

SERFF Tracking Number: JEPT-126348452 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 43837
Company Tracking Number:
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
Product Name: Group Short Term Disability Income
Project Name/Number: Group STD Riders Filing/GL1101-STD-30

Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: Group Short Term Disability Income SERFF Tr Num: JEPT-126348452 State: Arkansas

TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved-Closed State Tr Num: 43837

Sub-TOI: H11G.002 Short Term Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Cindi Allgire, Debbie

Turek, Bonnie White

Date Submitted: 10/21/2009

Disposition Date: 10/29/2009
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Group STD Riders Filing

Project Number: GL1101-STD-30

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/29/2009

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 07/28/2009

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 10/29/2009

Created By: Bonnie White

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Bonnie White

Filing Description:

See filing cover letter

Company and Contact

Filing Contact Information

Bonnie White, Compliance Manager

8801 Indian Hills Drive

bonnie.white@lfg.com

402-361-7273 [Phone]

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P.O. Box 2616 402-361-2568 [FAX]
 Omaha, NE 68114

Filing Company Information

The Lincoln National Life Insurance Company CoCode: 65676 State of Domicile: Indiana
 350 Church Street Group Code: 20 Company Type: Group
 Hartford, CT 06103 Group Name: State ID Number:
 (800) 423-2765 ext. [Phone] FEIN Number: 35-0472300

Filing Fees

Fee Required? Yes
 Fee Amount: \$420.00
 Retaliatory? Yes
 Fee Explanation: \$35 per forms x 12 form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Lincoln National Life Insurance Company	\$420.00	10/21/2009	31437936

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/29/2009	10/29/2009

SERFF Tracking Number: *JEPT-126348452* *State:* *Arkansas*
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Product Name: *Group Short Term Disability Income*
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Disposition

Disposition Date: 10/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: JEPT-126348452 State: Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Filing cover letter	Approved-Closed	Yes
Supporting Document	Appendix of Variability	Approved-Closed	Yes
Supporting Document	Certificate of Compliance	Approved-Closed	Yes
Form	Pre-Existing Condition Weekly Benefit	Approved-Closed	Yes
Form	Vocational Rehabilitation Benefit	Approved-Closed	Yes
Form	Rehabilitation Incentive Benefit	Approved-Closed	Yes
Form	Reasonable Accommodation Benefit	Approved-Closed	Yes
Form	Family Income Benefit	Approved-Closed	Yes
Form	Health Assessment Benefit	Approved-Closed	Yes
Form	Pre-Existing Condition Weekly Benefit	Approved-Closed	Yes
Form	Vocational Rehabilitation Benefit	Approved-Closed	Yes
Form	Rehabilitation Incentive Benefit	Approved-Closed	Yes
Form	Reasonable Accommodation Benefit	Approved-Closed	Yes
Form	Family Income Benefit	Approved-Closed	Yes
Form	Health Assessment Benefit	Approved-Closed	Yes

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Form Schedule

Lead Form Number: GL1101-STD-30

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/29/2009	GL1101-30-STD	Policy/Cont Pre-Existing ract/Fratern Condition Weekly al Benefit Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		68.000	30-STD (PRE- EXISTING CONDITION WEEKLY BENEFIT).pdf
Approved-Closed 10/29/2009	GL1101-31-STD	Policy/Cont Vocational ract/Fratern Rehabilitation Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		52.300	31-STD (VOCATIONA L REHABILITA TION BENEFIT).pdf
Approved-Closed 10/29/2009	GL1101-32-STD	Policy/Cont Rehabilitation ract/Fratern Incentive Benefit al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		61.800	32-STD (REHABILITA TION INCENTIVE BENEFIT).pdf
Approved-Closed 10/29/2009	GL1101-33-STD	Policy/Cont Reasonable ract/Fratern Accommodation al Benefit Certificate:	Initial		57.800	33-STD (REASONAB LE ACCOMMOD

