



The Lincoln National Life Insurance Company
A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066
(800) 423-2765 Online: www.LincolnFinancial.com

CERTIFIES THAT Group Policy No. 000010206023 has been issued to

City of Casper
(The Group Policyholder)

The issue date of the Policy is January 1, 2016.

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

Certificate of Insurance for Class 3

You are entitled to the benefits described in this Certificate if you are eligible for insurance under the provisions of the Policy. This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms.

A handwritten signature in cursive script that reads "Dennis R. Glass".

PRESIDENT

CERTIFICATE OF GROUP LIFE INSURANCE

City of Casper
000010206023
SCHEDULE OF INSURANCE

ELIGIBLE CLASS

Class 3 Retirees

City of Casper
000010206023
SCHEDULE OF INSURANCE
For
Class 3 - Retirees

LIFE INSURANCE

Benefit Amount

Personal Life Insurance

\$10,000

Personal Life Insurance will be reduced as follows:

- At age 70, benefits will reduce by 90% of the original amount.
- Benefits will terminate when you attain age 99.

If you first enroll for Personal Life Insurance at age 70 or older, the above age reductions will apply to:

- Any Guarantee Issue Amount available without evidence of insurability; and
- The maximum amount of insurance for which you are eligible.

City of Casper
000010206023
SCHEDULE OF INSURANCE
For
Class 3
LIFE INSURANCE (CONTINUED)

DEPENDENTS INSURANCE

Dependent Life Insurance	Benefit Amount
Spouse	\$1,000
Dependent Child (birth to 14 days)	\$500
Dependent Child (age 14 days to 26 years)	\$1,000

Spouse Life Insurance will be reduced as follows:
- by 50% of the original amount when you attain age 70.
Spouse Insurance will terminate when you attain age 99

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AMOUNT OF INSURANCE

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

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

Any decrease will take effect on the day of the change; whether or not you are Actively at Work.

DEFINITIONS

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

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

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

- (1) a Saturday, Sunday or holiday which is not a scheduled workday;
- (2) a paid vacation day, or other scheduled or unscheduled non-workday; or
- (3) an excused or emergency leave of absence (except a medical leave).

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation, whose Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

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

EMPLOYER means the Group Policyholder or the Participating Employer named on the Face Page.

FULL-TIME EMPLOYEE means an employee of the EMPLOYER:

- (1) whose employment with the EMPLOYER is the employee's principal occupation;
- (2) who is not a temporary or seasonal employee; and
- (3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance.

INSURANCE MONTH means:

- (1) that period of time beginning on the Issue Date of the Policy and extending for one month; and
- (2) each subsequent month beginning on the same day after that.

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

PHYSICIAN means a licensed practitioner of the healing arts other than the Insured Person or a relative of the Insured Person.

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

RETIREE means a FORMER FULL-TIME EMPLOYEE of the EMPLOYER who is eligible for retirement benefits.

ELIGIBILITY

If you are a Full-Time Employee and a member of an employee class shown in the Schedule of Insurance; then you will become eligible for the coverage provided by the Policy on the later of:

- (1) the Policy's date of issue; or
- (2) the day you complete the Waiting Period.

WAITING PERIOD. The Waiting Period does not apply to retirees.

EFFECTIVE DATES OF COVERAGES

Your insurance is effective on the latest of:

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

Evidence of insurability is required if:

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

EXCEPTIONS. If your coverage terminates due to an approved leave of absence or a military leave, any Waiting Period or evidence of insurability requirement will be waived upon your return; provided:

- (1) you return within six months after the leave begins;
- (2) you apply or are enrolled within 31 days after resuming Active Work; and
- (3) the reinstated amount of insurance does not exceed the amount which terminated.

If your coverage terminates due to a lay-off, the Company will waive any Waiting Period or evidence of insurability requirement upon your return; provided:

- (1) you return within one month after the date the lay-off begins;
- (2) you apply or are reenrolled within 31 days after resuming Active Work; and
- (3) the reinstated amount of insurance does not exceed the amount which terminated.

Reinstatement will take effect on the date you return to Active Work.

If your coverage terminates because your employment ends, the Company will waive any Waiting Period or evidence of insurability requirement upon your return; provided:

- (1) you are rehired within one month after employment terminated;
- (2) you apply or are reenrolled within 31 days after resuming Active Work; and
- (3) the reinstated amount of insurance does not exceed the amount which terminated.

Reinstatement will take effect on the date you return to Active Work.

