



Brotherhood of Locomotive Engineers and Trainmen

Division of the Rail Conference - International Brotherhood of Teamsters

Norfolk Southern Lines

General Committee of Adjustment

P.O. Box 1305

Powell, Tennessee

Telephone (865) 945-1391 Fax (865) 945-3715

William M. Overton, Jr.
General Chairman

William A. Thompson
First Vice General & S/T

Mark L. Wallace
Second Vice General

BLET VOLUNTARY LIFE INSURANCE NORFOLK SOUTHERN

Now is time to take advantage to purchase additional life insurance being offered on a **guarantee issue basis**, as long as you are currently working. No exams or health questions are asked and coverage is guaranteed issue! You are able to pick the program that best fits your individual need.

The Lincoln Financial term life plan offers high death benefits at a low cost. Your rates do not increase with age and coverage ends at retirement.

In this packet, you will find product highlights and an application. You may choose a \$100,000 or \$50,000 death benefit with NO health questions asked. Your spouse is eligible for \$25,000 of life insurance on a guarantee issue basis as long as you enroll in the program!

Children's coverage is \$10,000 per child with a single rate for all children, whether you have one or a dozen (up to age 19 or age 25 if child is a full time student).

All you need to do is choose the death benefit and complete the enclosed application. Once this is completed, return the signed forms back to:

Railroad Marketing
PO Box 787
Santa Clara, UT 84765

or fax it back to: (435) 688-1338.

If you have any further questions or need help in completing the application, please call Railroad Marketing toll free at 888-696-9951.

Sincerely,

William Thompson
Vice General Chairman



Voluntary Life Insurance

SUMMARY OF BENEFITS

Sponsored by: Brotherhood of Locomotive Engineers and Trainmen

| Life Benefit | Employee | Spouse | Dependent |
|-----------------|---|---|--|
| Amount | Choice of \$50,000 or \$100,000 Employees age 70 and older, maximum benefit is \$50,000. | \$25,000 Employee must elect coverage for spouse to be eligible. Not to exceed 50% of employee elected amount. | \$250 Child: 14 days to six months \$10,000 Child: Six months to age 19 (to age 25 if full-time student) Newborn children to age 14 days are not eligible for a benefit. |
| Minimum Amount | \$50,000 | \$25,000 | \$10,000 |
| Maximum Amount | \$100,000 | \$25,000 | \$10,000 |
| Guarantee Issue | \$100,000 under age 70 No Guarantee Issue age 70 and older | \$25,000 if employee is under age 65 No Guarantee Issue employee is age 65 or older. Spouse coverage terminates when employee attains age 70. | \$10,000 |

| Benefit Reduction | Employee | Spouse |
|-----------------------|--|--|
| Benefits will reduce: | 35% at age 65 An additional 25% of the original amount at age 70 An additional 15% of the original amount at age 75 Benefits terminate at age 80 or retirement, whichever is first. | 35% at employee age 65 Benefits terminate at employee age 70 or retirement, whichever occurs first. |

| Additional Benefits | |
|---------------------|--|
| See Definition: | Accelerated Death Benefit Conversion Portability |

| Eligibility | Employee | Spouse and Dependents |
|-------------|--|---|
| | All full-time active employees working 30 or more hours per week in an eligible class are eligible for coverage on the policy effective date. A delayed effective date will apply if the employee is not actively at work. | Cannot be in a period of limited activity on the day coverage takes effect. |

| Employee Twice Monthly Cost | | Spouse Twice Monthly Cost |
|-----------------------------|------------------|---------------------------|
| \$50,000 | \$100,000 | \$25,000 |
| \$11.50* | \$21.50* | \$5.00 |

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.
Dependent Monthly Cost = \$1.00 / Premium covers all dependent children regardless of the number of children.

* NS deduction fee included in premium. Deductions will come out of your paycheck twice monthly.

