The Lincoln National Life Insurance Company

Group Insurance Service Office
8801 Indian Hills Drive
Omaha, Nebraska 68114-4066

Office Use Only ID# ______________________

APPLICATION FOR GROUP INSURANCE

is hereby made to THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (the Company).

A. NAME AND ADDRESS

1. **Applicant's Full Legal Name** (exactly as to be shown in Group Policy): ______________________

____

2. **Main Office Address** (physical location and group situs state):

Street ______________________ City ______________________ State __________

Zip __________ Phone # (   ) __________ FAX # (   ) __________ E-Mail Address (if available) __________

B. REQUESTED COVERAGES

The following Group Insurance is applied for as specified in the sold case proposal(s). Complete the requested Effective Date for each coverage.

- ☐ Life & AD&D with Effective Date __________
- ☐ Long Term Disability with Effective Date __________
- ☐ Short Term Disability with Effective Date __________
- ☐ Dental with Effective Date __________
- ☐ Accident with Effective Date __________
- ☐ Critical Illness with Effective Date __________
- ☐ Voluntary Life with Effective Date __________
- ☐ Voluntary Life & AD&D with Effective Date __________
- ☐ Voluntary Long Term Disability with Effective Date __________
- ☐ Voluntary Short Term Disability with Effective Date __________
- ☐ Voluntary Dental with Effective Date __________

C. BUSINESS INFORMATION

1. **Nature of Business** (Please specify): ______________________

Years in Business 11133 __________ Federal Tax ID# __________

2. **Business is Organized As** (select one):

☐ Corporation ☐ Non-Profit Organization
☐ Partnership ☐ Proprietorship ☐ Other __________

3. **Financial Risk** (If Yes to any part, please explain below.)

☐ Yes ☐ No Has Applicant ever filed for bankruptcy?
☐ Yes ☐ No Does Applicant anticipate ceasing or materially reducing active business operations?
☐ Yes ☐ No Has Applicant opted out (or do they anticipate opting out) of Workers' Compensation?

Explanation: ______________________

4. **Binder** payment submitted: Amount $ __________ (if applicable)

D. REPLACEMENT COVERAGE

☐ Yes ☐ No Will all or part of this coverage **replace** any similar coverage? **If Yes, provide details of the prior plan below and enclose a copy of each inforce contract to be replaced.**

Coverage Type	Prior Carrier Name	Prior Plan Effective Date	Termination Date

E. FRAUD WARNING

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents a false information in a an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award from insurance proceeds shall be reported to the Colorado Division of insurance within the Department of Regulatory Services.

DC: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KENTUCKY: Any person who knowingly and with the intent to defraud an insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information containing any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA & RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

OTHER STATES (EXCEPT KANSAS): A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping to defraud) an insurance company.

F. AGREEMENT. The Applicant hereby applies for group insurance. The information in this Application is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance. Omission or misstatement of known information on this Application could affect the validity of any insurance issued and cause the denial of an otherwise valid claim. The Applicant understands that the requested group insurance will:

(a) be issued only if the requested insurance is acceptable to the Company and is legally permissible;
(b) be issued under a group Policy or Policies in the language customarily used by the Company;
(c) be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
(d) be subject to all exclusions and limitations of the Policy; and
(e) take effect on the date determined by the Company.

The Applicant understands that no agent or broker has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an employee is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms, and will be subject to any Active Work requirement. The Applicant agrees not to:

(a) collect or pay premiums (other than the Binder Premium, if any) for such insurance, before receiving the Company's notice of approval; or
(b) distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

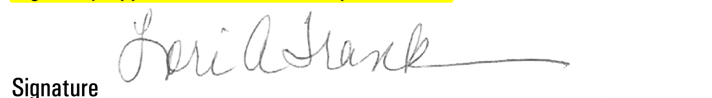
If dental insurance is requested, the Applicant agrees to provide employees and dependents notice of any applicable continuation rights, required by federal COBRA law or any similar state continuation law. Premium rate quotes were based on data submitted to the Company. Final premium rates will be determined by the actual composition of the group. This application and the Binder payment, if any, constitutes the consideration for any Policy issued. After receipt of the Policy, payment of the premium is deemed acceptance of the Policy's terms. If this Application is approved, it will be made a part of any Policy issued.

