

# The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana

Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066

Phone: (800) 423-2765 Fax: (877) 573-6177

## APPLICATION FOR GROUP INSURANCE

*is hereby made to The Lincoln National Life Insurance Company.*

### A. NAME AND ADDRESS

1. **Applicant's Full Legal Name** (exactly as to be shown in Group Policy): \_\_\_\_\_

2. **Main Office Address** (physical location and group situs state):

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ FAX # (\_\_\_\_) \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
(if available)

### B. REQUESTED COVERAGES

The following Group Insurance is applied for as specified in the sold case proposal(s). Complete the requested Effective Date for each coverage.

Basic Life & AD&D with Effective Date \_\_\_\_\_

Optional Life & AD&D with Effective Date \_\_\_\_\_

Long Term Disability with Effective Date \_\_\_\_\_

### C. BUSINESS INFORMATION

1. **Nature of Business** (Please specify): Education

Federal Tax ID# \_\_\_\_\_

2. **Business is Organized As** (select one):

Independent School District  Common School District  Jr. or Community College  Tax Appraisal District

3. **Financial Risk** (If Yes to any part, please explain below.)

Yes  No Has Applicant ever filed for bankruptcy?

Yes  No Does Applicant anticipate ceasing or materially reducing active business operations?

Yes  No Has Applicant opted out (or do they anticipate opting out) of Workers' Compensation?

Explanation: \_\_\_\_\_

4. Binder payment submitted: Amount \$ \_\_\_\_\_ (if applicable)

5. **NON-ERISA – No 5500, Schedule A.**

### D. REPLACEMENT COVERAGE

Yes  No Will all or part of this coverage **replace** any similar coverage? **If Yes, provide details of the prior plan below and enclose a copy of each inforce contract to be replaced.**

Coverage Type	Prior Carrier Name	Prior Plan Effective Date	Termination Date
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**E. FRAUD WARNING**

A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping to defraud) an insurance company.

**F. AGREEMENT.** The Applicant hereby applies for group insurance. The information in this Application is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance. Omission or misstatement of known information on this Application could affect the validity of any insurance issued and cause the denial of an otherwise valid claim. The Applicant understands that the requested group insurance will:

- (a) be issued only if the requested insurance is acceptable to the Company and is legally permissible;
- (b) be issued under a group Policy or Policies in the language customarily used by the Company;
- (c) be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
- (d) be subject to all exclusions and limitations of the Policy; and
- (e) take effect on the date determined by the Company.

The Applicant understands that no agent or broker has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an employee is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms, and will be subject to the Active Work requirement. The Applicant agrees not to:

- (a) collect or pay premiums (other than the Binder Premium, if any) for such insurance, before receiving the Company's notice of approval; or
- (b) distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

Writing Agent

Signed by Applicant's Authorized Representative:

Typed or Printed Name Crenshaw Whitley & Assoc., LLC Signature \_\_\_\_\_

License Number 18598 State TX Typed or Printed Name \_\_\_\_\_

Title \_\_\_\_\_

State Signed \_\_\_\_\_ Date \_\_\_\_\_



Must be signed prior to Effective Date

**LIFE/AD&D BENEFITS SUPPLEMENT**

Thank you for choosing to participate in the TASB Group Term Life Program. The Lincoln National Life Insurance Company is pleased to provide your coverage. In order to develop your policy, we will need to know more about you. Please complete the following questions.

**DISTRICT'S BENEFIT SCHEDULE**

CLASS NUMBER	CLASS DESCRIPTION	BENEFIT AMOUNT	CLASS PARTICIPATION

**EMPLOYER CONTRIBUTION PERCENTAGE**

BASIC LIFE/AD&D	OPTIONAL EMPLOYEE LIFE/AD&D	OPTIONAL SPOUSE LIFE/AD&D	OPTIONAL CHILD LIFE

**LIFE/AD&D ELIGIBILITY, WAITING PERIOD**

1. **Eligibility Waiting Period**

A. Present Employees (hired on or before the Effective Date of this Policy) who have not yet satisfied the new employee Eligibility Waiting Period:

- must also complete the new employee Eligibility Waiting Period before becoming eligible for insurance
- will not be required to satisfy an Eligibility Waiting Period before becoming eligible for insurance
- must be employed in an eligible class for \_\_\_\_\_ before becoming eligible for insurance

B. New Employees (hired after this Policy's Effective Date) must be employed in an eligible class with the Applicant for \_\_\_\_\_ before becoming eligible for insurance.