SERFF Tracking Number:	JEPT-126348452	State:	Arkansas
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Product Name:	Group Short Term Disability Income		
Project Name/Number:	Group STD Riders Filing/GL1101-STD-30		
	Amendmen		ATION
	t, Insert		BENEFIT).pdf
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Approved- GL1101- Closed 34-STD 10/29/2009	Policy/Cont Family Income ract/Fratern Benefit al	Initial	51.900
	Certificate:		34-STD
	Amendmen		(FAMILY
	t, Insert		INCOME
	Page,		BENEFIT).pdf
	Endorseme		
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Approved- GL1101- Closed 35-STD 10/29/2009	Policy/Cont Health Assessment ract/Fratern Benefit al	Initial	55.000
	Certificate:		35-STD
	Amendmen		(HEALTH
	t, Insert		ASSESSMEN
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	Endorseme		BENEFIT).pdf
	nt or Rider		
Approved- GL1102- Closed 23-STD 10/29/2009	Certificate Pre-Existing Amendmen Condition Weekly t, Insert Benefit	Initial	60.500
	Page,		23-STD
	Endorseme		(PRE-
	nt or Rider		EXISTING
			CONDITION
			WEEKLY
			BENEFIT).pdf
Approved- GL1102- Closed 24-STD 10/29/2009	Certificate Vocational Amendmen Rehabilitation Benefit t, Insert	Initial	51.000
	Page,		24-STD
	Endorseme		(VOCATIONA
	nt or Rider		L
			REHABILITA
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Approved- GL1102- Closed 25-STD 10/29/2009	Certificate Rehabilitation Amendmen Incentive Benefit t, Insert	Initial	61.900
			25-STD
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Approved- Closed 10/29/2009	GL1102- 26-STD	Page, Endorseme nt or Rider Certificate Reasonable Amendmen Accommodation t, Insert Benefit Page, Endorseme nt or Rider	Initial	53.600	INCENTIVE BENEFIT).pdf 26-STD (REASONAB LE ACCOMMOD ATION BENEFIT).pdf
Approved- Closed 10/29/2009	GL1102- 27-STD	Page, Endorseme nt or Rider Certificate Family Income Amendmen Benefit t, Insert Page, Endorseme nt or Rider	Initial	58.300	27-STD (FAMILY INCOME BENEFIT).pdf
Approved- Closed 10/29/2009	GL1102- 28-STD	Page, Endorseme nt or Rider Certificate Health Assessment Amendmen Benefit t, Insert Page, Endorseme nt or Rider	Initial	51.900	28-STD (HEALTH ASSESSMEN T BENEFIT).pdf

PRE-EXISTING CONDITION WEEKLY BENEFIT

BENEFIT. The Company will pay a Pre-Existing Condition Weekly Benefit to an Insured Person if he or she:

- (1) is Totally [or Partially] Disabled;
- (2) would otherwise not qualify for any benefits under this Policy due solely to a Pre-Existing Condition Limitation;
- (3) requires the Regular Care of a Physician; and
- (4) at his or her own expense, submits proof of continued Total [or Partial] Disability[,][and] Physician's care[, and reduced earnings (if Partially Disabled)] to the Company upon request.

AMOUNT. The amount of the Pre-Existing Condition Weekly Benefit is shown in the Schedule of Insurance.

The amount of the Pre-Existing Condition Weekly Benefit will not be less than the Minimum Weekly Benefit shown in the Schedule of Insurance.

Weekly Benefits under this provision are in lieu of any other Total [or Partial] Disability Weekly Benefits otherwise payable under this Policy.

DURATION. The Pre-Existing Condition Weekly Benefit starts on the Day Benefits Begin, and will cease on the earliest of:

- (1) the date the Insured Person ceases to be Totally [or Partially] Disabled;
- (2) the date the Insured Person dies;
- (3) the date the Maximum Benefit Period ends; or
- (4) the date the Pre-Existing Condition Benefit Period ends.

The Day Benefits Begin, Maximum Benefit Period, and the Pre-Existing Condition Benefit Period are shown in the Schedule of Insurance.

[EXCLUSION. The Pre-Existing Condition Weekly Benefit does not apply to increased amounts of optional, supplemental, or voluntary coverage elected by an Insured Person that are subject to Evidence of Insurability.]

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, [waiver of premium] and other provisions of this Policy.

VOCATIONAL REHABILITATION BENEFIT

BENEFIT. If an Insured Person is Disabled and is receiving Weekly Benefits under this Policy, he or she may be eligible for a Vocational Rehabilitation Benefit. This benefit consists of services which may include:

- (1) vocational evaluation, counseling, training or job placement;
- (2) job modification or special equipment; and
- (3) other services which the Company deems reasonably necessary to help the Insured Person return to work.

The Company will determine the Insured Person's eligibility and the amount of any benefit payable.

ELIGIBILITY. An Insured Person may be eligible for the Vocational Rehabilitation Benefit if the Company finds that he or she:

- (1) has a Disability that prevents the performance of the Main Duties of his or her Own Occupation;
- (2) has the physical and mental abilities needed to complete a Rehabilitation Program; and
- (3) is reasonably expected to return to work after completing the Rehabilitation Program; in view of his or her degree of motivation and the labor force demand for workers in the proposed occupation.

The Company must also find that the cost of the proposed services is less than its expected claim liability.

AMOUNT. The amount of any Vocational Rehabilitation Benefit will not exceed the Company's expected claims liability. This benefit will not be payable for services covered under the Insured Person's health care plan or any other vocational rehabilitation program. Payment may be made to the provider of the services, at the Company's option.

CONDITIONS. The Company, the Insured Person, or his or her Physician may first propose vocational rehabilitation. When a Rehabilitation Program is approved by the Company, this Policy's definition of "Disability" will be waived during the rehabilitation period; however, it will be reapplied after the Rehabilitation Program ends. The Company will determine the amount and duration of any Weekly Disability benefits payable after the Rehabilitation Program ends.