Writing Agent
Or Broker's Signature____________________

Typed or Printed Name____________________

License Number________________ State________

Signed by Applicant's Authorized Representative:



Signature____________________

Typed or Printed Name____________________

Title____________________

State Signed____________ Date____________

Must be signed prior to Effective Date

Employer Application
Group Vision Care Insurance

The Lincoln National Life Insurance Company
8801 Indian Hills Drive, Omaha, NE 68114

Requested Policy Effective Date: 01 / 01 /2017
Requested Policy Anniversary Date: / /

GENERAL INFORMATION

Group's Full Legal Name: (Include names of subsidiaries or affiliated companies) Neos Consulting Group

Street Address: 504 Lavaca Street Ste 1005

City: Austin | State: TX | Zip Code: 78701

Contact Person: **Lori A. Trank** | Telephone: **(512) 431-3843**

Fax Number: | E-Mail Address of Contact: **accounting@neosconsulting.com**

Billing Address (If Different): **P.O. Box 12986 Austin, TX 78711-2986**

Organization Type: ☒ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Political Subdivision ☐ Other

Multi Location Group? ☐ Yes ☒ No | Number of Locations: 1 | Locations:

Nature of Business: SIC 7379 | Industry Code:

Employer Identification Number (Tax Id Number) 56-2314260 | Subject to ERISA? ☒ Yes ☐ No If yes, ERISA plan number: 501

VISION PLAN PARTICIPATION AND SELECTION

Hours per week to be eligible: 40 | Benefit Waiting Period for New Hires: ☐ Date of event following _____ months of employment ☒ 1st of policy month following 0 months of employment ☐ Other:

Benefit Waiting Period Waived for Initial Enrollees: ☐ Yes ☒ No | Total Number of Employees on Payroll: | Total Number of full time/ eligible Employees:

Number of COBRA participants in total group: | Number of Retirees in total group: (applicable to groups of over 50 eligible subscribers)

Will employees retired by the Employer be eligible for coverage? ☐ Yes ☒ No | If yes, specify groups eligibility:

Premiums and Contributions

Tier Structure	Rates	Number of Enrolled Employees	Employer Contribution %	Employee Contribution %
Employee Only	6.80			
Employee + One				
Employee + Spouse	12.89			
Employee + Children	15.12			
Employee + Family	21.28			
Composite				
	Total Estimated Monthly Premium $			

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this Application BEFORE action is taken on this Application. Coverage is not in effect unless and until I receive notification of acceptance from the Company. If this Application is declined, the Company will return the premium deposit submitted with the Application. If my coverage is approved, premium is payable monthly in advance.

Group vision insurance products are underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut.

V-APP-PL (12/2012)

I represent that, to the best of my knowledge, the information I have provided in this Application, including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws, is accurate and truthful. I understand that the Company will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences as permitted by law.

I agree that the Company shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of newly eligible employees or dependents.

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this Application may be transmitted electronically to me and to the Group's employees.

Company disclosure regarding producer compensation: We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. In general, our total bonuses are less than 10% of total producer compensation paid. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

FRAUD WARNING NOTICES: (Please review the notice that applies in your state.)

For applicants in Alabama, Arkansas, West Virginia, and Rhode Island:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in Colorado:
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For applicants in Hawaii:
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

For applicants in Kentucky:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For applicants in Louisiana:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in New Jersey:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in New Mexico:
ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

For applicants in Ohio:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For applicants in Oklahoma:
Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For applicants in Oregon:
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

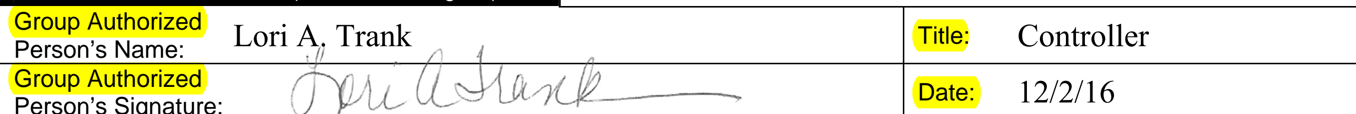
For applicants in the state of Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For applicants in all other states:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For applicants in Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

GROUP SIGNATURE (form must be signed)

Group Authorized Person's Name: Lori A. Trank	Title: Controller
Group Authorized Person's Signature:	Date: 12/2/16



AGENT/BROKER INFORMATION

Agent/Broker Name:		Agency:
Agent/Broker Signature:		Date:
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	Email Address:
Commissions Payable To:	Agent/Broker Number:	

V-APP-PL (12/2012)

Administration and Benefit Supplement Sheet

Legal Name of Group: Neos Consulting Group, LLC

1. Group Contact Information

Who is the Main Contact at your group? (This is the contact for Policy and Compliance Administration.)

