proof, the Company will refund up to 12 months' premium paid for your life insurance, from your 1st day of Permanent Total Disability.

AMOUNT CONTINUED. The amount of Personal Life Insurance continued by this section:
(1) will be the amount in effect on the day your Permanent Total Disability begins; and
(2) will be subject to the reductions and terminations in effect under the Policy on the day your Permanent Total Disability begins.

If you receive an Accelerated Death Benefit, the amount will be reduced in accord with that provision. Any Accidental Death and Dismemberment Benefit will not be continued.

ADDITIONAL PROOF. At any time during this continuation, the Company may require you:
(1) to submit further proof of your continued Permanent Total Disability; and
(2) to be examined by a Physician of the Company's choice, as often as reasonably necessary.

After the first two years of Permanent Total Disability, the Company will not request proof or an exam more than once a year. Proof will be at your expense.

Exception: If the Company requests to have you examined by a Physician of its choice, the exam will be at the Company's expense.

If you die after submitting proof, further proof must be submitted to the Company showing that your Permanent Total Disability continued until death.

If you die within 12 months after your Permanent Total Disability begins, but before submitting proof:
(1) your death benefit will still be paid under the terms of the Policy; but
(2) the Company must first receive satisfactory proof that your Permanent Total Disability continued from your last day of Active Work until your date of death.

TERMINATION. Any life insurance continued under this section will automatically terminate on the earliest of:

(1) the day your Permanent Total Disability ends;
(2) the day you fail to take a required medical examination;
(3) the 60th day after the Company mails a request for additional proof, if it is not given;
(4) the effective date of your individual conversion policy, with respect to any amount of life insurance converted in accord with the Conversion Privilege section; or
(5) the day you reach 65.

RIGHTS AFTER TERMINATION. If life insurance extended under this section ends, and you **do not return** to a class eligible for Policy coverage, then you or your Dependent may exercise the Conversion Privilege. To do so, you must make written application and the first premium payment within 31 days after your Permanent Total Disability ends. You may elect term life insurance for a one-year period, prior to the issuance of a term life or whole life conversion policy. See the Conversion Privilege, Conditions 1, 2 and 3, for details.

If your Permanent Total Disability ends, and you **do return** to an eligible class**,** then your Policy coverage will resume:

(1) when premium payments are resumed; and
(2) any conversion policy is surrendered as provided below.

CONVERSION POLICIES. If you have exercised the Conversion Privilege, and the benefits payable under the Policy and the conversion policy combined would exceed:

(1) your original amount of Policy coverage prior to the conversion; or
(2) any greater amount for which you later become insured under the Policy;

then benefits will be payable under the terms of the Policy.

However:

(1) the conversion policy must first be surrendered to the Company; and
(2) no claim may be made under the conversion policy, except for refund of premium less any dividends and policy loans.

ACCELERATED DEATH BENEFIT

BENEFIT. The Accelerated Death Benefit is an advance payment of part of your Personal Life Insurance. If you are diagnosed by a Physician as Terminally Ill; then it may be paid to you, in a lump sum, once during your lifetime. To qualify you must:

(1) have satisfied the Active Work requirement under the Policy; and
(2) have at least $2,000 of Personal Life Insurance under the Policy on the day before the Accelerated Death Benefit is paid.

Receiving the Accelerated Death Benefit will reduce the Death Benefit payable at your death, as shown on the next page.

DEFINITIONS. "Remaining Life Insurance" means the amount of Personal Life Insurance which remains in force on your life after an Accelerated Death Benefit is paid.

"Terminally Ill" means you have a medical condition which is expected to cause your death within 12 months.

APPLYING FOR THE ACCELERATED DEATH BENEFIT. To withdraw the Accelerated Death Benefit, you (or your legal representative) must send the Company:

(1) written election of the Accelerated Death Benefit, on a special claim form which the Company supplied within the prior 30 days; and
(2) satisfactory proof that you are Terminally Ill, including a Physician's written statement.

Within 5 days of receiving your claim form, the Company will send you a written notice showing:

(1) the amount of the Accelerated Death Benefit requested, and the amount to be paid in cash;
(2) the amount of Life Insurance which would be payable at death, if no Accelerated Death Benefit is withdrawn;
(3) the Remaining Life Insurance which would be payable at death, after payment of the requested Accelerated Death Benefit is withdrawn; and
(4) the effect upon premium payments for the Remaining Life Insurance.

Before making payment, the Company will allow you a period of 5 days from the date on which the written notice is transmitted to review this information. No benefit will be paid during the review period. You may revoke the request to withdraw the Accelerated Death Benefit, at any time before the Company makes payment.

The Company reserves the right to decide whether the proof is satisfactory. The Company may have you examined, at its own expense, by one or more Physicians of its choice.

AMOUNT OF THE ACCELERATED DEATH BENEFIT. You may elect to withdraw an Accelerated Death Benefit in any $1,000 increment. The amount is subject to:

(1) a minimum of $10,000 or 10% of your amount of Personal Life Insurance (whichever is less); and
(2) a maximum of $500,000 or 75% of your amount of Personal Life Insurance (whichever is less).

To determine the Accelerated Death Benefit, the Company will use the amount of your Personal Life Insurance in force on the day before payment is made.

Exception: Your Personal Life Insurance may be scheduled to reduce within 12 months of the date you apply for an Accelerated Death Benefit. In that event, the Company will use the reduced amount.

CONDITIONS. The Accelerated Death Benefit is available only on your Personal Life Insurance in force under the Policy. It is not available:

(1) on any Dependent Life Insurance under the Policy; or
(2) on any conversion coverage purchased in accord with the Conversion Privilege.

The Accelerated Death Benefit is available only to you. It will not be paid when the Company knows of a third party's interest in the proceeds. The Accelerated Death Benefit will not be available when any part of your Personal Life Insurance must be paid:

(1) to your child, spouse or former spouse;
(2) pursuant to a legal separation agreement, divorce decree, child support order or other court order.