LIMITATION. This Policy will not cover any period of Disability for an Insured Person who has received a Vocational Rehabilitation Benefit and has failed to complete the Rehabilitation Program, without Good Cause.

DEFINITIONS.

"**Good Cause,**" as used in this provision, means the Insured Person's:

- (1) documented physical or mental impairments, which render the Insured Person unable to take part in or complete a Rehabilitation Program;
- (2) involvement in a medical program, which prevents or interferes with the Insured Person's taking part in or completing a Rehabilitation Program; or
- (3) participating in good faith in some other vocational rehabilitation program, which:
 - (a) conflicts with taking part in or completing a Rehabilitation Program developed by the Company; and
 - (b) is reasonably expected to return the Insured Person to work.

"**Rehabilitation Program**" means a written vocational rehabilitation program:

- (1) which the Company develops with input from:
 - (a) the Insured Person;
 - (b) the Insured Person's Physician; and
 - (c) any current or prospective employer, when appropriate; and
- (2) which describes the Program's goals; each party's responsibilities; and the times, dates and costs of the rehabilitation services.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, [waiver of premium,] and other provisions of this Policy.

REHABILITATION INCENTIVE BENEFIT

BENEFIT. The Company will pay a Rehabilitation Incentive Benefit to an Insured Person who is Totally [or Partially] Disabled and who actively participates in a Rehabilitation Program approved by the Company.

AMOUNT. The amount of the Rehabilitation Incentive Benefit is shown in the Schedule of Insurance.

The Rehabilitation Incentive Benefit is paid in addition to any other Policy benefits, and is not subject to Policy provisions that would otherwise reduce the benefit amount, such as the Other Income Benefits provision.

DURATION. The Rehabilitation Incentive Benefit starts on the latest of:

- (1) the date the Insured Person begins to participate in an approved Rehabilitation Program; or
- (2) the date the Company approves the Insured Person's Rehabilitation Program.

The Rehabilitation Incentive Benefit will cease on the earliest of:

- (1) the date the Weekly Total [or Partial] Disability Benefits would otherwise cease under this Policy; or
- (2) the date the Insured Person ceases participation in an approved Rehabilitation Program.

DEFINITION.

"Rehabilitation Program" means a written vocational rehabilitation program:

- (1) which the Company develops with input from:
 - (a) the Insured Person;
 - (b) the Insured Person's Physician; and
 - (c) any current or prospective employer, when appropriate; and
- (2) which describes the Program's goals; each party's responsibilities; and the times, dates and costs of the rehabilitation services.

PROOF. Written proof of active participation in a Rehabilitation Program must be given:

- (1) within 90 days after the Day Benefits Begin; or
- (2) as soon as reasonably possible after that.

Proof of active participation must be provided at the Insured Person's own expense. The proof must be sent to the Company's Group Insurance Service Office. It should include the Insured Person's name and address and the number of this Policy.

Exception: Failure to furnish proof of active participation in a Rehabilitation Program within the required time period will not invalidate the benefit, if it is shown that it was done:

- (1) as soon as reasonably possible; and
- (2) in no event more than one year after it was required.

These time limits will not apply while the Insured Person lacks legal capacity.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, [waiver of premium,] and other provisions of this Policy.

REASONABLE ACCOMMODATION BENEFIT

BENEFIT. If an Insured Person is Disabled and is receiving Weekly Benefits under this Policy, then the Group Policyholder may be eligible for a Reasonable Accommodation benefit. This benefit reimburses the Group Policyholder for 50% of the expense incurred for reasonable accommodation services for the Insured Person, but will not exceed the lesser of:

- (1) a maximum benefit of \$2500 for any one Insured Person; or
- (2) the Company's expected liability for the Insured Person's Weekly Disability Income claim.

Such services may include:

- (1) providing the Insured Person a more accessible parking space or entrance;
- (2) removing barriers or hazards to the Insured Person from the worksite;
- (3) special seating, furniture or equipment for the Insured Person's work station;
- (4) providing special training materials or translation services during the Insured Person's training; and
- (5) other services the Company deems reasonably necessary to help the Insured Person return to work with the Group Policyholder.

ELIGIBILITY. The Company will determine the Group Policyholder's eligibility to receive the Reasonable Accommodation benefit. To qualify for the Reasonable Accommodation benefit, the Group Policyholder must have an Insured Person:

- (1) whose Disability prevents the performance of his or her Own Occupation at the Group Policyholder's worksite;
- (2) who has the physical and mental abilities needed to perform his or her Own Occupation or another occupation at the Group Policyholder's worksite, but only with the help of the proposed accommodation; and
- (3) who is reasonably expected to return to work with the help of the proposed accommodation.