TERMINATION OF COVERAGE

Your coverage terminates on the earliest of:

- (1) the day the Policy terminates;
- (2) the last day of the Insurance Month in which you request termination;
- (3) the last day of the period for which the premium for your insurance has been paid;
- (4) the day you cease to be a member of an employee class shown in the Schedule of Insurance;
- (5) with respect to any particular insurance benefit, the day the part of the Policy providing that benefit terminates;
- (6) the day your employment with the Employer terminates; unless you are eligible for Retirement Benefits; or
- (7) the day you enter the armed services of any state or country on active duty; except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.)

Ceasing Active Work terminates your eligibility. However, it may be possible to continue all or part of your insurance during a temporary lay off, leave of absence or military leave; or while you are unable to work due to sickness or injury. The conditions concerning such a continuance may be found in the Policy. See your Employer for this information.

DEATH BENEFIT

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

BENEFICIARY

Your Beneficiary is the person or persons named on your enrollment card. The Beneficiary may be changed in accord with the terms of the Policy. If you have not named a Beneficiary, or if no named Beneficiary is living when you die; then the death benefit will be paid to your:

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

ASSIGNMENTS

Personal Life Insurance may be assigned. The assignments allowed under the Policy are absolute assignments and funeral assignments as described below.

No assignment will be binding on the Company unless and until:

- (1) it is made on a form furnished by the Company;
- (2) the original is completed and filed with the Company at its Group Insurance Service Office;
and
- (3) it is approved by the Company.

The Company and the Employer do not assume responsibility for the validity or effect of an assignment.

ABSOLUTE ASSIGNMENTS. You may make an irrevocable assignment of your Personal Life Insurance as a gift (with no consideration), providing you have the legal capacity and the mental capacity to do so. It may be made to a trust or to one or more of your relatives, their estates, or to a trustee of a trust under which one of the relatives is a beneficiary.

The term "relatives" includes, but is not limited to, your spouse, parents, grandparents, aunts, uncles, siblings, children, adopted children, stepchildren, and grandchildren.

In some states, community property is an established form of ownership that must be considered in making an assignment. If you make an absolute assignment to two or more assignees, such assignees will be joint owners with the right of survivorship between them. You should consult with your own legal advisor before making an assignment.

Once the assignment has been recorded by the Company, you can no longer change the beneficiary and cannot apply for conversion. Only the assignee can change the beneficiary designation if the previous designation is revocable. An assignment will have no effect on a prior irrevocable beneficiary designation. Only the assignee can apply for conversion but only when the Conversion Privilege provision would have been available to you in the absence of the assignment under the Policy.

An absolute assignment cannot be used as a collateral assignment.

FUNERAL ASSIGNMENTS. Upon your death, the beneficiary may assign the Personal Life Insurance benefit to a funeral home for payment of burial expenses. After payment has been made for the burial expenses to the assigned funeral home, the remaining death benefit is then paid in accord with the Beneficiary and Settlement Options sections of the Policy.

CONVERSION PRIVILEGE

If your insurance or insurance on a Dependent terminates for any reason except:

- (1) termination or amendment of the Policy; or
- (2) your request for:
 - (a) termination of insurance; or
 - (b) cancellation of your payroll deduction,

an individual life policy, known as a conversion policy, may be purchased without evidence of insurability.

To purchase a conversion policy, application and payment of the first premium must be made within 31 days after the life insurance is terminated.

The conversion policy will:

- (1) be in an amount not to exceed the amount of life insurance which was terminated; less any amount of group life insurance for which the person becomes eligible under this or any other Policy within 31 days after the termination;
- (2) be on any form (except term) then issued by the Company at the age and amount for which application is made;
- (3) be issued at the person's age at nearest birthday;
- (4) be issued without disability or other supplemental benefits; and
- (5) require premiums based on the class of risk to which the person then belongs.

A conversion policy also may be purchased if:

- (1) all or part of your insurance or insurance on a Dependent terminates due to amendment or termination of the Policy; and
- (2) the person applying for the conversion policy has been covered continuously under the Policy for at least three years.

The conversion policy will take effect on the later of:

- (1) its date of issue; or
- (2) 31 days after the date the insurance terminated.

If death occurs during the 31 day conversion period, the Company will pay the life insurance which could have been converted even if no one applied for the conversion policy.

When your insurance terminates, written notice of your right to convert will be given to you.

If written notice is not given to you at least 15 days before the end of the 31 day conversion period, an additional period in which to convert will be granted. Any such extension of the conversion period will expire on the earliest of:

- (1) 15 days after you are given the written notice; or
- (2) 60 days after the end of the 31 day conversion period, even if you are never given such notice.