You may have named an irrevocable beneficiary, assigned coverage, or filed for bankruptcy. In that event, an Accelerated Death Benefit will be paid only with the written consent of your beneficiary, your assignee, or the bankruptcy court.

EFFECT ON AMOUNT OF LIFE INSURANCE. After an Accelerated Death Benefit is paid, the Remaining Life Insurance in force on your life will equal:

(1) the amount of your Personal Life Insurance in effect on the day before the Accelerated Death Benefit is paid; minus
(2) the amount of the Accelerated Death Benefit withdrawn.

Upon payment of an Accelerated Death Benefit, the Company will issue a new Certificate or amendment, showing the amount of Remaining Life Insurance. This amount will remain in effect:

(1) subject to timely payment of premiums; unless the Insured Person has qualified for an Extension of Death Benefit under the Policy; and
(2) subject to any age reduction and termination provisions contained in the Policy.

You may exercise the Conversion Privilege after an Accelerated Death Benefit is paid. In that case, the amount of the conversion policy will not exceed the amount of your Remaining Life Insurance.

You may have Accidental Death and Dismemberment benefits under the Policy. In that case, the Principal Sum will not be affected by the payment of an Accelerated Death Benefit.

EFFECT ON DEATH BENEFIT. If you die after receiving an Accelerated Death Benefit, the amount of Remaining Life Insurance in force on the date of your death will be paid as a Death Benefit. Payment will be made in accord with the Beneficiary section of the Policy.

If you die after applying for an Accelerated Death Benefit, but before the Company has made payment, then:

(1) your request will be void; and
(2) no Accelerated Death Benefit will be paid.

The amount of Personal Life Insurance in force on the date of your death will be paid in accord with the Beneficiary section of the Policy.

EFFECT ON TAXES AND GOVERNMENT BENEFITS. Any Accelerated Death Benefit amount withdrawn may be taxable income to you. Receipt of the Accelerated Death Benefit may also affect your eligibility for:

(1) Medicaid;
(2) Aid to Families with Dependent Children;
(3) Supplemental Security Income; and
(4) other government benefits.

But no health care facility, as defined in Section 20 of New York Public Health Law, can require a person to withdraw an Accelerated Death Benefit as a condition of receiving health care there.

For these reasons, you should consult a qualified tax or legal advisor, or any appropriate social service agency, before applying for an Accelerated Death Benefit. The Company is not responsible for any tax owed or government benefit denied, as a result of the Accelerated Death Benefit payment.

LIMITATION. No Accelerated Death Benefit will be paid if you are Terminally Ill due to:

(1) a suicide attempt, during your first two years of coverage under the Policy; or
(2) an intentionally self-inflicted injury.

CONVERSION PRIVILEGE

GENERAL BENEFIT. An individual life policy, known as a conversion policy, may be purchased from the Company without evidence of insurability, if all or part of your life insurance under the Policy terminates because of:

(1) your termination of employment or membership in an eligible class;
(2) a reduction in the amount of coverage due to age; a change in class; or a Policy amendment, to take effect immediately or at any later date; or
(3) termination of the Policy.

At your option, the conversion policy or policies will cover any Dependents whose Policy coverage was terminated or reduced, due to one of the above events. A conversion policy will also be available to any Dependents whose life insurance under the Policy is terminated or reduced, due to:

(1) your death, divorce or annulment; or
(2) your Dependent child's ceasing to be an eligible dependent.

To purchase a conversion policy, you or your Dependent must make written application and the first premium payment, within 31 days after life insurance is terminated or reduced.

EFFECTIVE DATES. The coverage provided by an individual conversion policy issued under this Section will take effect immediately upon termination of the person's group insurance under the Policy.

CONDITIONS

1. **Conversion Policy.** Any policy issued under this Conversion Privilege will:
   (a) be for an amount that does not exceed the amount of life insurance which was terminated or by which life insurance was reduced, less any Replacement Coverage (defined below);
   (b) be on any life insurance form then issued by the Company, at the age and amount for which application is made (except term life insurance is available only as provided below);
   (c) be issued without disability or other supplemental benefits; and
   (d) require premiums based on the class of risk to which the person then belongs, and the form and amount of the policy at his or her attained age.

   "Replacement Coverage," as used in this section, means any amount of group term life insurance for which you become eligible:
   (a) under any group policy issued or reinstated by the Company or any other insurer;
   (b) within 45 days after the Policy is terminated by the Group Policyholder or the Company.

2. **Term Life Insurance for One Year.** A conversion policy may be issued for a reason other than your termination of employment or membership due to Permanent Total Disability. In that case, the applicant may elect:
   (a) term life insurance for a one-year period;
   (b) prior to the issuance of a whole life conversion policy as described above.

3. **Term Life Insurance for Longer Period.** A conversion policy may be issued because of your termination of employment or membership due to Permanent Total Disability. In that case, the applicant may elect:
   (a) term life insurance for a one-year period;
   (b) prior to the issuance of a term life or whole life conversion policy as described above.

   To qualify for a term life conversion policy, you must send the Company written notice during your period of disability, while living. You must furnish satisfactory proof of Permanent Total Disability:
   (a) within the 7th through the 12th months of such disability; or
   (b) as soon as reasonably possible after that.

   Failure to give notice and furnish proof by the end of the 12th month of disability will not invalidate or reduce a claim, if proof is furnished:
   (a) as soon as reasonably possible; and
   (b) not later than the end of the 24th month of disability (unless you lacked legal capacity).

   "Permanent Total Disability" means that due to a sickness or injury you:
   (a) are unable to engage in any employment or occupation for which you are or become qualified by reason of education, training or experience;
   (b) remain continuously unable to do so for at least 12 months in a row; and
   (c) do not engage in any gainful employment or occupation during that period.

4. **Premium Mode.** At the Insured Person's or Dependent's option, the premium for the conversion policy or term life insurance policy will be payable in any mode the Company customarily offers under that policy.

5. **Contestable Period.** You may have made a statement regarding insurability under the group Policy. If so, that statement may be used:
   (a) to contest the validity of the individual conversion policy; but only
   (b) to the extent it could have been used to contest the validity of your coverage under the group Policy, had it remained in effect.

