All Full-Time Employees of Kenyon Companies, Inc.

Benefits At-A-Glance

Supplemental Life and AD&D Insurance

The Lincoln Term Life and AD&D Insurance Plan:

- Provides a cash benefit to your loved ones in the event of your death
- Provides an additional cash benefit to your loved ones if you die — or to you if you lose a limb or your eyesight — in a covered accident when you add optional AD&D insurance
- Features group rates for Kenyon Companies, Inc. employees
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services
- Also includes *TravelConnect*℠ services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

Employee	
Guaranteed coverage amount during initial offering or approved special enrollment period	$150,000
Newly hired employee guaranteed coverage amount	$150,000
Continuing employee guaranteed coverage annual increase amount	Choice of $25,000
Maximum coverage amount	5 times your annual salary ($250,000 maximum in increments of $25,000)
Minimum coverage amount	$25,000
Optional AD&D coverage amount	Equal to the life insurance amount chosen
Spouse	
Guaranteed coverage amount during initial offering or approved special enrollment period	$30,000
Newly hired employee guaranteed coverage amount	$30,000
Continuing employee guaranteed coverage annual increase amount	Choice of $10,000
Maximum coverage amount	50% of the employee coverage amount ($100,000 maximum in increments of $10,000)
Minimum coverage amount	$10,000
Optional AD&D coverage amount	Equal to the life insurance amount chosen
Dependent Children	
6 months to age 19 (to age 25 if full-time student) guaranteed coverage amount	$10,000
Age 14 days to 6 months guaranteed coverage amount	$250

The Lincoln National Life Insurance Company

What your benefits cover

Employee Coverage

Guaranteed Life and Optional AD&D Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to $150,000 without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase your coverage amount by $25,000 without providing evidence of insurability . If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.
- You can increase this amount by up to $25,000 during the next limited open enrollment period.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 5 times your annual salary ($250,000 maximum) with evidence of insurability. See the Evidence of Insurability page for details.
- The maximum coverage amount for employees 70 and older who are electing coverage for the first time is $50,000.
- Your coverage amount will reduce by 35% when you reach age 65; an additional 25% of the original amount when you reach age 70; an additional 15% of the original amount when you reach age 75; and an additional 15% of the original amount when you reach age 80.

Spouse Coverage - You can secure term life and AD&D insurance for your spouse if you select coverage for yourself.

Guaranteed Life and Optional AD&D Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to 50% of your coverage amount ($30,000 maximum) for your spouse without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase the coverage amount for your spouse by $10,000 without providing evidence of insurability. If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.
- You can increase this amount by up to $10,000 during the next limited open enrollment period.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 50% of your coverage amount ($100,000 maximum) for your spouse with evidence of insurability.
- Coverage amounts are reduced by 35% when an employee reaches age 65

Dependent Children Coverage - You can secure term life insurance for your dependent children when you choose coverage for yourself.

Guaranteed Life Insurance Coverage Options: $10,000

Additional Plan Benefits

Accelerated Death Benefit	Included
Premium Waiver	Included
Conversion	Included
Portability	Included
Seat Belt & Airbag	Included with AD&D
Common Carrier	Included with AD&D

Benefit Exclusions

Like any insurance, this term life and AD&D insurance policy does have exclusions.

For life insurance, a suicide exclusion may apply.

For AD&D, benefits will not be paid if death results from suicide, or death/dismemberment occurs while:

- Inflicting or attempting to inflict injury to one's self
- Participating in a riot or as a result of war or act of war
- Serving as a member of the military, including the Reserves and National Guard
- Committing or attempting to commit a felony
- Deliberately inhaling gas (such as carbon monoxide) or using drugs other than those prescribed by a physician and administered as prescribed
- Flying in a non-commercial airplane or aircraft, such as a balloon or glider
- Driving while intoxicated (with a blood alcohol level of .08 grams or more per 100 milliliters of blood)

In addition, the AD&D insurance policy does not cover sickness or disease, including the medical and surgical treatment of a disease.

A complete list of benefit exclusions is included in the policy. State variations apply.

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

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

LifeKeys® services are provided by ComPsych® Corporation, Chicago, IL. TravelConnect℠ travel assistance services are provided by On Call International, Salem NH. On Call International must coordinate and provide all arrangements in order for eligible services to be covered. ComPsych® and On Call International are not Lincoln Financial Group companies and Lincoln Financial Group does not administer these Services. Each independent company is solely responsible for its own obligations. Coverage is subject to contract language that contains specific terms, conditions, and limitations.