Definitions

| | |
|----------------------------------|---|
| Accelerated Death Benefit | When diagnosed as terminally ill (having 12 months or less to live), you may withdraw up to 75% of your life insurance coverage to a maximum of \$250,000. The death benefit will be reduced by the amount withdrawn. To qualify, you satisfied the Active Work rule and have been covered under this policy for at least 12 months. Check with your tax advisor or attorney before exercising this option. |
| Conversion | If you terminate your employment or become ineligible for this coverage, you have the option to convert all or part of the amount of coverage in force to an individual life policy on the date of termination without Evidence of Insurability. Conversion election must be made within 31 days of your date of termination. |
| Guarantee Issue | For timely entrants enrolled within 31 days of becoming eligible, the Guarantee Issue amount is available without any Evidence of Insurability requirement. Evidence of Insurability will be required for any amounts above this, for late enrollees or increase in insurance, and it will be provided at your own expense. |
| Limited Activity | A period when a spouse or dependent is confined in a health care facility; or, whether confined or not, is unable to perform the regular and usual activities of a healthy person of the same age and sex. |
| Portability | If coverage has been in force for at least 12 months, you may continue coverage for a specified period of time after your employment by paying the required premium. Portability is available if you cease employment for a reason other than total disability or retirement. A written application must be made within 31 days of your termination. |
| Term Life | Coverage provided to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible and premium is paid. There is no cash value associated with this product. |
| Exclusion: Suicide | Benefits will not be paid if the death results from suicide within two years after coverage is effective. May apply if employee contributes toward the premium. |

Additional Benefits

| | |
|--|---|
| BeneficiaryConnectSM | Support services for beneficiaries who have experienced a loss. |
| TravelConnectSM | Travel assistance services for employees and eligible dependents traveling more than 100 miles from home. |

For assistance or additional information

Contact Railroad Marketing at (800) 696-9951 or log on to www.railroadmarketing.com

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

©2008 Lincoln National Corporation

Group Insurance products are issued by The Lincoln National Life Insurance Company (Ft. Wayne, IN), which is not licensed and does not solicit business in New York. In New York, group insurance products are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group companies. Product availability and/or features may vary by state. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Each affiliate is solely responsible for its own financial and contractual obligations.

Railroad Marketing Insurance Services
PO Box 787
Santa Clara UT 84765



888-696-9951



ENROLLMENT FORM FOR GROUP INSURANCE

| | | | |
|------------------------|--------------------------------|---|-------------------------------|
| Please Use Ink or Type | GROUP ID: BLENORFOL2 | GROUP POLICY #: VLI 40-0001000-09903 | Billing Division or Location: |
|------------------------|--------------------------------|---|-------------------------------|

A. Employee Information (Complete for ALL Enrollments)

| | | | | | |
|---|--|----------------|------------------------|--------------|--------------------|
| Employer Name/Company Name (Please Print) Brotherhood of Locomotive Engineers | | | County | Employer ZIP | State |
| Employee Last Name | First Name | Middle Initial | Social Security Number | | Date of Birth |
| Spouse Last Name | First Name | Middle Initial | Social Security Number | | Phone Number |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single | | Email Address | | Employee ID Number |

B. Product Selection (Complete for ALL Enrollments)

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

| TYPE OF COVERAGE | COVERAGE AMOUNT | Monthly PREMIUM |
|--|--|--------------------|
| Voluntary Employee Life Insurance * <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> \$ 50,000 <input type="checkbox"/> \$100,000 | \$23.00 \$43.00 |
| Voluntary Spouse Life Insurance * <input type="checkbox"/> Yes <input type="checkbox"/> No | \$25,000 | \$10.00 |
| Voluntary Child Life Insurance * <input type="checkbox"/> Yes <input type="checkbox"/> No | \$10,000 | \$2.00 |

C. Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)

| | | | | | |
|------------------------------------|-------|----|-----------------------------|------------------------|-----|
| Primary Beneficiary's Last Name | First | MI | Relationship of Beneficiary | Social Security Number | |
| Street Address | | | City | State | Zip |
| Contingent Beneficiary's Last Name | First | MI | Relationship of Beneficiary | Social Security Number | |
| Street Address | | | City | State | Zip |

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

E. Request for Coverages

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

REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company. I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.

NOT ENROLL myself in the Program. I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOT ENROLL my dependents in the Program. I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTICE: 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.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name: _____ Employee Signature: _____ Date: _____