6. **Suicide Exclusion.** The individual conversion policy may include a suicide exclusion. If so, it will cease to apply two years after the date you became insured under the group Policy.

NOTICE OF CONVERSION PRIVILEGE. When your Personal Insurance terminates or reduces for a reason entitling you to convert, written notice of the right to convert is to be:
   (1) given personally to you;
   (2) mailed by the Group Policyholder to you, at your last known address; or
   (3) mailed by the Company to you, at your last known address, as furnished by the Group Policyholder.

This written notice is to be given within 15 days before or after the termination or reduction of Policy coverage. If the written notice is not given on time, the 31-day conversion period will be extended as follows.
   (1) If the written notice is given more than 15 days but less than 90 days after the termination or reduction, the conversion period will be extended to the 45th day following the date of the notice.
   (2) If the written notice is not given within 90 days after the termination or reduction, the conversion privilege will end on the 90th day following the termination or reduction.

DEATH DURING CONVERSION PERIOD. The Company will pay a death benefit under the Policy, if you:

(1) are entitled to purchase a conversion policy; and
(2) die within the applicable 31, 45 or 90-day application period shown above.

This death benefit will equal the amount of the Personal Life Insurance which could have been converted. It will be paid even if no one applied for the conversion policy. If the first premium was paid for the conversion policy, then:

(1) the amount of the premium will be refunded; and
(2) the conversion policy will be void.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT FOR YOU. The Company will pay the benefit listed below, if:

(1) you sustain an Accidental bodily injury while insured under this provision; and
(2) that injury directly causes one of the following losses within 365 days after the date of the Accident.

The loss must result directly from the injury and from no other causes.

LOSS	BENEFIT FOR COMMON CARRIER ACCIDENT	BENEFIT FOR OTHER COVERED ACCIDENT
Loss of Life	2 Times Principal Sum	Principal Sum
Loss of One Member (Hand, Foot or Eye)	Principal Sum	½ Principal Sum
Loss of Two or More Members	2 Times Principal Sum	Principal Sum
Quadriplegia (Paralysis of Both Arms and Both Legs)	2 Times Principal Sum	Principal Sum
Paraplegia (Paralysis of Both Legs)	Principal Sum	½ Principal Sum
Hemiplegia (Paralysis of Arm and Leg of Same Side)	Principal Sum	½ Principal Sum

The Principal Sum for your class is shown in the Schedule of Insurance.

MAXIMUM PER PERSON. If you sustain more than one loss resulting from the same Accident, the benefit:

(1) will be the one largest amount listed;
(2) will not exceed two times the Principal Sum for all of your combined losses resulting from a Common Carrier Accident; and
(3) will not exceed the Principal Sum for all of your combined losses resulting from any other covered Accident.

TO WHOM PAYABLE. Benefits for your loss of life will be paid to your Beneficiary. All other benefits will be paid to you.

LIMITATIONS. Benefits are not payable for any loss if the loss resulted, directly or indirectly, from or was in any degree caused by:

(1) disease, physical or mental infirmity, Sickness, or medical or surgical treatment of these;
(2) suicide, attempted suicide, or intentional self-inflicted injury;
(3) being under the influence of any narcotic, unless administered on the advice of a Physician;
(4) participation in the commission of a felony;
(5) war or any act of war, declared or undeclared; or participation in a riot or insurrection;
(6) duty as a member of any military, including Reserves or National Guard;
(7) aviation, except as a fare-paying passenger on a scheduled or chartered flight operated by a scheduled airline; or
(8) your driving a motor vehicle while intoxicated.

DEFINITIONS.

"Accident" or "Accidental" refers to an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated.

"Aviation" means travel or flight in or on any device used for aerial navigation, including but not limited to, airplanes, helicopters, balloons, gliders, parachutes, hang gliders and parasails.

"Beneficiary" means the person(s) named on your enrollment form. You may change the Beneficiary by filing a written notice of the change with the Company at its Group Insurance Service Office.

"Common Carrier Accident" means a covered Accidental bodily injury, which is sustained while riding as a fare paying passenger (not a pilot, operator or crew member) in or on, boarding or getting off from a Common Carrier.

"Common Carrier" means any land, air or water conveyance operated under a license to transport passengers for hire.

"Intoxicated" means the person's blood alcohol level meets or exceeds the level in determining intoxication under the laws of the jurisdiction where the accident occurs.

"Loss of a Member" includes the following:
(1) "Loss of Hand or Foot," means complete severance through or above the wrist or ankle joint.
(2) "Loss of an Eye," means total and irrevocable loss of sight in that eye.

"Narcotic" means any substance which:
(1) is classified as such by the American Psychiatric Association; and
(2) is subject to legal restriction or requires a Physician's written prescription.
The term includes (but is not limited to) cannabis, cocaine, opiates, amphetamines, hallucinogens, sedatives, hypnotics and anxiolytics.

"Sickness" includes:
(1) illness;
(2) pregnancy; or
(3) infection, except when the infection is due to an Accidental cut or wound.

REPATRIATION BENEFIT

BENEFIT. The Company will pay a Repatriation Benefit, if:

(1) you are insured for Accidental Death and Dismemberment Insurance under the Policy on the date of the Accident;
(2) you die as a result of a covered Accident at least 150 miles from your principal place of residence; and
(3) expense is incurred for the preparation and transportation of your body to a mortuary within 30 miles of your place of residence.

This benefit will be in addition to all other benefits payable under the Policy. This benefit will equal the expenses incurred for the preparation and transportation of your body to a mortuary subject to a maximum of $5,000. This benefit will be paid:

(1) when the benefit for Accidental loss of life is paid; or
(2) when the Company receives proof of expense incurred, if later.

PROOF. In order for this benefit to be payable, proof of payment for any expenses incurred for Repatriation must be provided to the Company.

TO WHOM PAYABLE. Benefits for Repatriation will be paid to the Insured Person's Beneficiary.

