



Underwritten by: 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
 (800) 423-2765 fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Group ID:	Group Policy #:	Billing Division or Location:
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Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name		County	Employer ZIP	State
Employee First Name / Middle Initial / Last Name		Social Security Number		Date of Birth
Street Address / City / State / Zip				
Gender:	Marital Status:	() Home Phone	() Work Phone	
Spouse First Name / Middle Initial / Last Name		Spouse Social Security Number		Spouse Date of Birth

Employee Work Information (Complete for ALL Enrollments)

Average Work Week Hours:	Occupation:	Annual Earnings: \$	Full-Time Employment Date:	Rehire Date:
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Product Selection (Complete for ALL Enrollments)

: Please mark box/boxes for coverages you are applying for. Coverage amounts subject to limitations/exclusions as stated in the policy.

Class	Effective Date	Type of Coverage	Amount of Coverage	Premium
		Basic Group Life/AD&D <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Employer Paid

Optional Coverage NOTE: Please mark box/boxes for coverages you are applying for. Coverage amounts subject to limitations/exclusions as stated in the policy.

Type of Coverage	Selecting yes authorizes my employer to payroll deduct premium(s)	Amount of Coverage	Premium
Optional Employee Life + AD&D <i>Employee must elect optional life coverage in order to elect spouse and/or dependent coverage</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No*	<input type="checkbox"/> \$20,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> OTHER \$ _____	Life+AD&D
Optional Spouse Life + AD&D <i>Employee must elect optional life coverage in order to elect spouse and/or dependent coverage. Spouse coverage selection may not exceed 50% of the Employee optional amount selected</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No*	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> OTHER \$ _____	
Optional Dependent Child Benefit <i>Employee must elect optional life coverage in order to elect spouse and/or dependent coverage</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No*	<input type="checkbox"/> \$10,000	

*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

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.				

NOTE: A PERSON COMMITS 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.

The insurance requested on this enrollment form will not be effective until approved by the Home Office of Lincoln National Life Insurance Company, and the initial premium is paid to 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: _____