



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

# Here is your Enrollment Form.

Follow these steps to complete the form.

Print clearly in ink.

Step 1: Fill in or confirm your personal information.

Step 2: Fill in dependent information, if any.

Step 3: Select your benefits.

Step 4: Assign beneficiaries.

Step 5: Confirm enrollment.

Step 6: Sign, date & return the form.

Group ID: \_\_\_\_\_

## 1. Your Personal Information

Group/Employer/Participating Organization Name			County	Zip	State
_____			_____	_____	_____
Your First Name	Middle Name/MI	Last Name	Social Security No.	Employee ID No.	Date of Birth
_____	_____	_____	____-____-____	_____	____/____/____
Street Address (Include Apt. or Suite No.)			City	State	Zip
_____			_____	_____	_____
Home Phone	Cell Phone	Work Phone	Email Address		
( ) - _____	( ) - _____	( ) - _____	_____		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single			

## Employer Completes this Section.

Billing Division or Location: \_\_\_\_\_

Sort Group/Code: \_\_\_\_\_ Payroll Cycle: \_\_\_\_\_

Policy #(s): \_\_\_\_\_

Average Hours Worked Per Week: \_\_\_\_\_  Full-time  Part-time Occupation: \_\_\_\_\_

Earnings:  Hourly  Weekly  Monthly  Yearly \$ \_\_\_\_\_ Date of Employment: \_\_\_\_/\_\_\_\_/\_\_\_\_

Actively at Work?  Yes  No Date of Rehire: \_\_\_\_/\_\_\_\_/\_\_\_\_

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

**3. Benefit Selection — Choose your benefits.**

Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions stated in the policy and certificate.

Basic Group Insurance				
Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium (Weekly)
Class	Effective Date			
_____	____/____/____	Life & AD&D		Your Employer pays

Voluntary/Optional Group Insurance				
Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions as stated in the policy and certificate.				
Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium (Weekly)
Class	Effective Date			
_____	____/____/____	Optional Life <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$_____	\$_____

\*By selecting "No," application for insurance 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--

**4. Select Your Beneficiaries — Choose who receives your insurance benefits.**

**Primary Beneficiary(ies)**  
**The Primary Beneficiary is the person(s) you identify to receive insurance benefits upon your death.**

**If more than three Primary Beneficiaries, please attach a separate sheet of paper.  
 If multiple Primary Beneficiaries, total percentage of all combined must equal 100%.**

First Name	Middle Initial	Last Name
_____		
Street Address	City	State Zip
_____		
Social Security Number	Date of Birth	Relationship to You Percentage Phone Number
____-____-_____	____/____/____	_____% (____) - _____

First Name	Middle Initial	Last Name
_____		
Street Address	City	State Zip
_____		
Social Security Number	Date of Birth	Relationship to You Percentage Phone Number
____-____-_____	____/____/____	_____% (____) - _____

First Name	Middle Initial	Last Name
_____		
Street Address	City	State Zip
_____		
Social Security Number	Date of Birth	Relationship to You Percentage Phone Number
____-____-_____	____/____/____	_____% (____) - _____

**Contingent Beneficiary(ies) and Other Beneficiary Designations**

A Contingent Beneficiary will receive benefits only if the Primary Beneficiary(ies) does not survive you. Please attach a separate sheet to identify a Contingent Beneficiary. If multiple Contingent Beneficiaries, total percentage of all combined must equal 100%. To name a Beneficiary(ies) by product, attach a separate sheet identifying product and beneficiary.

## 5. Confirm Enrollment

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

- ENROLL FOR INSURANCE for which I am or may become eligible** under the group policies issued by The Lincoln National Life Insurance Company, or its insurance partners. If contributions are required, I authorize my Employer to deduct premium from my pay.
- NOT ENROLL myself in the group insurance offered.** I understand if I enroll for insurance 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 group insurance offered.** I understand if I enroll my dependents for insurance at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

### Fraud Warning/State Disclosure(s)

**A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.**

**FOR CRITICAL ILLNESS INSURANCE: A PERSON WHO IS ALREADY COVERED BY MEDICAID IS NOT ELIGIBLE FOR THIS INSURANCE AND CANNOT BE INCLUDED IN THE GROUP.**

**REVIEW THE ANSWERS ON THIS APPLICATION CAREFULLY. IF ANY OF YOUR ANSWERS ARE INCORRECT OR UNTRUE, EVEN IF UNINTENTIONAL, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE IF THE MISREPRESENTATION IS DEEMED TO BE MATERIAL.**

## 6. Sign and Return

I understand the group insurance requested will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners. A delayed effective date will apply if you are not Actively at Work/an Active Member. A delayed effective date may apply to your dependent, if he or she is confined in a hospital or health care facility or is in a period of limited activity on the date insurance would otherwise take effect.

I understand the information provided is for enrollment in group insurance as offered by my Employer and will not be used for underwriting purposes.

The information provided is complete, true, and accurate to the best of my knowledge.

Your Full Name (Print): \_\_\_\_\_

Your Signature: **X** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Complete and return this form.**

**(Be sure to sign and date the form to start your insurance.)**

**Questions? Call 800-423-2765**