No death benefit will be payable under the Policy after the 31 day conversion period has expired even though the right to convert may be extended.

DEPENDENTS LIFE INSURANCE

DEATH BENEFIT. If your Dependent dies while insured under the Policy, the Company will pay the amount of Dependents Life Insurance in effect on the date of the death. This amount is shown in the Schedule of Insurance. The death benefit will be paid to you. If you are not living when your Dependent dies, the death benefit will be paid to your beneficiary or in accord with the Facility of Payment section of the Policy.

DEPENDENT. A Dependent means a person who meets the definition of your dependent under the provision of the U.S. Internal Revenue Code; and is your:

- (1) spouse who is not legally separated from you;
- (2) unmarried child at least 14 days but less than 26 years of age;
- (3) unmarried child less than 26 years of age, if attending an accredited educational institution for the minimum credit hours required to maintain full-time student status there; or
- (4) unmarried child who is totally and permanently disabled and who became so disabled prior to reaching 26 years of age.

A legally adopted child is considered your child from the date of placement in your home for an agency adoption; or from the date the adoption petition is filed, if later, for a private adoption.

In addition to naturally born and legally adopted children, the word "child" includes your stepchild or foster child; provided the child resides in your household and is dependent on you for principal support.

The term Dependent does not include anyone serving in the armed forces of any state or country; except for duty of 30 days or less for training in the Reserves or National Guard.

ELIGIBILITY. You become eligible for Dependents Life Insurance on the later of:

- (1) the date you become eligible for other coverages provided by the Policy;
- (2) the effective date of this section; or
- (3) the date you first acquire a Dependent.

EFFECTIVE DATE. Your Dependents Life Insurance will become effective on the later of:

- (1) the date you become eligible for Dependents Life Insurance;
- (2) the date you sign your payroll deduction order and apply for the coverage; or
- (3) the date the Company approves any required evidence of insurability on all your Dependents.

If you acquire a new Dependent while insured for Dependents Life Insurance, his or her insurance will become effective on the date the Dependent is acquired.

If a Dependent is confined in a hospital on the date insurance would otherwise take effect, his or her insurance will become effective on the 10th day following final discharge from the hospital.

EVIDENCE OF INSURABILITY. Each of your Dependents must submit evidence of insurability to the Company, if you apply for Dependents Life Insurance:

- (1) more than 31 days after the date you become eligible for Dependents Life Insurance;
- (2) after requesting to terminate Dependents Life Insurance or cancelling the payroll deduction order; or
- (3) after coverage has automatically terminated, due to failure to pay premium by the end of the grace period.

DEPENDENTS LIFE INSURANCE
(Continued)

INDIVIDUAL TERMINATION OF DEPENDENT INSURANCE. Your Dependents Life Insurance will cease for all your Dependents on the earliest of:

- (1) the date your Personal Insurance terminates;
- (2) the date Dependent Life Insurance is discontinued under the Policy;
- (3) the date you cease to be in a class of employees eligible for Dependent Life Insurance;
- (4) the date you request that the Dependent Life Insurance be terminated; or
- (5) the last day of the period for which you have made any required contribution for the cost of the Dependents Life Insurance.

Dependents Life Insurance on a particular Dependent will cease on the earliest of:

- (1) the date he or she ceases to be a Dependent as defined in the Policy;
- (2) the date he or she becomes covered under the Policy as an Insured Person; or
- (3) the date he or she enters the armed forces of any state or country on active duty; except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium).

**CLAIMS PROCEDURES
FOR LIFE OR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

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

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of an accidental death or dismemberment claim must be given within 20 days after the loss occurs; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

- (1) your name and address; and
- (2) the number of the Policy.

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

Proof of Claim. The Company must be given written proof of claim within 90 days after the date of the loss; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must show the nature, date and cause of the loss. In addition to the information requested on the claim form, documentation must include:

- (1) A certified copy of the death certificate, for proof of death.
- (2) A copy of any police report, for proof of accidental death or dismemberment.
- (3) A signed authorization for the Company to obtain more information.
- (4) Any other items the Company may reasonably require in support of the claim.

*** Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim; 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 claimant lacks legal capacity.

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

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

If you fail to cooperate with an examiner or fail to take an exam, without good cause; then the Company may deny benefits, until the exam is completed. In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

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

Valid life insurance claims will accrue interest, from the date of death until final settlement. The rate will be the same rate the Company pays for funds left on deposit.