The Company must also find that the requested Reasonable Accommodation benefit is less than the expected liability for the Insured Person's Weekly Disability Income claim.

WRITTEN PROPOSAL. The reasonable accommodation services must be provided in accord with a written proposal, which is developed with input from:

- (1) the Group Policyholder;
- (2) the Insured Person; and
- (3) the Insured Person's Physician, when appropriate.

The proposal must state:

- (1) the purpose of the proposed accommodation; and
- (2) the times, dates, and costs of the services.

CONDITIONS. The Company, the Group Policyholder, the Insured Person, or the Insured Person's Physician may first propose an accommodation.

The proposal must be approved by the Company in writing.

The Company will reimburse the Group Policyholder upon receipt of proof that the Group Policyholder:

- (1) has provided the services for the Insured Person; and
- (2) has paid the provider for the services.

OTHER PROVISIONS. Unless stated otherwise, the Reasonable Accommodation benefit is subject to all the Definitions, Exclusions, Claims Procedures, [waiver of premium,] and other provisions of this Policy.

FAMILY INCOME BENEFIT

BENEFIT. The Company will pay a benefit to the Eligible Survivor(s) when satisfactory written proof is received that an Insured Person died:

- (1) after Disability had continued for at least 14 consecutive days; and
- (2) while receiving a Weekly Benefit.

If payment becomes due to the Insured Person's children; then payment will be made to:

- (1) the surviving children, in equal shares; or
- (2) a person named by the Company to receive payments on the children's behalf.

This payment will be valid and effective against all claims by others representing, or claiming to represent, the Insured Person's children.

If there are no Eligible Survivors, payment will be made to the Insured Person's estate.

AMOUNT. The Family Income Benefit is shown in the Schedule of Insurance. [Reductions for Other Income Benefits will not apply.]

If any state disability plan compulsory death benefits become payable upon the Insured Person's death, then any Family Income Benefit amount payable will be reduced by such compulsory death benefits.

DEFINITION.

"**Eligible Survivor(s)**" means the Insured Person's:

- (1) surviving spouse or domestic partner; or, if none,
- (2) surviving children who are under age 25 on the Insured Person's date of death.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, [waiver of premium,] and other provisions of this Policy.

HEALTH ASSESSMENT BENEFIT

BENEFIT. The Company will pay a Health Assessment Benefit to an Insured Person who has a Health Assessment Test performed during the Health Assessment Period shown in the Schedule of Insurance.

AMOUNT. The amount and payment frequency of the Health Assessment Benefit is shown in the Schedule of Insurance.

It is not subject to Policy provisions that would otherwise reduce the benefit amount, such as the Other Income Benefits provision.

DEFINITION.

Health Assessment Test means any of the following tests:

- (1) abdominal aortic aneurysm ultrasonography;
- (2) blood test for triglycerides;
- (3) bone marrow testing;
- (4) bone density screening;
- (5) breast ultrasound;
- (6) CA 15-3 (blood test for breast cancer);
- (7) CA125 (blood test for ovarian cancer);
- (8) carotid ultrasound;
- (9) CEA (blood test for colon cancer);
- (10) chest X-ray;
- (11) colonoscopy;
- (12) EKG;
- (13) double contrast barium enema;
- (14) fasting blood glucose test;
- (15) flexible sigmoidoscopy;
- (16) hemoccult stool analysis;
- (17) mammography;
- (18) pap smear;
- (19) PSA (blood test for prostate cancer);
- (20) serum cholesterol test to determined level of HDL and LDL;
- (21) serum protein electrophoresis (blood test for myeloma);
- (22) stress test;
- (23) thermography; or
- (24) any other preventive assessment test recommended by the American Medical Association.

PROOF. The Company must receive written proof of a Health Assessment Test, in accordance with the Proof of Claim section of the Claims Procedures provision.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, [waiver of premium,] and other provisions of this Policy.

PRE-EXISTING CONDITION WEEKLY BENEFIT

BENEFIT. The Company will pay you a Pre-Existing Condition Weekly Benefit if you:

- (1) are Totally [or Partially] Disabled;
- (2) would otherwise not qualify for any benefits under the Policy due solely to a Pre-Existing Condition Limitation;
- (3) require the Regular Care of a Physician; and
- (4) at your own expense, submit proof of continued Total [or Partial] Disability[,][and] Physician's care[, and reduced earnings (if Partially Disabled)] to the Company upon request.

AMOUNT. The amount of the Pre-Existing Condition Weekly Benefit is shown in the Schedule of Insurance.

The amount of the Pre-Existing Condition Weekly Benefit will not be less than the Minimum Weekly Benefit shown in the Schedule of Insurance.

Weekly Benefits under this provision are in lieu of any other Total [or Partial] Disability Weekly Benefits otherwise payable under the Policy.