Name: Lori Trank Phone #: (512) 431-3843 Email: accounting@neosconsulting.com

Who should we set up as the Primary Benefit Administrator for our website?
Note: this person will be in charge of the web account and can delegate access to other users.

Name: Lori Trank Phone #: (512)431-3843 Email: accounting@neosconsulting.com

2. Subsidiaries/Divisions

Does your company have any divisions or subsidiaries?

☐ Yes ☐ No

If yes, please provide location information (use page 3 if there is more than one).
Name: ______ Tax ID: ______
Address: ______ City/State/Zip: ______

3. Aggregator or Third Party Vendor Administration

Does your company use an outside vendor to help administer member eligibility?

☐ Yes ☐ No

If yes, please provide contact information below:
Vendor Name: ______ Contact person: ______
Phone: ______ Email: ______
Address: ______ City/State/Zip: ______

4. Billing Administration

Who is the billing/administrative contact at your group?

☒ Same as main contact.
☐ Different than main contact (this would be the billing administrator, TPA, vendor, or Aggregator.)
Name: ______ Phone #: ______ Email: ______

Please select your billing option (there are two choices, please select one):

☐ Self-Billing: Your company will handle employee administration and send LFG the total # of lives, volume and premium by line of coverage on a monthly basis. *(NOTE: Periodically LFG will request a back-up census.)*
☐ List-billing: LFG will provide a monthly invoice showing all members and applicable premiums by line of coverage.

Where should we mail the invoices? (Please select one.)

☐ Use address on the application.
☒ Different address: **P.O. Box 12986** City/State/Zip: **Austin, TX 78711-2986**

Payroll Deduction Cycle (for Employee paid benefits):

☐ Monthly (12) ☐ Semi-monthly (24) ☐ Bi-weekly (26) ☐ Weekly (52) ☐ Other: ______

Structure of List-Bill Invoices (there are three choices, please select one):

☐ One bill, with members listed alphabetically from A-Z
☐ Please provide separate invoices by location/line of coverage (add details to the "Special Instructions" section on page 3).
☐ Please sort my bill by sub-groups (add details to the "Special Instructions" section on page 3).

Accident & Critical Illness Billing (if applicable):

☐ Self-Billed: You will remit the premium amount deducted during the remittance period and provide a member level deduction listing along with the payment. You pay as **deducted.**
☐ List-Billed: LFG will provide you an invoice on a monthly basis or every four weeks (depending on how you deduct). The invoice will show each Employee's premium broken out by coverage. You pay as **billed.**

Deduction mode: ☐ Monthly (12) ☐ Semi-monthly (24) ☐ Bi-weekly (26) ☐ Weekly (52) ☐ Other: ______

5. ERISA

Does your company have an ERISA Plan Number?

☐ Yes –Please provide:
☐ Plan Year End Date: ______ Plan #'s: ☐ Life______ ☐ STD______ ☐ LTD______ ☐ Dental______
☐ Vol Life ______ ☐ Vol STD______ ☐ Vol LTD______ ☐ Accident______ ☐ Critical Illness ______
☐ No – we are not subject to ERISA and/or we have not filed for an ERISA number with our tax advisor.

***If the ERISA plan administrator is different than main contact, please provide details below.*

Administration and Benefit Supplement Sheet

6. Replacing coverage *(This applies to STD, LTD and Dental)*

If yes, please provide a copy of the prior carrier booklets (this is needed for Claims purposes):

☐ Attached

☐ Will be provided in a future email

7. Additional Benefits

Are the following benefits included?

Dependent Life (on Basic Life policy): ☐ Yes ☐ No If Yes, Employer Contribution is __________%

Stand Alone AD&D: ☐ Yes ☐ No *(This is a separate Voluntary AD&D policy from the Life or Voluntary Life.)*

8. Minimum Hours *(State restrictions may apply.)*

How many hours per week do employees need to work to be eligible for coverage?

☐ _30______(Standard for Full-Time is 30 hours per week)

☐ Varies by class (please add details to comment section on page 3)

☐ Are Part-Time Employees included? ☐ Yes ☒ No ☐ Hours worked per week: ____________________

9. Waiting Period *(State restrictions may apply.)*

When will New Hires be eligible for coverage?

☐ Date of Hire

☐ ________Days ☐ ________Months ☐ ________Years ☐ Other: ____________________

Do you have any current employees who are still in the above waiting period?