Benefits will not be payable for any loss excluded under the Accidental Death and Dismemberment Insurance Limitations section.

EDUCATION BENEFIT

BENEFIT. The Company will pay an Education Benefit for each of your eligible Dependent Children, if you:

(1) are injured in a covered accident, for which Accidental Death and Dismemberment Benefits are payable, while insured under the Policy;
(2) die as a direct result of such injuries within 365 days after the accident; and
(3) are survived by one or more Dependent Children who are eligible for the benefit.

To be eligible for the Education Benefit, your Dependent Child:

(1) must be dependent on you for principal support;
(2) must be enrolled as a Full-Time Student on the date of your death or within 365 days after that date; and
(3) must incur expenses after the date of your death for tuition, fees, books, room and board, or any other costs payable directly to (or approved and certified by) that school.

This benefit will be paid in addition to all other benefits payable under the Policy. The benefit will equal the actual expense incurred after the date of your death up to 5% of your Principal Sum, subject to a maximum of $5,000 for each eligible Dependent Child per year, for up to 4 consecutive years or until age 25. The benefit will be paid to your Dependent Child, if your child has reached the age of majority. Otherwise, benefits will be paid to your child's legal guardian. The first payment will be made:

(1) when the benefit for accidental loss of life is paid; or
(2) when the Company receives proof of payment for the expenses incurred and that your eligible Dependent Child meets the above requirements, if later.

Subsequent payments will be made when the Company receives:

(1) verification that the eligible Dependent Child continues to be a Full-Time Student during each additional semester/year; and
(2) proof of payment for the expenses incurred.

"Full-Time Student" means a Dependent Child who:

(1) is attending a licensed or accredited college, university or vocational school (beyond the 12th grade);
(2) is considered a full-time student based upon that school's standards; and
(3) incurs expenses for tuition, fees, books, room and board, or other costs payable directly to (or approved or certified by) that school.

"Child" includes your naturally born child, legally adopted child, stepchild, and foster child.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Accidental Death and Dismemberment Insurance Limitations section.

ALTERNATE BENEFIT. If you have no Dependent Child who is eligible for the Education Benefit on the date you die, as described above; then the Company will pay an additional benefit of $1,000 to your Beneficiary. Payment will be in addition to all other Policy benefits.

SPOUSE TRAINING BENEFIT

BENEFIT. The Company will pay a Spouse Training Benefit to your surviving Spouse, if you:

(1) are injured in a covered accident, for which Accidental Death and Dismemberment Benefits are payable, while insured under the Policy;
(2) die as a direct result of such injuries within 365 days after the accident; and
(3) are survived by a Spouse who is eligible for the benefit.

To be eligible for the Spouse Training Benefit, your Spouse:

(1) must still be your legal spouse, whose marriage to you has not ended by divorce or annulment, on the date of the accident;
(2) must be enrolled as a student on the date of your death or within 365 days after that date in any school to retrain or refresh skills needed for employment; and
(3) must incur expenses after the date of your death for tuition, fees, books, room and board or other costs payable directly to (or approved or certified by) that school.

This benefit will be paid in addition to all other benefits payable under the Policy. The benefit will equal the actual expense incurred after the date of your death up to 5% of your Principal Sum; subject to a maximum of $5,000. The benefit will be paid for one year. Payment will be made:

(1) when the benefit for accidental loss of life is paid; or
(2) when the Company receives proof of expense incurred and that the Spouse meets the above requirements, if later.

EXCLUSIONS. Benefits will not be payable for any loss excluded under the Accidental Death and Dismemberment Insurance Limitations section.

ALTERNATE BENEFIT. If you have no Spouse who is eligible for the Spouse Training Benefit on the date you die, as described above; then the Company will pay an additional benefit of $1,000 to your Beneficiary. Payment will be in addition to all other Policy benefits.

CHILD CARE BENEFIT

BENEFIT. The Company will pay a Child Care Benefit for each of your eligible Dependent Children, if you:

(1) are injured in a covered accident, for which Accidental Death and Dismemberment Benefits are payable, while insured under the Policy;
(2) die as a direct result of such injuries within 365 days after the accident; and
(3) are survived by one or more Dependent Children who are eligible for the benefit.

To be eligible for the Child Care Benefit, your Dependent Child must:

(1) be dependent on you for principal support;
(2) be under age 13 on the date of the accident; and
(3) attend a licensed Child Care Center on a regular basis on the date of your death or within 365 days after that date.

The Child Care Benefit is paid in addition to all other Policy benefits. The benefit will equal the actual expense incurred after the date of your death, up to 5% of your Principal Sum; subject to a maximum of $5,000 for each eligible Dependent Child per year. The benefit will be paid to the legal guardian of the eligible Dependent Child:

(1) for up to 4 consecutive years; or
(2) until your Dependent Child's 13th birthday (whichever occurs first).

The first payment will be made:

(1) when the benefit for accidental loss of life is paid; or
(2) when the Company receives proof of expense incurred and that an eligible Dependent Child meets the above requirements; if later.

Subsequent payments will be made quarterly on a reimbursement basis when the Company receives:

(1) verification that your eligible Dependent Child continues to attend a licensed Child Care Center on a regular basis; and
(2) satisfactory proof of payment for the child care expense incurred.

DEFINITIONS. "Child Care Center" means any facility (other than a family day care home) which:

(1) is licensed as such by the state; and
(2) provides non-medical care and supervision for children in a group setting; and
(3) cares for children at least 6 but less than 24 hours per day.

"Child" includes your naturally born child, legally adopted child, stepchild, and foster child.

"Expense Incurred" means the cost for the supervision and care of a Dependent Child, excluding any fees for extra activities, which are directly payable to a Child Care Center.

EXCLUSIONS. Benefits will not be paid:

(1) when the Dependent Child's care is provided by (or at a facility operated by) the child's grandparent, parent, aunt, uncle or sibling; or
(2) for any loss excluded under the Accidental Death and Dismemberment Insurance Limitations section of the Policy.