DURATION. The Pre-Existing Condition Weekly Benefit starts on the Day Benefits Begin, and will cease on the earliest of:

- (1) the date you cease to be Totally [or Partially] Disabled;
- (2) the date you die;
- (3) the date the Maximum Benefit Period ends; or
- (4) the date the Pre-Existing Condition Benefit Period ends.

The Day Benefits Begin, Maximum Benefit Period, and the Pre-Existing Condition Benefit Period are shown in the Schedule of Insurance.

[EXCLUSION. The Pre-Existing Condition Weekly Benefit does not apply to increased amounts of optional, supplemental, or voluntary coverage you elect that are subject to Evidence of Insurability.]

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, [waiver of premium] and other provisions of the Policy.

VOCATIONAL REHABILITATION BENEFIT

BENEFIT. If you are Disabled and are receiving Weekly Benefits under the Policy, you may be eligible for a Vocational Rehabilitation Benefit. This benefit consists of services which may include:

- (1) vocational evaluation, counseling, training or job placement;
- (2) job modification or special equipment; and
- (3) other services which the Company deems reasonably necessary to help you return to work.

The Company will determine your eligibility and the amount of any benefit payable.

ELIGIBILITY. You may be eligible for the Vocational Rehabilitation Benefit if the Company finds that you:

- (1) have a Disability that prevents the performance of the Main Duties of your Own Occupation;
- (2) have the physical and mental abilities needed to complete a Rehabilitation Program; and
- (3) are reasonably expected to return to work after completing the Rehabilitation Program; in view of your degree of motivation and the labor force demand for workers in the proposed occupation.

The Company must also find that the cost of the proposed services is less than its expected claim liability.

AMOUNT. The amount of any Vocational Rehabilitation Benefit will not exceed the Company's expected claims liability. This benefit will not be payable for services covered under your health care plan or any other vocational rehabilitation program. Payment may be made to the provider of the services, at the Company's option.

CONDITIONS. The Company, you, or your Physician may first propose vocational rehabilitation. When a Rehabilitation Program is approved by the Company, the Policy's definition of "Disability" will be waived during the rehabilitation period; however, it will be reapplied after the Rehabilitation Program ends. The Company will determine the amount and duration of any Weekly Disability benefits payable after the Rehabilitation Program ends.

LIMITATION. The Policy will not cover any period of Disability if you have received a Vocational Rehabilitation Benefit and have failed to complete the Rehabilitation Program, without Good Cause.

DEFINITIONS.

"**Good Cause,**" as used in this provision, means your:

- (1) documented physical or mental impairments, which render you unable to take part in or complete a Rehabilitation Program;
- (2) involvement in a medical program, which prevents or interferes with your taking part in or completing a Rehabilitation Program; or
- (3) participating in good faith in some other vocational rehabilitation program, which:
 - (a) conflicts with taking part in or completing a Rehabilitation Program developed by the Company; and
 - (b) is reasonably expected to return you to work.

"**Rehabilitation Program**" means a written vocational rehabilitation program:

- (1) which the Company develops with input from:
 - (a) you;
 - (b) your Physician; and
 - (c) any current or prospective employer, when appropriate; and
- (2) which describes the Program's goals; each party's responsibilities; and the times, dates and costs of the rehabilitation services.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, [waiver of premium,] and other provisions of the Policy.

REHABILITATION INCENTIVE BENEFIT

BENEFIT. The Company will pay you a Rehabilitation Incentive Benefit if you are Totally [or Partially] Disabled and actively participating in a Rehabilitation Program approved by the Company.

AMOUNT. The amount of the Rehabilitation Incentive Benefit is shown in the Schedule of Insurance.

The Rehabilitation Incentive Benefit is paid in addition to any other Policy benefits, and is not subject to Policy provisions that would otherwise reduce the benefit amount, such as the Other Income Benefits provision.

DURATION. The Rehabilitation Incentive Benefit starts on the latest of:

- (1) the date you begin to participate in an approved Rehabilitation Program; or
- (2) the date the Company approves your Rehabilitation Program.

The Rehabilitation Incentive Benefit will cease on the earliest of:

- (1) the date the Weekly Total [or Partial] Disability Benefits would otherwise cease under the Policy; or
- (2) the date you cease participation in an approved Rehabilitation Program.

DEFINITION.

"Rehabilitation Program" means a written vocational rehabilitation program:

- (1) which the Company develops with input from:
 - (a) you;
 - (b) your Physician; and
 - (c) any current or prospective employer, when appropriate; and
- (2) which describes the Program's goals; each party's responsibilities; and the times, dates and costs of the rehabilitation services.

PROOF. Written proof of active participation in a Rehabilitation Program must be given:

- (1) within 90 days after the Day Benefits Begin; or
- (2) as soon as reasonably possible after that.