☐ Yes ☒ No

If yes, when are these employees eligible for coverage?

☐ Policy Effective Date ☐ After completion of the new hire waiting period

(NOTE: Employees who have already satisfied the waiting period will go on the plan(s) immediately.)

When Part-Time Employees move to Full-Time status:

☐ The waiting period will begin the day the Employee moves from Part-Time to Full-Time status. *(This is standard.)*

☐ Any time incurred as a Part-Time Employee will count toward the new hire waiting period.

10. Employee Effective Date *(State restrictions may apply.)*

After the waiting period is satisfied, when will the employee be effective?

☐ Not applicable – employee is effective on date of hire.

☐ The day following completion of the waiting period.

☐ First of the month following completion of the waiting period. *(NOTE: If the end of the waiting period lands on the first day of the month, Employee will be effective the first day of the next month.)*

☐ First of the month following/coinciding completion of the waiting period. *(NOTE: If the end of the waiting period lands on the first day of the month, Employee will be effective that same day.)*

☐ Other: ____________________

11. Rehire Provision

If an Employee leaves your company due to layoff or termination and is rehired, his/her benefits will be effective:

☐ Date of return if rehired within the first 12 months.

☐ After completing new hire waiting period, as indicated in Section 8 above.

☐ Other – will discuss during the administration call.

(NOTE: Benefits for employees returning to work within 6 months for Leave of Absence will be effective for benefits on the date of their return.)

12. Definition of Earnings

Please check all that apply. If selecting Prior Year W2's, then choose tax year or calendar year (earnings are determined on last day worked).

☐ Base pay ☐ Commissions ☐ Overtime ☐ Bonus (averaged over _____months)

☐ Prior tax year W2's ☐ Prior calendar year W2's ☐ Other: ____________________

Do you have any K-1 Earners?

☐ Yes ☐ No

If yes, we will use: ☐ Prior tax year K-1 earnings ☐ Prior calendar year K-1 earnings

13. Funding

Does your group have a Section 125/Cafeteria Plan?

☐ Yes ☐ No

If Yes, does **Employee** premium come from the section 125/Cafeteria Plan? ☐ Yes ☐ No

Check applicable coverages: ☐ Dental ☐ Vision ☐ Short Term Disability ☐ Long Term Disability ☐ Accident ☐ Critical Illness

Administration and Benefit Supplement Sheet

14. Location of Employees

Do you have any employees working in CA, HI, NJ, NY or RI? If so, how many, in what states, and how many are covered by the state disability plans?

☐ Yes ☒ No — If yes, how many, in what state, and how many are covered by the state disability plan? ____________________

Do you have any employees working or living outside the United States?

☐ Yes ☒ No — If yes, how many, where, expected return date? ____________________

15. Enrollments

☐# of eligible Employees____________ How are we enrolling? ☐ Census ☐ Enrollment Forms ☐ Both

16. Certificates

For your convenience, we will email an electronic copy of the contracts, certificates and initial billing to you at the end of onboarding, unless you indicate otherwise in the note section below. Certificates will be available for you to download and distribute to covered employees. If a paper supply of certificates is needed, please indicate by checking the box below.

☐ Paper If box is checked, please indicate how many are needed: ______________

17. Taxability for Disability Benefits

For Short Term Disability, do you want LFG to pay the Employer's portion of FICA taxes?

☐ Yes: LFG will pay the Employer's portion of FICA taxes. In addition, LFG will automatically print and mail the W2's to the Employee. *(Additional rates may apply for FICA match service.)*

☐ No: LFG will provide monthly FICA reports. Your company will pay the Employer's portion of FICA taxes.

If "No", please select ONE of these options:

☐ W2's are not needed, as Employer plans to add STD payments to the Employee's regular wage W2.

☐ LFG will print and mail the W2 paperwork to the Employer in January of each year (this will have the Employer's company name and EIN). Employer is responsible for reviewing the paperwork for accuracy, distributing W2's to Employees, and reporting W2's to the government.

NOTE: FICA match and W2 Reporting are automatically included for Long Term Disability at no additional charge.

For contributory Short Term and Long Term Disability benefits, the Employee's premium is funded from:

☐ Pre-Tax Payroll Deductions: Employees will receive the benefit after taxes (LFG will withhold taxes).

☐ Post-Tax Payroll Deductions: Employees will receive the benefit with no taxes taken out.

Completed By:

Lori A. Trank, Controller — **12/16/16**

Broker or Client Name (Type or write in.) — Date

Special Instructions (please use additional space, if needed):