ALTERNATE BENEFIT. If you have no Dependent Child who is eligible for the Child Care Benefit on the date you die, as described above; then the Company will pay an additional benefit of $1,000 to your Beneficiary. Payment will be in addition to all other Policy benefits.

SAFE DRIVER BENEFIT

BENEFIT. If you die as a direct result of a covered auto accident, for which Accidental Death and Dismemberment Benefits are payable; then:

(1) an additional Seat Belt Benefit will be payable, if you were wearing a properly fastened seat belt at the time of the accident; and
(2) an additional Air Bag Benefit will be payable, if the auto was equipped with air bag(s).

The Seat Belt Benefit equals $10,000 or 10% of the Principal Sum, whichever is less; and the Air Bag Benefit equals $10,000 or 10% of the Principal Sum, whichever is less. The Seat Belt Benefit and the Air Bag Benefit will not be less than $1,000. The Principal Sum is the amount payable because of your accidental death.

A copy of the police report must be submitted with the claim. The position of the seat belt or presence of an air bag must be certified by:

(1) the official accident report; or
(2) the coroner, traffic officer or other investigating officer.

Upon receipt of satisfactory written proof, the additional benefit will be paid in accord with the Beneficiary section.

DEFINITIONS. As used in this provision:

"Auto" means a 4-wheel passenger car, station wagon, jeep, pick-up truck or van-type car. It must be licensed for use on public highways. It includes a car owned or leased by the Group Policyholder.

"Intoxicated" shall be defined as by the jurisdiction where the accident occurs.

"Narcotic" means any substance which:

(1) is classified as such by the American Psychiatric Association; and
(2) is subject to legal restriction or requires a Physician's written prescription.

The term includes (but is not limited to) cannabis, cocaine, opiates, amphetamines, hallucinogens, sedatives, hypnotics and anxiolytics.

"Seat Belt" means a properly installed:

(1) seat belt or lap and shoulder restraint; or
(2) other restraint approved by the National Highway Traffic Safety Administration.

LIMITATIONS. Safe Driver Benefits will not be paid if:

(1) the Accidental Death and Dismemberment Benefit is not paid under the Policy for your death;
(2) at the time of the accident, you were driving while intoxicated; or
(3) at the time of the accident, you were under the influence of any narcotic (except when taken on the advice of a Physician).

CLAIMS PROCEDURES
FOR LIFE BENEFITS

NOTE: This Certificate may include an Extension of Death Benefit or an Accelerated Death Benefit. If so, please refer to that section for special claim procedures.

CLAIM FORMS. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, you or your Beneficiary (the claimant) may send the Company written proof of claim in a letter. It should state the nature, date and cause of the loss.

PROOF OF CLAIM. Proof of claim must be provided at the claimant's own expense. It must show the nature, date and cause of death. Documentation must include:

(1) a certified copy of the death certificate, for proof of death;
(2) a signed authorization for the Company to obtain more information; and
(3) any other items the Company may reasonably require in support of the claim.

EXAM OR AUTOPSY. At anytime while a claim is pending, the Company may have you examined:

(1) by a Physician of the Company's choice;
(2) as often as reasonably required.

The Company may delay benefits until an exam is completed, if:

(1) you fail to cooperate with an examiner, fail to take an exam, or delay an exam scheduled by the Company; and
(2) the Company determines that the failure or delay is without good cause.

In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any benefits payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE. Any benefits payable for your death will be paid in accord with the Beneficiary, Facility of Payment, and Settlement Options sections of the Policy.

The Policy may include Dependent Life Insurance. If so, any benefits payable for an insured Dependent's death will be paid to:

(1) you, if you survive that Dependent; or
(2) your Beneficiary or in accord with the Facility of Payment section, if the you do not survive that Dependent.

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim, the written notice will:

(1) explain the reason for the denial, under the terms of the Policy and any internal guidelines;
(2) inform the claimant of the right to request a review of the Company's decision, and the procedure and time limit for doing so; and
(3) describe any additional information or items needed to support the claim.

If reasonably possible, the Company will send this notice within:

(1) 90 days after receiving the first proof of a death claim; or
(2) 45 days after receiving the first proof of a claim for any Extension of Death Benefit or Accelerated Death Benefit available under the Policy.

Delay Notice. If the Company needs more time to process a claim, due to special circumstances, an extension will be permitted. If needed, the Company will send the claimant a written delay notice:
(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain:
(1) the special circumstances which require the delay; and
(2) when a decision can be expected.

In any event, the Company must send written notice of its decision within:
(1) 180 days after receiving the first proof of a death claim; or
(2) 105 days after receiving the first proof of a claim for any Extension of Death Benefit or Accelerated Death Benefit available under the Policy.

If the Company fails to do so, there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time periods for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within:
(1) 60 days after receiving a denial notice of a death claim; or
(2) 180 days after receiving a denial notice of a claim for any Extension of Death Benefit or Accelerated Death Benefit available under the Policy.

To request a review, the claimant must send the Company:
(1) a written request; and
(2) any written comments or other items to support the claim.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:
(1) any further appeal procedures available under the Policy;
(2) the claimant's right to access relevant claim information; and
(3) the right to bring legal action.

For a death claim, the notice will be sent:
(1) within 60 days after the Company receives the request for review; or
(2) within 120 days, if a special case requires more time.

For a claim for any Extension of Death Benefit or Accelerated Death Benefit available under the Policy, the notice will be sent:
(1) within 45 days after the Company receives the request for review; or
(2) within 90 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case, it will send the claimant a written delay notice by the 30th day after receiving the request for review. The notice will explain:
(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

Exception: The Company may need more information from the claimant to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time periods for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974**).** Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this provision. After the required reviews:

(1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
(2) the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim, full reimbursement to the Company is required within 60 days. If reimbursement is not made, the Company has the right to:

(1) reduce future benefits until full reimbursement is made; and
(2) recover such overpayments from you or your Beneficiary or estate.

Such reimbursement is required whether the overpayment is due to fraud, the Company's error in processing a claim, or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after written proof of claim is required to be given.