Proof of active participation must be provided at your own expense. The proof 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 furnish proof of active participation in a Rehabilitation Program within the required time period will not invalidate the benefit, if it is shown that it was done:

- (1) as soon as reasonably possible; and
- (2) in no event more than one year after it was required.

These time limits will not apply while you lack legal capacity.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, [waiver of premium,] and other provisions of the Policy.

REASONABLE ACCOMMODATION BENEFIT

BENEFIT. If you are Disabled and are receiving Weekly Benefits under the Policy, then the Group Policyholder may be eligible for a Reasonable Accommodation benefit. This benefit reimburses the Group Policyholder for 50% of the expense incurred for reasonable accommodation services for you, but will not exceed the lesser of:

- (1) a maximum benefit of \$2500 for any one Insured Person; or
- (2) the Company's expected liability for your Weekly Disability Income claim.

Such services may include:

- (1) providing you a more accessible parking space or entrance;
- (2) removing barriers or hazards to you from the worksite;
- (3) special seating, furniture or equipment for your work station;
- (4) providing special training materials or translation services during your training; and
- (5) other services the Company deems reasonably necessary to help you return to work with the Group Policyholder.

ELIGIBILITY. The Company will determine the Group Policyholder's eligibility to receive the Reasonable Accommodation benefit. To qualify for the Reasonable Accommodation benefit, the Group Policyholder must have an Insured Person:

- (1) whose Disability prevents the performance of his or her Own Occupation at the Group Policyholder's worksite;
- (2) who has the physical and mental abilities needed to perform his or her Own Occupation or another occupation at the Group Policyholder's worksite, but only with the help of the proposed accommodation; and
- (3) who is reasonably expected to return to work with the help of the proposed accommodation.

The Company must also find that the requested Reasonable Accommodation benefit is less than the expected liability for your Weekly Disability Income claim.

WRITTEN PROPOSAL. The reasonable accommodation services must be provided in accord with a written proposal, which is developed with input from:

- (1) the Group Policyholder;
- (2) you; and
- (3) your Physician, when appropriate.

The proposal must state:

- (1) the purpose of the proposed accommodation; and
- (2) the times, dates, and costs of the services.

CONDITIONS. The Company, the Group Policyholder, you, or your Physician may first propose an accommodation.

The proposal must be approved by the Company in writing.

The Company will reimburse the Group Policyholder upon receipt of proof that the Group Policyholder:

- (1) has provided the services for you; and
- (2) has paid the provider for the services.

OTHER PROVISIONS. Unless stated otherwise, the Reasonable Accommodation benefit is subject to all the Definitions, Exclusions, Claims Procedures, [waiver of premium,] and other provisions of the Policy.

FAMILY INCOME BENEFIT

BENEFIT. The Company will pay a benefit to the Eligible Survivor(s) when satisfactory written proof is received that you died:

- (1) after Disability had continued for at least 14 consecutive days; and
- (2) while receiving a Weekly Benefit.

If payment becomes due to your children; then payment will be made to:

- (1) the surviving children, in equal shares; or
- (2) a person named by the Company to receive payments on the children's behalf.

This payment will be valid and effective against all claims by others representing, or claiming to represent, your children.

If there are no Eligible Survivors, payment will be made to your estate.

AMOUNT. The Family Income Benefit is shown in the Schedule of Insurance. [Reductions for Other Income Benefits will not apply.]

If any state disability plan compulsory death benefits become payable upon your death, then any Family Income Benefit amount payable will be reduced by such compulsory death benefits.

DEFINITION.

"**Eligible Survivor(s)**" means your:

- (1) surviving spouse or domestic partner; or, if none,
- (2) surviving children who are under age 25 on your date of death.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, [waiver of premium,] and other provisions of the Policy.

HEALTH ASSESSMENT BENEFIT

BENEFIT. The Company will pay you a Health Assessment Benefit if you have a Health Assessment Test performed during the Health Assessment Period shown in the Schedule of Insurance.

AMOUNT. The amount and payment frequency of the Health Assessment Benefit is shown in the Schedule of Insurance.

It is not subject to Policy provisions that would otherwise reduce the benefit amount, such as the Other Income Benefits provision.

DEFINITION.

Health Assessment Test means any of the following tests:

- (1) abdominal aortic aneurysm ultrasonography;
- (2) blood test for triglycerides;
- (3) bone marrow testing;
- (4) bone density screening;
- (5) breast ultrasound;
- (6) CA 15-3 (blood test for breast cancer);
- (7) CA125 (blood test for ovarian cancer);
- (8) carotid ultrasound;
- (9) CEA (blood test for colon cancer);
- (10) chest X-ray;
- (11) colonoscopy;
- (12) EKG;
- (13) double contrast barium enema;
- (14) fasting blood glucose test;
- (15) flexible sigmoidoscopy;
- (16) hemoccult stool analysis;
- (17) mammography;
- (18) pap smear;
- (19) PSA (blood test for prostate cancer);
- (20) serum cholesterol test to determined level of HDL and LDL;
- (21) serum protein electrophoresis (blood test for myeloma);
- (22) stress test;
- (23) thermography; or
- (24) any other preventive assessment test recommended by the American Medical Association.