2. **Employee Effective Date** - Subject to the Active Work rule, employees become insured on:

- 1st day of employment (If no Eligibility Waiting Period)
- 1st day of the insurance month coinciding with or next following completion of the Eligibility Waiting Period
- The day following completion of the Eligibility Waiting Period
- Other (must be approved by the Home Office) \_\_\_\_\_

3. **Excluded Classes** - The Policy standardly excludes retirees, temporary, seasonal or part-time employees working less than the Minimum Hours selected.  
Also exclude the following: \_\_\_\_\_

NOTE: Subject to Active Work Rule, benefit increases will take effect on the 1st day of the insurance month coinciding with or next following the increase, unless requested otherwise in **REMARKS** and agreed upon by the Company. Decreases will take effect on the date of the change.

**REMARKS**

**FOR HOME OFFICE USE ONLY**

**LONG TERM DISABILITY BENEFITS  
SUPPLEMENT**

Thank you for choosing to participate in the TASB Group LTD Program. The Lincoln National Life Insurance Company is pleased to provide your coverage. In order to develop your policy, we will need to know more about you. Please complete the following questions.

**DISTRICT'S BENEFIT SCHEDULE**

CLASS NUMBER	CLASS DESCRIPTION	BENEFIT AMOUNT	CLASS PARTICIPATION

**EMPLOYER CONTRIBUTION PERCENTAGE**

LTD

**LTD ELIGIBILITY, WAITING PERIOD**

1. **Eligibility Waiting Period**
  - A. Present Employees (hired on or before the Effective Date of this Policy) who have not yet satisfied the new employee Eligibility Waiting Period:
    - must also complete the new employee Eligibility Waiting Period before becoming eligible for insurance
    - will not be required to satisfy an Eligibility Waiting Period before becoming eligible for insurance
    - must be employed in an eligible class for \_\_\_\_\_ before becoming eligible for insurance
  - B. New Employees (hired after this Policy's Effective Date) must be employed in an eligible class with the Applicant for \_\_\_\_\_ before becoming eligible for insurance.
2. **Employee Effective Date** - Subject to the Active Work rule, employees become insured on:
  - 1st day of employment (If no Eligibility Waiting Period)
  - 1st day of the insurance month coinciding with or next following completion of the Eligibility Waiting Period
  - The day following completion of the Eligibility Waiting Period
  - Other (must be approved by the Home Office) \_\_\_\_\_
3. **Excluded Classes** - The Policy standardly excludes retirees, temporary, seasonal or part-time employees working less than the Minimum Hours selected.  
Also exclude the following: \_\_\_\_\_  
NOTE: Subject to Active Work Rule, benefit increases will take effect on the 1st day of the insurance month coinciding with or next following the increase, unless requested otherwise in **REMARKS** and agreed upon by the Company. Decreases will take effect on the date of the change.

**LTD EARNINGS DEFINITION**

- In no event will salary exceed the amount shown in the Employer's payroll records, or for which premium has been paid (if less).**
- Earnings standardly include **monthly base salary**, or hourly pay for regularly scheduled work (excluding overtime), and any **commissions** averaged over prior 12 Months. Earnings will be determined on **the last day worked**; unless requested otherwise. If any other compensation is to be included or alternate definition is wanted, describe below:
- Also include: \_\_\_\_\_ Instead base on:
- Bonuses averaged over 36 Months. \_\_\_\_\_
  - Other (subject to Home Office Approval) \_\_\_\_\_
  - Each Employee's W-2 earnings for prior year.
  - Other (subject to Home Office Approval) \_\_\_\_\_

**REMARKS**