CLAIMS PROCEDURES
FOR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

NOTICE OF CLAIM. Written notice of an accidental death or dismemberment claim must be given:
(1) within 30 days after the loss occurs; or
(2) as soon as reasonably possible after that.

The notice must be sent to the Company's Group Insurance Service Office. It should include your name and address and the number of the Policy.

Exception: Failure to give notice of claim within the required time period will not invalidate or reduce the claim if it is shown that the notice was furnished as soon as reasonably possible.

CLAIM FORMS. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, you or your Beneficiary (the claimant) may send the Company written proof of claim in a letter. It should state the nature, date and cause of the loss.

PROOF OF CLAIM. The Company must be given written proof of an accidental death or dismemberment claim:
(1) within 90 days after the date of the loss; or
(2) as soon as reasonably possible after that.

Proof of claim must be provided at the claimant's own expense. It must show the nature, date and cause of the loss. Documentation must include:
(1) a certified copy of the death certificate, for proof of death;
(2) a copy of any police report, for proof of accidental death or dismemberment;
(3) a signed authorization for the Company to obtain more information; and
(4) any other items the Company may reasonably require in support of the claim.

Exception: Failure to furnish proof of claim within the required time period will not invalidate or reduce the claim if it is shown that the notice was furnished as soon as reasonably possible.

EXAM OR AUTOPSY. At anytime while a claim is pending, the Company may have you examined:
(1) by a Physician of the Company's choice;
(2) as often as reasonably required while a claim or appeal is pending.

The Company may delay benefits until an exam is completed, if:
(1) you fail to cooperate with an examiner, fail to take an exam, or delay an exam scheduled by the Company; and
(2) the Company determines that the failure or delay is without good cause.

In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any benefits payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE. Any benefits payable for your death will be paid to your Beneficiary. Any benefit (other than your death benefit) will be paid to you.

Facility of Payment. All or part of your accidental death benefit may become payable to your estate when:
(1) there is no surviving Beneficiary to receive such benefit; or
(2) the Beneficiary is a minor or other person who is not considered competent to give a valid release.

In that event, the Company has the option to pay one or more of the following:
(1) your surviving spouse, parent(s), child or children; or
(2) your surviving brother(s) or sister(s).

No payment made under this Facility of Payment section may exceed $500. Any payment made in good faith under this section will fully discharge the Company, to the extent of the payment. Any remaining benefit will remain payable to your estate.

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim, the written notice will:
(1) explain the reason for the denial, under the terms of the Policy and any internal guidelines;
(2) inform the claimant of the right to appeal the denial, and the procedure and time limit for doing so; and
(3) describe any additional information or items needed to support the claim.

The claim decision notice will be sent within 15 days after the Company resolves the claim. It will be sent within 60 days after the Company receives the first proof of claim, if reasonably possible.

Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. In that event, the Company will send the claimant a written delay notice:
(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain:
(1) the special circumstances which require the delay; and
(2) when a decision can be expected.

If the claimant does not receive a written decision by the 60th day after the Company receives the first proof of claim, there is a right to an immediate review, as if the claim was denied.

Exception: The Company may need more information from the claimant to process a claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above 60-day time limit for claim processing.

REVIEW PROCEDURE. Within 60 days after receiving a denial notice, the claimant may request a claim review by sending the Company:
(1) a written request; and
(2) any written comments or other items to support the claim.

He or she may request certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will state the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:
(1) any further appeal procedures available under the Policy;
(2) the claimant's right to access relevant claim information; and
(3) the right to bring legal action.

This notice will be sent within 60 days after the Company receives the request for review, if reasonably possible.

Delay Notice. If the Company needs more than 60 days to process an appeal, in a special case, it will send the claimant a written delay notice by the 30th day after receiving the request for review. The notice will explain:

(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

Exception: The Company may need more information from the claimant to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above 60-day time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974**).** Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this provision. After the required reviews:

(1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
(2) the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim, full reimbursement to the Company is required within 60 days. If reimbursement is not made, the Company has the right to:

(1) reduce future benefits until full reimbursement is made; or
(2) recover such overpayments from you or your Beneficiary or estate.

Such reimbursement is required whether the overpayment is due to fraud, the Company's error in processing a claim, or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after written proof of claim is required to be given.

NOTICE TO CERTIFICATE HOLDERS

POLICY TERMINATION. If the Policy is to be terminated by the Company for a reason other than nonpayment of premium by the Group Policyholder, the Company will give the Group Policyholder advance notice of its intent to terminate the Policy. You will be informed of this event by the Group Policyholder at least 31 days prior to the Policy's termination date; unless the Group Policyholder:

(1) has taken steps to avoid Policy termination; or
(2) has contracted with another insurer to provide similar, continuous coverage.

In the event the Group Policyholder or Company terminates the Policy and the Group Policyholder does not provide replacement coverage with another carrier, please see the Conversion Privilege provision in this Certificate:

(1) for when to expect a notice; and
(2) for the time periods allowed to convert, if no notice is given.

NOTICE TO CERTIFICATE HOLDERS
INSURED FOR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

POLICY TERMINATION. If the Accidental Death and Dismemberment coverage is to be terminated by the Company for a reason other than nonpayment of premium by the Group Policyholder, the Company will give the Group Policyholder advance notice of its intent to terminate the Policy coverage. You will be informed of this event by the Group Policyholder at least 31 days prior to the Policy coverage's termination date; unless the Group Policyholder:

(1) has taken steps to avoid Policy coverage termination; or
(2) has contracted with another insurer to provide similar, continuous coverage.

SUMMARY PLAN DESCRIPTION

The following information together with your group insurance certificate issued to you by Lincoln Life & Annuity Company of New York of Syracuse, New York, is the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 to be distributed to participants in the Plan. This Summary Plan Description is only intended to provide an outline of the Plan's benefits. The Plan Document will govern if there is any discrepancy between the information contained in this Description and the Plan.

The name of the Plan is: Group Life, Accidental Death and Dismemberment Insurance for Employees of Friends Academy Spending Plan.