PROOF. The Company must receive written proof of a Health Assessment Test, in accordance with the Proof of Claim section of the Claims Procedures provision.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, [waiver of premium,] and other provisions of the Policy.

SERFF Tracking Number: JEPT-126348452 State: Arkansas
 Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 43837
 Company Tracking Number:
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
 Product Name: Group Short Term Disability Income
 Project Name/Number: Group STD Riders Filing/GL1101-STD-30

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	10/29/2009
Comments:		
Attachment: FL102109 STD Riders Read Cert.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	10/29/2009
Bypass Reason: N/A		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Filing cover letter	Approved-Closed	10/29/2009
Comments:		
Attachment: FL102109 STD Riders Cover Letter.pdf		

	Item Status:	Status Date:
Satisfied - Item: Appendix of Variability	Approved-Closed	10/29/2009
Comments:		
Attachment: FL102109 STD Riders Appendix.pdf		

	Item Status:	Status Date:
Satisfied - Item: Certificate of Compliance	Approved-Closed	10/29/2009
Comments:		
Attachment:		

SERFF Tracking Number: *JEPT-126348452* *State:* *Arkansas*
Filing Company: *The Lincoln National Life Insurance Company* *State Tracking Number:* *43837*
Company Tracking Number:
TOI: *H11G Group Health - Disability Income* *Sub-TOI:* *H11G.002 Short Term*
Product Name: *Group Short Term Disability Income*
Project Name/Number: *Group STD Riders Filing/GL1101-STD-30*
FL102109 STD Riders Cert of Compliance.pdf

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

READABILITY CERTIFICATION

This is to certify that the forms shown below have achieved the indicated Flesch Reading Ease Score.

<u>FORM NO.</u>	<u>FLESCH SCORE</u>
GL1101-30-STD	68.0
GL1101-31-STD	52.3
GL1101-32-STD	61.8
GL1101-33-STD	57.8
GL1101-34-STD	51.9
GL1101-35-STD	55.0
GL1102-23-STD	60.5
GL1102-24-STD	51.0
GL1102-25-STD	61.9
GL1102-26-STD	53.6
GL1102-27-STD	58.3
GL1102-28-STD	51.9



(An Officer of the Company)

Pamela Telfer

Assistant Vice President – Product Compliance



October 21, 2009

ARKANSAS INSURANCE DEPARTMENT
1200 W. THIRD STREET
LITTLE ROCK, AR 72201-1904

The Lincoln National Life Insurance Company
8801 Indian Hills Drive
Omaha, NE 68114-4066
toll free (800) 423-2765

NAIC No.: 0020-65676
FEIN No.: 35-0472300

Re: Group Short-Term Disability Forms
Forms: GL1101-30-STD et al (See attached list)

Enclosed for filing with your Department are copies of the captioned forms. We are requesting that these be approved for general use with any of our previously approved Group Policy Series GL1101 and Group Certificate Series GL1102 forms. These are marketed primarily to employer groups via licensed brokers and agents.

These insert pages describe new features of our Group Short Term Disability Income product, available at a group policyholder's request.

The Pre-Existing Condition Weekly Benefit will pay a benefit to an insured who would otherwise have been found ineligible for STD benefits due to a pre-existing condition.

The Family Income Benefit will pay a benefit to the eligible survivors of an insured who died while receiving benefits under the policy. If there are no eligible survivors, the Family Income Benefit becomes payable to the insured person's estate.

The Health Assessment Benefit will be paid to an insured who has one or more of the listed preventive/wellness tests performed during a period described in the policy.

The Rehabilitation Assistance package consists of three benefits: the Vocational Rehabilitation Benefit, which pays a disabled insured for services including vocational evaluation, counseling, training, and job modification; the Reasonable Accommodation Benefit, which is paid to a group policyholder for expenses incurred for accommodation of a disabled insured; and the Rehabilitation Incentive Benefit, which pays a benefit to a disabled insured who actively participates in a rehabilitation program approved by the company.

The forms have been filed with and approved by Indiana, our domiciliary state, on July 28, 2009.

Page 2

October 21, 2009

Group Short-Term Disability Forms Filing

The Appendix of Variability, Readability Certification, and Certificate of Compliance are attached. Your review and notice of approval will be greatly appreciated. If you have questions, please feel free to contact me.

Sincerely,

A handwritten signature in cursive script that reads "Bonnie White".

