The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID:	GROUP POLICY #:	Billing Division or Location: 1326447; 1354126

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print)		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		Date of Birth
Street Address		City	State	Zip
Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single	Home Phone		Work Phone

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐Hourly ☐Monthly ☐Weekly ☐Yearly $____________________________	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Basic 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.

Class	Effective Date	Type of Coverage			Amount of Coverage	Total Premium
		Basic Group Life/AD&D	☒**Yes**	☐**No***	**$**	Employer Paid
		Short Term Disability	☒**Yes**	☐**No***	**$**	Employer Paid
		Long Term Disability	☒**Yes**	☐**No***	**$**	Employer Paid
		Dental	☐**Yes**	☐**No**	☐Employee Only ☐Employee/Spouse ☐Employee/Children ☐Employee/Spouse/Children	**$**

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

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.

Has Employee or Spouse used any type of tobacco or nicotine in the past 12 months? Employee: ☐Yes ☐No
Spouse: ☐Yes ☐No

TYPE OF COVERAGE			AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life Insurance	☐**Yes**	☐**No***	$	$
Voluntary Employee Optional AD&D	☐**Yes**	☐**No***	Equal to Life Insurance Amount	$
Voluntary Spouse Life Insurance	☐**Yes**	☐**No***	$	$
Voluntary Spouse Optional AD&D	☐**Yes**	☐**No***	Equal to Life Insurance Amount	$
Voluntary Dependent Child Benefit	☐**Yes**	☐**No***		$

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

Accident Coverage NOTE: Please mark the box or boxes for each plan/benefits you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.			
Type of Coverage	**Selecting Yes authorizes my employer to payroll deduct premium(s).**	**Amount of Coverage**	**Bi-Weekly Premium**
Accident-Choice On the job accident coverage Health Assessment (wellness)	☐Yes ☐No	☐Employee Only ☐Employee Plus Spouse ☐Employee Plus Child(ren) ☐Family	$8.84 $12.97 $14.51 $19.87

--Actual deductions may vary slightly from above illustrations due to rounding--

C. Beneficiary Information (Complete ONLY for Life/AD&D or Accident with AD&D or Critical Illness)						
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.						

D. Dependent and Other Insurance Information (Complete only for Critical Illness or Dental/Vision Coverage)						
	Last Name **SSN (Optional)**	**First Name**	**Middle Initial**	**Gender**	**Date of Birth**	**Full-time Student**
Child						☐Yes ☐No
Child						☐Yes ☐No
Child						☐Yes ☐No
Child						☐Yes ☐No

Are you or any of your eligible dependents covered by any other dental/vision plan? ☐**YES (If YES, please list)** ☐**NO**

Name of Insured	**Insurance Company Name/Phone and Policy Number**	**Employer**	**Coverage**
			☐**Dental** ☐**Vision**
			☐**Dental** ☐**Vision**
			☐**Dental** ☐**Vision**

Please See Last Page/Reverse for Beneficiary and Signature

Employee Name: ___________________________ SSN: ________________________________

	Last Name SSN (Optional)	First Name	Middle Initial	Gender	Date of Birth	Full-time Student
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No
Child						☐ Yes ☐ No

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 enroll 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 enroll 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 enroll 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.

NOTE: 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.

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, or its insurance partners, 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 an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

I understand that the vision care insurance benefit plan I have selected provides reimbursement for certain vision costs which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my provider or me for vision care expenses which I have incurred may not be covered by my vision care insurance benefit plan.

Employee Full Name:____________________________ Employee Signature:_________________________ Date:_______________