TO WHOM PAYABLE

Death. Any benefits payable for your death will be paid in accord with the Beneficiary, Facility of Payment and Settlement Options sections of the Policy. If the Policy includes Dependent Life Insurance; then any benefits payable for an insured Dependent's death will be paid to:

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

Dismemberment. If the Policy includes Accidental Death and Dismemberment Benefits; then any benefit, other than your death benefit, will be paid to you.

CLAIMS PROCEDURES (Continued)

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

- (1) the reason for the denial, under the terms of the Policy and any internal guidelines;
- (2) how the claimant may request a review of the Company's decision; and
- (3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after resolving the claim. If reasonably possible, the Company will send it within:

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

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case; then an extension will be permitted. If needed, the Company will send the claimant a written delay notice:

- (1) by the 15th day after receiving the first proof of claim; and
- (2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances which require the delay, and when a decision can be expected. In any event, the Company must send written notice of its decision within:

- (1) 180 days after receiving the first proof of a death or dismemberment claim; or
- (2) 105 days after receiving the first proof of a claim for any Extension of Death Benefit available under the Policy.

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

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

REVIEW PROCEDURE. The claimant may request a claim review, within:

- (1) 60 days after receiving a denial notice of a death or dismemberment claim; or
- (2) 180 days after receiving a denial notice of a claim for any Extension of Death Benefit available under the Policy.

To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim; then the notice will also describe:

- (1) any further appeal procedures available under the Policy;
- (2) the right to access relevant claim information; and
- (3) the right to request a state insurance department review, or to bring legal action.

For a death or dismemberment claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time. For a claim for any Extension of Death Benefit available under the Policy, the notice will be sent within 45 days after the Company receives the request for review; or within 90 days, if a special case requires more time.

CLAIMS PROCEDURES (Continued)

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

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

Exception: If the Company needs more information from the claimant to process an appeal; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974). Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this section. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required reviews; then the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

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

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

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

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

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that the Policy clearly reserves to the Group Policyholder or Employer, the Company has the authority to:

- (1) manage the Policy and administer claims under it; and
- (2) interpret the provisions and resolve questions arising under the Policy.

The Company's authority includes (but is not limited to) the right to:

- (1) establish and enforce procedures for administering the Policy and claims under it;
- (2) determine your eligibility for insurance and entitlement to benefits;
- (3) determine what information the Company reasonably requires to make such decisions; and
- (4) resolve all matters when a claim review is requested.

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; subject to your or your Beneficiary's rights to:

- (1) request a state insurance department review; or
- (2) bring legal action.

CERTIFICATE AMENDMENT

**TO BE ATTACHED TO AND MADE A PART OF THE CERTIFICATE FOR GROUP POLICY:
000010206023**

ISSUED TO: City of Casper

The definition of DEPENDENT shown in the DEPENDENTS LIFE INSURANCE is amended to read:

DEPENDENT. A Dependent means a person who is your:

- (1) spouse, who is not legally separated from you;
- (2) child less than 26 years of age; or
- (3) child who is totally and permanently disabled and who became so disabled prior to reaching 26 years of age.

The word "child" includes:

- (1) your natural child, legally adopted child, or stepchild;
- (2) a child placed with you for the purpose of adoption, from the date of placement; and
- (3) a foster child for whom you have assumed full parental responsibility and control.

This amendment takes effect on January 1, 2015, or on the Insured Person's effective date of coverage under the Policy; whichever is later. In all other respects, the Policy remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

**NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER
THE WYOMING LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of Wyoming who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Wyoming Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Wyoming Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Wyoming. You should not rely on coverage by the Wyoming Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales or to induce you to purchase any kind of insurance policy.

**The Wyoming Life and Health Insurance Guaranty Association
P.O. Box 36009
Denver, CO 80236-0009
303-292-5022**

**State of Wyoming Department of Insurance
106 East 6th Avenue
Cheyenne, Wyoming 82002
800-438-5768**

The state law that provides for this safety-net coverage is called the Wyoming Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Wyoming Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Association if:

- * they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- * the insurer was not authorized to do business in this state: or
- * their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a stipulated premium insurance company, a local mutual burial association, a mutual assessment company or similar plan in which the policy-holder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- * any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- * any policy of reinsurance (unless an assumption certificate was issued);
- * interest rate yields that exceed an average rate;
- * dividends;
- * credits given in connection with the administration of a policy by a group contractholder;
- * annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions;
- * unallocated annuity contracts (which give rights to group contractholders, not individuals); or
- * any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of \$500,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$500,000 limit, the Association will not pay more than \$100,000 in cash surrender values for life insurance policies, \$300,000, for basic hospital, medical, and surgical insurance or major medical insurance, \$300,000 for disability insurance, disability income insurance and long-term care insurance, \$100,000 for coverages not defined as disability insurance or disability income insurance or basic hospital medical and surgical insurance or major medical insurance or long-term care insurance, including any net cash surrender and net cash withdrawal values, \$250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal values, or \$300,000 in life insurance death benefits -- again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

ISSUED TO: City of Casper

Your Certificate is amended by the addition of the following provisions.