Bonnie White, CEBS, FLMI, RHU, MHP, HIA, ALHC
Compliance Manager
Lincoln Financial Group
Voice: (800) 423-2765 ext. 7273
Fax: (402) 361-2568
E-Mail: bonnie.white@lfg.com

Enclosures

LIST OF SUBMITTED FORMS

Policy Form	Certificate Form	Description
GL1101-30-STD	GL1102-23-STD	Pre-Existing Condition Weekly Benefit
GL1101-31-STD	GL1102-24-STD	Vocational Rehabilitation Benefit
GL1101-32-STD	GL1102-25-STD	Rehabilitation Incentive Benefit
GL1101-33-STD	GL1102-26-STD	Reasonable Accommodation Benefit
GL1101-34-STD	GL1102-27-STD	Family Income Benefit
GL1101-35-STD	GL1102-28-STD	Health Assessment Benefit

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

APPENDIX OF VARIABILITY

Supplemental Information on Alternate Versions and Variables for Forms in Group Policy Series GL1101 and Certificate Series GL1102

The following forms may be used with the group Short Term Disability Income benefits provided in these Series. Forms numbered GL1101 are policy insert pages, while those numbered GL1102 are certificate insert pages.

1. **Pre-Existing Condition Weekly Benefit. Forms GL1101-30-STD and GL1102-23-STD**

Policy form *GL1101-30-STD* and certificate form *GL1102-23-STD* describe the Pre-Existing Condition Weekly Benefit. The bracketed references to Partial Disability may be removed for policies that do not cover Partial Disability. The bracketed exclusion may be omitted for policies that do not provide optional/supplemental/voluntary coverage. The reference to Evidence of Insurability in the exclusion may be omitted but not reworded. The bracketed reference to waiver of premium in the Other Provisions section may be omitted when not applicable.

2. **Vocational Rehabilitation Benefit. Forms GL1101-31-STD and GL1102-24-STD**

Policy form *GL1101-31-STD* and certificate form *GL1102-24-STD* describe the Vocational Rehabilitation Benefit. The bracketed reference to waiver of premium in the Other Provisions section may be omitted when not applicable.

3. **Rehabilitation Incentive Benefit. Forms GL1101-32-STD and GL1102-25-STD**

Policy form *GL1101-32-STD* and certificate form *GL1102-25-STD* describe the Rehabilitation Incentive Benefit. The bracketed references to Partial Disability may be removed for policies that do not cover Partial Disability. We request variable filing of the underlined "Group Insurance Service Office" in order to accommodate any future changes to the company's claims processing/service location. The bracketed reference to waiver of premium in the Other Provisions section may be omitted when not applicable.

4. **Reasonable Accommodation Benefit. Forms GL1101-33-STD and GL1102-26-STD**

Policy form *GL1101-33-STD* and certificate form *GL1102-26-STD* describe the Reasonable Accommodation Benefit. The underlined percentage may range from 10% to 70%. The underlined maximum benefit amount may range from \$1,000 to \$10,000. The bracketed reference to waiver of premium in the Other Provisions section may be omitted when not applicable.

5. **Family Income Benefit. Forms GL1101-34-STD and GL1102-27-STD**

Policy form *GL1101-34-STD* and certificate form *GL1102-27-STD* describe the Family Income Benefit. We request that the underlined period in the Benefit section be filed as variable, with a range of 1 to 30 days, with 14 days as the standard. We request variable filing of the bracketed text in the Amount section, so that it may be omitted for nonintegrated plans. The underlined reference to "domestic partner" in the definition of Eligible Survivor(s) may be omitted when not applicable, or reworded to accommodate any state-specific coverage requirements for domestic partnerships, civil unions, or other such arrangements. The underlined child age may range from 19-27, with 25 as the standard, and will never be less than required by state law. The bracketed reference to waiver of premium in the Other Provisions section may be omitted when not applicable.

6. **Health Assessment Benefit. Forms GL1101-35-STD and GL1102-28-STD**

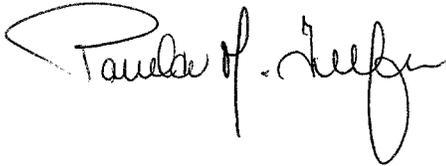
Policy form *GL1101-35-STD* and certificate form *GL1102-28-STD* describe the Health Assessment Benefit. We request variable filing of the bracketed list of tests so that inapplicable items may be omitted, but not reworded. We further request that the underlined item (24) be variable so that new tests may be added to the list as they become available. The bracketed reference to waiver of premium in the Other Provisions section may be omitted when not applicable. reference to waiver of premium in the Other Provisions section may be omitted when not applicable.

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: The Lincoln National Life Insurance Company

Form Number(s): GL1101-30-STD, et al.

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

A handwritten signature in black ink, appearing to read "Pamela M. Telfer". The signature is fluid and cursive, with a large initial "P" and a long, sweeping underline.

Signature of Company Officer

Pamela M. Telfer

Name

Assistant Vice President, Product Compliance & State Filing

Title

October 21, 2009

Date