Insurance products (policy series GL1101) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply.

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Monthly Supplemental Life and AD&D Insurance Premium
Here's how little you pay with group rates.

Employee Age Range	Life Premium Rate	Life & AD&D Premium Rate
0 - 24	0.0000700	0.0001150
25 - 29	0.0000700	0.0001150
30 - 34	0.0000700	0.0001150
35 - 39	0.0001000	0.0001450
40 - 44	0.0001600	0.0002050
45 - 49	0.0002600	0.0003050
50 - 54	0.0004900	0.0005350
55 - 59	0.0007700	0.0008150
60 - 64	0.0008800	0.0009250
65 - 69	0.0016000	0.0016450
70 - 74	0.0031600	0.0032050
75 - 79	0.0087000	0.0087450
80 - 99	0.0196100	0.0196550

Group Rates for You

The estimated monthly premium for life insurance only or life and optional AD&D insurance is determined by multiplying the desired amount of coverage (in increments of $25,000) by the employee age-range premium rate.

$__________ X __________ = $______________

coverage amount   premium rate   monthly premium

Note: Rates are subject to change and can vary over time.

Employee Age Range	Life Only Premium Rate	Life & AD&D Premium Rate
0 - 24	0.0000700	0.0001150
25 - 29	0.0000700	0.0001150
30 - 34	0.0000700	0.0001150
35 - 39	0.0001000	0.0001450
40 - 44	0.0001600	0.0002050
45 - 49	0.0002600	0.0003050
50 - 54	0.0004900	0.0005350
55 - 59	0.0007700	0.0008150
60 - 64	0.0008800	0.0009250
65 - 69	0.0016000	0.0016450
70 - 74	0.0031600	0.0032050
75 - 79	0.0087000	0.0087450
80 - 99	0.0196100	0.0196550

Group Rates for Your Spouse

The estimated monthly premium for life insurance only or life and optional AD&D insurance is determined by multiplying the desired amount of coverage (in increments of $10,000) by the employee age-range premium rate.

$__________ X __________ = $______________

coverage amount   premium rate   monthly premium

Note: Rates are subject to change and can vary over time.

Dependent Children Monthly Premium for Life Insurance Coverage

Coverage Amount	Monthly Premium
$10,000	$2.00

The Lincoln National Life Insurance Company

Please see prior page for product information.

Group Rates for Your Dependent Children

One affordable monthly premium covers all of your eligible dependent children.

Note: You must be an active Kenyon Companies, Inc. employee to select coverage for a spouse and/or dependent children. To be eligible for coverage, a spouse or dependent child cannot be confined to a health care facility or unable to perform the typical activities of a healthy person of the same age and gender.

The Lincoln National Life Insurance Company

Please see prior page for product information.

Lincoln Financial Group®

Kenyon Companies, Inc.

Benefits At-A-Glance

All Full-Time Non-CA Employees

Voluntary Short-term Disability Insurance

The Lincoln Short-term Disability Insurance Plan:

- Provides a cash benefit when you are out of work for up to 11 weeks due to injury, illness, surgery, or recovery from childbirth
- Features group rates for employees
- Provides a partial cash benefit if you can only do part of your job or work part time
- Offers a fast, no-hassle claims process

Voluntary Short-term Disability	
Weekly benefit amount	60% of your weekly salary, limited to $1,000 per week
Sickness elimination period	14 days
Accident elimination period	14 days
Maximum coverage period	11 weeks

Sickness Elimination Period: You must be out of work for 14 days due to an illness before you can collect disability benefits. You can begin collecting benefits on day 15.

Accident Elimination Period: You must be out of work for14 days due to an accidental injury before you can collect disability benefits. You can begin collecting benefits on day 15.

Recurrent Disability Benefits

- If you become disabled for the same condition within 14 days following your prior disability, your benefits will continue under the same claim.

Additional Plan Benefits	
Benefits Integration	Included
Rehabilitation Assistance	Included
Family Income Benefit	Included
Portability	Included
Premium Waiver	Included

Evidence of Insurability

- When you are first offered this coverage (and during approved open enrollment periods), you may be able to take advantage of this important coverage with no evidence of insurability (proof of health).