**PRIOR INSURANCE CREDIT UPON TRANSFER OF
LIFE INSURANCE CARRIERS**

This provision prevents loss of life insurance coverage for you, which could otherwise occur solely because of a transfer of insurance carriers. The Policy will provide the following Prior Insurance Credit, when it replaces a prior plan.

"**Prior Plan**" means a prior carrier's group life insurance policy, which the Policy replaced within 1 day of the prior plan's termination date.

FAILURE TO SATISFY ACTIVE WORK RULE. Subject to payment of premiums, the Policy will provide life coverage if you:

- (1) were insured under the prior plan on its termination date;
- (2) were otherwise eligible under the Policy; but were not Actively-At-Work due to Injury or Sickness on its Effective Date;
- (3) are not entitled to any extension of life insurance under the prior plan; and
- (4) are not Totally Disabled (as defined in the Extension of Death Benefit section of the Policy) on the date the Policy takes effect.

AMOUNT OF LIFE INSURANCE. Until you satisfy the Policy's Active Work rule, the amount of your group life insurance under the Policy will not exceed the amount for which you were insured under the prior plan on its termination date.

This Amendment takes effect on your effective date of coverage under the Policy. In all other respects, your Certificate remains unchanged.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY



Officer of the Company

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

Information We May Collect And Use

We collect personal information about you to help us identify you as our customer or our former customer; to process your requests and transactions; to offer investment or insurance services to you; to pay your claim; to analyze in order to enhance our products and services; or to tell you about our products or services we believe you may want and use; and as otherwise permitted by law. The type of personal information we collect depends on the products or services you request and may include the following:

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

How We Use Your Personal Information

We may share your personal information within our companies and with certain service providers. They use this information to process transactions you have requested; provide customer service; to analyze in order to enhance our products and services; and inform you of products or services we offer that you may find useful. Our service providers may or may not be affiliated with us. They include financial service providers (for example, third party administrators; broker-dealers; insurance agents and brokers, registered representatives; reinsurers and other financial services companies with whom we have joint marketing agreements). Our service providers also include non-financial companies and individuals (for example, consultants; vendors; and companies that perform marketing services on our behalf). Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law.

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners, regulatory authorities and law enforcement officials, and to other non-affiliated or affiliated parties as permitted by law. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or share your information with outside marketers who may want to offer you their own products and services; nor do we share information we receive about you from a consumer reporting agency. You do not need to take any action for this benefit.**

Security of Information

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. Our employees are authorized to access your information only when they need it to provide you with products, services, or to maintain your accounts. Employees who have access to your personal information are required to keep it confidential. Employees are trained on the importance of data privacy.

Your Rights Regarding Your Personal Information

Access: We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you request a copy of the information, we may charge you a fee for copying and mailing costs. In very limited circumstances, your request may be denied. You may then request that the denial be reviewed.

Accuracy of Information: If you feel the personal information we have about you is inaccurate or incomplete, you may ask us to amend the information. Your request must be in writing and must include the reason you are requesting the change. We will respond within 30 business days. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years. If your requested change is denied, we will provide you with reasons for the denial. You may write to request the denial be reviewed. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request.

Accounting of Disclosures: If applicable, you may request an accounting of disclosures made of your medical information, except for disclosures:

- For purposes of payment activities or company operations;
- To the individual who is the subject of the personal information or to that individual's personal representative;
- To persons involved in your health care;
- For notification for disaster relief purposes;
- For national security or intelligence purposes;
- To law enforcement officials or correctional institutions; or
- For which an authorization is required.

You may request an accounting of disclosures for a time period of less than two years from the date of your request.

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

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

Questions about your personal information should be directed to:

Lincoln Financial Group
Attn: Enterprise Compliance and Ethics
Corporate Privacy Office, 7C-01
1300 S. Clinton St.
Fort Wayne, IN 46802

Please include all policy/contract/account numbers with your correspondence.

*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Financial Group Trust Company, Inc.
Lincoln Investment Advisors Corporation
Lincoln Financial Distributors, Inc.

Lincoln Life & Annuity Company of New York
Lincoln Retirement Services Company, LLC
Lincoln Variable Insurance Products Trust
The Lincoln National Life Insurance Company