Lincoln Financial Group®

Lincoln Life & Annuity Company of New York
Service Office Address: 8801 Indian Hills Drive, Omaha, NE 68114-4066
Home Office: Syracuse, NY
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FEE/OVERRIDE DISCLOSURE FORM - NY

Group Information:

Group Name: _____

Group ID: _____

PRODUCER TYPE: Please check each type of producer that will be receiving compensation in connection with this group.

☐ Writing Broker ☐ Third Party Administrator (TPA) ☐ Enroller/Enrollment Firm
☐ General Agent ☐ Broker's Broker

Writing Producer complete and sign this form for each group in which an override or fee will be assessed. Please return the form to your Lincoln Financial Group Regional Office.

FEES:

☐ **Yes, fees apply for the above group. Fees are payment(s) for specific services performed for the group as indicated below. Please mark all that apply below.**

Service	Fee Percentage	Coverage (mark all that apply)
Assistance in the development and preparation of plan material or documents	1%	☐ Life ☐ STD ☐ LTD ☐ Dental ☐ Vol. Life ☐ Vol. STD ☐ Vol. LTD ☐ Vol. Dental
Assistance in conducting member satisfaction surveys and montoring customer satisfaction	1%	☐ Life ☐ STD ☐ LTD ☐ Dental ☐ Vol. Life ☐ Vol. STD ☐ Vol. LTD ☐ Vol. Dental
Assistance in collection of premiums from customers	2%	☐ Life ☐ STD ☐ LTD ☐ Dental ☐ Vol. Life ☐ Vol. STD ☐ Vol. LTD ☐ Vol. Dental
Assistance in the development and implementation of customer billing	1%	☐ Life ☐ STD ☐ LTD ☐ Dental ☐ Vol. Life ☐ Vol. STD ☐ Vol. LTD ☐ Vol. Dental
Assistance in claims administration	1%	☐ Life ☐ STD ☐ LTD ☐ Dental ☐ Vol. Life ☐ Vol. STD ☐ Vol. LTD ☐ Vol. Dental
Consultation in connection with collective bargaining	1%	☐ Life ☐ STD ☐ LTD ☐ Dental ☐ Vol. Life ☐ Vol. STD ☐ Vol. LTD ☐ Vol. Dental
Assistance in enrollment meetings or site visits	2%	☐ Life ☐ STD ☐ LTD ☐ Dental ☐ Vol. Life ☐ Vol. STD ☐ Vol. LTD ☐ Vol. Dental
Assembly and analysis of claims experience	1%	☐ Life ☐ STD ☐ LTD ☐ Dental ☐ Vol. Life ☐ Vol. STD ☐ Vol. LTD ☐ Vol. Dental

Fees will be paid ☐ 1 year ☐ 2 year ☐ date the policy terminates ☐ Other

Fee Recipient Name: _____

Address: _____

_____

Fee Recipient Tax ID#: _____

Group ID: _____

OVERRIDE COMMISSION:

☐ **Yes, Overrides apply to the above group. Overrides are payment(s) to a general agent or manager for managing an agency or for performing administration functions only (for example a broker's broker). Overrides for the above policy to be paid as follows (complete for all coverages that apply):**

Coverage	Override %	Coverage	Override %
Life	_____	Vol. Life	_____
STD	_____	Vol. STD	_____
LTD	_____	Vol. LTD	_____
Dental	_____	Vol. Dental	_____

Override will be paid ☐ **1 year** ☐ **2 year** ☐ **date the policy terminates** ☐ **Other**

Override Recipient Name: _____

Override Recipient Address: _____

_____

Override Recipient Tax ID#: _____

I hereby represent that all information provided on this form is true and correct to the best of my knowledge and belief. I understand that Lincoln Life & Annuity Company of New York will rely on this information to comply with certain record-keeping and disclosure requirements. I further understand that I may be required to disclose the information provided on this form to the customer.

Writing Producer Name: _____

Writing Producer Address: _____

_____

Writing Producer Tax ID#: _____ **Date:** _____

Writing Producer Signature: _____