The name, address and ZIP code of the Sponsor of the Plan is: Friends Academy, 270 Duck Pond Road, Locust Valley, NY, 11560.

Employer Identification Number (EIN): 11-1633485 IRS Plan Number: 501

The name, business address, ZIP code and business telephone number of the Plan Administrator is: Friends Academy, 270 Duck Pond Road, Locust Valley, NY, 11560, (516) 393-4291.

The Plan Administrator is responsible for the administration of the Plan and is the designated agent for the service of legal process for the Plan. Functions performed by the Plan Administrator include: the receipt and deposit of contributions, maintenance of records of Plan participants, authorization and payment of Plan administrative expenses, selection of the insurance consultant, selection of the insurance carrier and assisting Lincoln Life & Annuity Company of New York. Lincoln Life & Annuity Company of New York has the sole discretionary authority to determine eligibility and to administer claims in accord with its interpretation of policy provisions, on the Plan Administrator's behalf.

Type of Administration. The Plan is administered directly by the Plan Administrator with benefits provided in accordance with provisions of the group insurance policy issued by Lincoln Life & Annuity Company of New York whose Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska.

Type of Plan. The benefits provided under the Plan are: Group Life, Accidental Death and Dismemberment Insurance benefits.

Type of Funding Arrangement: Lincoln Life & Annuity Company of New York.

All employees are given a Certificate of Group Insurance which contains a detailed description of the Benefits. The Certificate also contains the Schedule of Insurance which includes the amount of Personal Life insurance, AD&D Principal Sum, Dependent Life amounts (if any), Waiting Period and age reduction information. If your Booklet, Certificate or Schedule of Insurance has been misplaced, you may obtain a copy from the Plan Administrator at no charge.

Eligibility. Full-time employees working at least 30 hours per week.

Employees become eligible on the first day of active full-time employment.

CONTRIBUTIONS: You are not required to make contributions for Personal Life & AD&D Insurance.

The Plan's year ends on: December 31st of each year.

The name and section of relevant Collective Bargaining Agreements: None

The name, title and address of each Plan Trustee: None

Loss of Benefits. The Plan Administrator may terminate the policy, or subject to Lincoln Life & Annuity Company of New York's approval, may modify, amend or change the provisions, terms and conditions of the policy. Coverage will also terminate if the premiums are not paid when due. No consent of any Insured Person or any other person referred to in the policy will be required to terminate, modify, amend or change the policy. See your Plan Administrator to determine what, if any, arrangements may be made to continue your coverage beyond the date you cease active work.

Claims Procedures. You may obtain claim forms and instructions for filing claims from the Plan Administrator or from the Group Insurance Service Office of Lincoln Life & Annuity Company of New York. To expedite the processing of your claim, instructions on the claim form should be followed carefully; be sure all questions are answered fully. In accordance with ERISA, Lincoln Life & Annuity Company of New York will send you or your beneficiary a written notice of its claim decision within:

- 90 days after receiving the first proof of a death or dismemberment claim (180 days under special circumstances);
- 45 days after receiving the first proof of a claim for any Extension of Death Benefit or Accelerated Death Benefit, if available under the Policy (105 days under special circumstances).

If a claim is partially or wholly denied, this written notice will explain the reason(s) for denial, how a review of the decision may be requested, and whether more information is needed to support the claim. You, or another person on your behalf, may request a review of the claim by making a written request Lincoln Life & Annuity Company of New York within:

- 60 days after receiving a denial notice of a death or dismemberment claim;
- 180 days after receiving a denial notice of a claim for any Extension of Death Benefit or Accelerated Death Benefit, if available under the Policy.

This written request for review should state the reasons why you feel the claim should not have been denied and should include any additional documentation to support your claim. You may also submit for consideration additional questions or comments you feel are appropriate, and you may review certain non-privileged information relating to the request for review. Lincoln Life & Annuity Company of New York will make a full and fair review of the claim and provide a final written decision to you or your beneficiary within:

- 60 days after receiving the request for a review of a death or dismemberment claim (120 days under special circumstances);
- 45 days after receiving the request for review of a claim for any Extension of Death Benefit or Accelerated Death Benefit, if available under the Policy (90 days under special circumstances).

If more information is needed to resolve a claim, the information must be supplied within 45 days after requested. Any resulting delay will not count toward the above time limits for claims or appeals processing. Please refer to your certificate of insurance for more information about how to file a claim, how to appeal a denied claim, and for details regarding the claims procedures.

Statement of ERISA Rights

The following statement of ERISA rights is required by federal law and regulation. As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if any, and updated summary plan description. The administrator may make a reasonable charge for copies.

Receive a summary of the plan's annual financial report if the plan covers 100 or more participants. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

What Does Lincoln Financial Do with Your Personal Information?

The Lincoln Financial companies* are committed to protecting your privacy. To provide the products and services you expect from a financial services leader, we must collect personal information about you. This Notice describes our current privacy practices. While your relationship with us continues, we will update and send our Privacy Practices Notice as required by law. Even after that relationship ends, we will continue to protect your personal information. You do not need to take any action because of this Notice, but you do have certain rights as described below.

We are committed to the responsible use of information and protecting individual privacy rights. As such, we look to leading data protection standards to guide our privacy program. These standards include collecting data through fair and lawful means, such as obtaining your consent when appropriate.

Financial companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this carefully to understand what we do.

Information We May Collect and Use

We collect personal information about you:

- to help us identify you as a consumer, our customer or our former customer;
- to process your requests and transactions;
- to offer investment, insurance, retirement and other financial services to you;
- to pay your claim;
- to analyze in order to enhance our products and services;
- to tell you about our products or services we believe you may want and use; and
- as otherwise permitted by law.