Pre-existing Condition

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

Benefit Exclusions & Reductions

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

- Your disability is the result of a self-inflicted injury or act of war
- Your disability occurs while you are committing a felony or participating in a riot

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

- Sick pay from your employer
- A state disability plan or similar compulsory benefit act or law
- A retirement plan
- Social Security
- Any form of employment
- Workers' Compensation

This is an incomplete list of benefit exclusions. A complete list is included in the policy. State variations apply.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the policy, the policy will govern.

Group insurance products and services described herein are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. In New York, insurance products are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group® companies. Product availability and/or features may vary by state. Limitations and exclusions apply. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations.

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Voluntary Short-term Disability Premium
Here's how little you pay with group rates.

Use the employee voluntary short-term disability premium rate table provided to below to calculate your cost and benefit. The following example calculates the monthly cost for an employee with annual earnings of $35,400.

Note: The maximum weekly covered earnings are equal to the maximum weekly benefit divided by the benefit percentage.

Calculation Example		Example	You
Step 1	Enter the monthly premium rate per $10 of weekly benefit.	$0.435	
Step 2	Enter your weekly earnings. *Divide your annual earnings by 52.*	$681	
Step 3	If your weekly earnings are greater than the maximum weekly covered earnings of $1,667, indicate $1,667. Otherwise, indicate the amount from Step 2.	$681	
Step 4	Calculate your weekly benefit. Multiply Step 3 by 0.60.	$408	
Step 5	Enter your weekly benefit in increments of $10. *To calculate, divide the amount in Step 4 by 10.*	40.8	
Step 6	Calculate your cost. Multiply Step 1 by Step 5.	$17.77	

This worksheet allows you to approximate your monthly contributions for voluntary short-term disability insurance coverage. Cost of insurance may change in the future due to age and/or coverage amount elected.

Lincoln Financial Group

Please see prior page for product information.

Kenyon Companies, Inc. provides this valuable benefit at no cost to you.

Full-Time Administrators enrolled in the Employer's Group Medical Plan

Full-Time Employees enrolled in the Employer's Group Medical

Life and AD&D Insurance

Safeguard the most important people in your life.

Think about what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like covering everyday expenses, paying off debt, and protecting savings. AD&D provides even more coverage if you die or suffer a covered loss in an accident.

AT A GLANCE:

- A cash benefit of $50,000, up to $50,000 without providing evidence of insurability to your loved ones in the event of your death, plus a matching cash benefit if you die in an accident
- A cash benefit to you if you suffer a covered loss in an accident, such as losing a limb or your eyesight
- *LifeKeys*® services, which provide access to counseling, financial, and legal support
- *TravelConnect*℠ services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

ADDITIONAL DETAILS

Conversion: You can convert your group term life coverage to an individual life insurance policy without providing evidence of insurability if you lose coverage due to leaving your job or for another reason outlined in the plan contract. AD&D benefits cannot be converted.

Benefit Reduction: Coverage amounts begin to reduce at age 65 and benefits terminate at retirement. See the plan certificate for details.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

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The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: 800-423-2765 Fax: 877-573-6177

Here is your Enrollment Form.

If you have questions when completing this form call HR at 602-233-1191

Group ID: ____________________

Follow these steps to complete the form.
Print clearly in ink.
Step 1: Fill in or confirm your personal information.
Step 2: Fill in dependent information, if any.
Step 3: Select your benefits.
Step 4: Assign beneficiaries.
Step 5: Confirm enrollment.
Step 6: Sign, date & Email the form to **benefits@kenyonweb.com**.

1. Your Personal Information

Group/Employer/Participating Organization Name ____________________ County __________ Zip ______ State ______

Your First Name ______ Middle Name/MI ______ Last Name ______ Social Security No. ______-____-______ Employee ID No. ______ Date of Birth ___/___/____

Street Address (Include Apt. or Suite No.) ____________________ City __________ State ______ Zip ______

Home Phone (   )   - ______ Cell Phone (   )   - ______ Work Phone (   )   - ______ Email Address ______

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

2. Personal Information on Dependents — Complete if you are enrolling dependents.

☐ **Spouse**

First Name ______ Middle Name/MI ______ Last Name ______ Social Security No. ______-______-______ Date of Birth ___/___/____

Provide contact information if different than Your information above.

