



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:
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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: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		Home Phone ()		Work Phone ()

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$	\$
		Dependent Life <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$	\$
		Optional Employee Life/AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$	\$
		Optional Spouse Life/AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$	\$
		Optional Child Life <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$	\$
		Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$	\$
		Long Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$	\$
		Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Children <input type="checkbox"/> 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.

--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	Weekly Premium
Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Select One: <input type="checkbox"/> Select <input type="checkbox"/> Choice <input type="checkbox"/> Preferred <input type="checkbox"/> Elite	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus Spouse <input type="checkbox"/> Employee Plus Child(ren) <input type="checkbox"/> Family	\$ \$ \$ \$

The following Optional Benefits may be elected if Accident coverage is elected.
Accident coverage for Dependents must be elected in order to elect any Dependent coverage for the Optional Benefits.

Type of Coverage	Selecting Yes authorizes my employer to payroll deduct premium(s).	Amount of Coverage	Weekly Premium
		Check One:	
Health Assessment - \$50	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus Spouse <input type="checkbox"/> Employee Plus Child(ren) <input type="checkbox"/> Family	\$ \$ \$ \$
Sickness Hospital Confinement - \$100	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus Spouse <input type="checkbox"/> Employee Plus Child(ren) <input type="checkbox"/> Family	\$ \$ \$ \$
Accident Sickness Disability - \$2,000	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus Spouse	\$ \$
Accident Disability - \$2,000	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus Spouse	\$ \$

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

Critical Illness 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.

To apply the appropriate tobacco/non-tobacco rates, please answer the following question:

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	Plan Option(s)	Amount of Coverage	Weekly Premium
Critical Illness <input type="checkbox"/> Yes <input type="checkbox"/> No* Base Plan includes: Wellness Category Heart Category Cancer Category Organ Category Quality of Life Category Child Category** Treatment Care Benefit*** Permanent and Total Disability Benefit Accident Benefit Occupational HIV/Occupational Hepatitis Benefit**** **Child Category covers Dependent children only. ***Not available for children. ****Not available for spouses or children.	Employee Spouse* *Spouse amount cannot exceed Employee amount. Child** **Child amount cannot exceed 50% of Employee amount.	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000	\$ \$ \$

The following Optional Benefit(s) may be elected if Critical Illness coverage is elected.

Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit.

Optional Benefit	Plan Option(s)	Amount of Coverage	Weekly Premium
Heart Category <input type="checkbox"/> Yes <input type="checkbox"/> No*	Employee Spouse Child	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000	\$ \$ \$
Cancer Category <input type="checkbox"/> Yes <input type="checkbox"/> No*	Employee Spouse Child	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000	\$ \$ \$

*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--

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 Accident or Critical Illness or Dental/Vision Coverage)						
	Last Name	First Name	Middle Initial	Gender	Date of Birth	Full-time Student
	SSN (Optional)					
Child						<input type="checkbox"/> Yes <input type="checkbox"/> No
Child						<input type="checkbox"/> Yes <input type="checkbox"/> No
Child						<input type="checkbox"/> Yes <input type="checkbox"/> No
Child						<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you or any of your eligible dependents covered by any other dental/vision plan? <input type="checkbox"/> YES (If YES, please list) <input type="checkbox"/> NO						
Name of Insured	Insurance Company Name/Phone and Policy Number		Employer		Coverage	
					<input type="checkbox"/> Dental <input type="checkbox"/> Vision	
					<input type="checkbox"/> Dental <input type="checkbox"/> Vision	
					<input type="checkbox"/> Dental <input type="checkbox"/> Vision	

E. Request for Coverages
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:
<input type="checkbox"/> 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.
<input type="checkbox"/> 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.
<input type="checkbox"/> 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 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.

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: _____