The types of personal information we collect depend on your relationship and on the products or services you request and may include the following:

- **Information from you:** When you submit your application or other forms, you give us information such as your name; address; Social Security number; your financial health; and employment history. We may also collect voice recordings or biometric data for use in accordance with applicable law.
- **Information about your transactions:** We maintain information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; payment details; and your payment and claims history.
- **Information from outside our family of companies:** If you are applying for or purchasing insurance products, we may collect information from consumer reporting agencies, such as your credit history; credit scores; and driving and employment records. With your authorization, we may also collect information (such as medical information, retirement information, and information related to Social Security benefits), from other individuals or businesses.
- **Information from your employer:** If your employer applies for or purchases group products from us, we may obtain information about you from your employer or group representative to enroll you in the plan.

When you are no longer our customer, we continue to share your information as described in this notice.

How We Share and Use Your Personal Information

We may share your personal information within our companies and with certain service providers. They may use this information:

- to process transactions you, your employer, or your group representative have requested;
- to provide customer service;
- to analyze in order to evaluate or enhance our products and services;
- to gain customer insight; to provide education and training to our workforce and customers; and/or
- to inform you of products or services we offer that you may find useful.

Our service providers may or may not be affiliated with us. Affiliates are companies related by common ownership or control. Nonaffiliates are companies not related by common ownership or control. They include:

- Financial service providers: third party administrators; broker-dealers; insurance agents and brokers; registered representatives; reinsurers and other financial services companies with which we have joint marketing agreements. A joint marketing agreement is a formal agreement between nonaffiliated financial companies that together market financial products or services to you. Our joint marketing partners include, but are not limited to, insurance providers and financial technology solutions.
- Non-financial companies and individuals: consultants; vendors; and companies that perform marketing services on our behalf.

Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law. We may execute agreements with our service providers that permit the service provider to process your personal information outside of the United States, when not prohibited by our contracts and permitted by applicable law.

When you apply for one of our products:

- We may share information about your application with credit bureaus.
- We may provide information to group policy owners or their designees (for example, to your employer for employer-sponsored plans and their authorized service providers).
- We may provide information to regulatory authorities, law enforcement officials, and to other nonaffiliated or affiliated parties as permitted by law.
- In the event of a sale of all or part of our businesses, we may share customer information with the acquiror as part of the sale.
- **We do not sell or release your information to outside marketers who may want to offer you their own products and services unless we receive your express consent; nor do we release information we receive about you from a consumer reporting agency.**

All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Lincoln chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	**Does Lincoln share?**	**Can you limit this sharing?**
For our everyday business purposes—such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes—to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes—information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes—information about your creditworthiness	No	We Don't Share
For our affiliates to market to you	Yes	Yes (We only share if we receive your express consent)
For nonaffiliates to market to you	Yes	Yes (We only share if we receive your express consent)

Federal law gives you the right to limit only:

- sharing for our affiliates' everyday business purposes – information about your creditworthiness;
- sharing for our affiliates to market to you; and
- sharing for nonaffiliates to market to you.

State laws and individual companies may give you additional rights to limit sharing. California residents can review our California Privacy Notice located at https://www.lincolnfinancial.com/public/general/privacy/californiaprivacynotice.

Security of Information

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. Our employees are authorized to access your information only when they need it to perform their job responsibilities. Employees who have access to your personal information are required to keep it confidential. Employees are required to complete privacy training annually.

Your Rights Regarding Your Personal Information

This Privacy Notice describes how you can exercise your rights regarding your personal information. Lincoln complies with all applicable laws and regulations regarding the provision of personal information. The rights provided to you in this Privacy Notice will be administered in accordance with your state's specific laws and regulations.

Access to personal information: You must submit a written request to receive a copy of your personal information. You may see your personal information in person, or you may ask us to send you a copy of your personal information by mail or electronically, whichever you prefer. We will need to verify your identity before we process the request. Within 30 business days of receiving your request, we will, depending on the specific request you make, (1) inform you of the nature and substance of the recorded personal information we have about you; (2) permit you to obtain a copy of your personal information; and (3) provide the identity (if recorded) of persons to whom we disclosed your personal information within two years prior to the request (if this information is not recorded, we will provide you with the names of those insurance institutions, agents, insurance support organizations or other persons to whom such information is normally disclosed). We will send you notification within 30 business days if we need additional time to respond to your request. If you request a copy of your information by mail, we may charge you a fee for copying and mailing costs.

Changes to personal information: If you believe that your personal information is inaccurate or incomplete, you may ask us to correct, amend, or delete the information. Your request must be in writing and must include the reason you are requesting the change. We will respond within 30 business days from the date we receive your request.

If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received your personal information within the past two years. We will also send the updated information to any insurance support organization that gave us the information and any insurance support organization that systematically received personal information from us within the prior 7 years unless that support organization no longer maintains your personal information.

If we deny your request to correct, amend, or delete your information, we will provide you with the reasons for the denial. You may write to us and concisely describe what you believe our records should say and why you disagree with our denial of your request to correct, amend, or delete that information. We will file this communication from you with the disputed information, identify the disputed information if it is disclosed, and provide notice of the disagreement to the recipients and in the manner described in the paragraph above.

Basis for adverse underwriting decision: You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate, or terminate your coverage.

Your state may provide for additional privacy protections under applicable laws. We will protect your information in accordance with these additional protections.

If you would like to exercise your rights regarding your personal information, please provide your full name, address and telephone number and either email your inquiry to our Data Subject Access Request Team at DSAR@lfg.com or mail to: Lincoln Financial, Attn: Corporate Privacy Office, 1301 South Harrison St., Fort Wayne, IN 46802. **The DSAR@lfg.com email address should only be used for inquiries related to this Privacy Notice.**

For general account service requests or inquiries unrelated to this Privacy Notice, please call 1-877-ASK-LINC.

*This information applies to the following Lincoln Financial companies:

First Penn-Pacific Life Insurance Company
Lincoln Financial Distributors, Inc.
Lincoln Financial Group Trust Company, Inc.
Lincoln Financial Investments Corporation (formerly Lincoln Investment Advisors Corporation)
Lincoln Life & Annuity Company of New York
Lincoln Life Assurance Company of Boston
Lincoln Retirement Services Company, LLC
Lincoln Variable Insurance Products Trust
The Lincoln National Life Insurance Company
Lincoln Financial Insurance Agency Incorporated