Home Phone (   )   - ______ Cell Phone (   )   - ______ Work Phone (   )   - ______ Email Address ______

Dependent Children – List all children you are enrolling (attach a separate sheet, if needed).

First Name Middle Name/MI Last Name	SSN (Optional)	Gender	DOB	Full-time Student
	______-____-______	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No
	______-____-______	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No
	______-____-______	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No

Employer Completes this Section.

Billing Division or Location: ____________________

Sort Group/Code: ____________________ Payroll Cycle: ____________________

Policy #(s): ____________________

Average Hours Worked Per Week: ________ ☐ Full-time ☐ Part-time Occupation: ____________________

Earnings: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly $__________ Date of Employment:______/____/________

Actively at Work? ☐ Yes ☐ No Date of Rehire:__________/____/________

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

3. Benefit Selection — Continued. Choose your benefits.

To apply the appropriate tobacco/non-tobacco rates, please answer the following question:

In the past 12 months, have You or Your Spouse smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?

You: ☐ **Yes** ☐ **No**
Your Spouse: ☐ **Yes** ☐ **No**

Voluntary/Optional Group Insurance - Complete if selecting more than the standard benefit.

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

3. Benefit Selection — Continued. Choose your benefits.

Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium (Weekly)
Class	Effective Date			
______	____/____/____	Voluntary Life & AD&D ☐ **Yes** ☐ **No***	$____________	$____________
______	____/____/____	Voluntary Life Only ☐ **Yes** ☐ **No***	$____________	$____________
______	____/____/____	Voluntary Dependent (Spouse Only) Life & AD&D ☐ **Yes** ☐ **No*** *You must be enrolled for Life & AD&D insurance in order to add spouse and/or child insurance.*	$____________	$____________
______	____/____/____	Voluntary Dependent (Spouse Only) Life Only ☐ **Yes** ☐ **No*** *You must be enrolled for Life insurance in order to add spouse and/or child insurance.*	$____________	$____________
______	____/____/____	Voluntary Dependent (Child Only) Life Only ☐ **Yes** ☐ **No*** *You must be enrolled for Life insurance in order to add spouse and/or child insurance.*	$____________	$____________
______	____/____/____	Voluntary Short Term Disability (STD) ☐ **Yes** ☐ **No***	Weekly Benefit Amount: $_______	$____________

*By selecting "No," application for insurance at a later date may require further medical information and/or a physical exam, which will be at my own expense.

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

4. Select Your Beneficiaries — Choose who receives your insurance benefits.

Primary Beneficiary(ies)
The Primary Beneficiary is the person(s) you identify to receive insurance benefits upon your death.

If more than three Primary Beneficiaries, please attach a separate sheet of paper.
If multiple Primary Beneficiaries, total percentage of all combined must equal 100%.

First Name ______ Middle Initial ______ Last Name ______

Street Address ______ City ______ State ______ Zip ______

Social Security Number ____-___-_____ Date of Birth ___/___/___ Relationship to You ______ Percentage ______% Phone Number (___) ___-______

First Name ______ Middle Initial ______ Last Name ______

Street Address ______ City ______ State ______ Zip ______

Social Security Number ____-___-_____ Date of Birth ___/___/___ Relationship to You ______ Percentage ______% Phone Number (___) ___-______

First Name ______ Middle Initial ______ Last Name ______

Street Address ______ City ______ State ______ Zip ______

Social Security Number ____-___-_____ Date of Birth ___/___/___ Relationship to You ______ Percentage ______% Phone Number (___) ___-______

Contingent Beneficiary(ies) and Other Beneficiary Designations

A Contingent Beneficiary will receive benefits only if the Primary Beneficiary(ies) does not survive you. Please attach a separate sheet to identify a Contingent Beneficiary. If multiple Contingent Beneficiaries, total percentage of all combined must equal 100%. To name a Beneficiary(ies) by product, attach a separate sheet identifying product and beneficiary.

5. Confirm Enrollment

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

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

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

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

Fraud Warning/State Disclosure(s)

A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

6. Sign and Email to benefits@kenyonweb.com

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

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

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

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

Your Full Name (Print): ____

Your Signature: X____ **Date** ______/_____/______

Complete and return this form.

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

Questions? Call 800-423-2765

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