

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

ENROLLMENT FORM FOR GROUP INSURANCE

TEXAS ASSOCIATION OF SCHOOL BOARDS

GROUP ID:	GROUP POLICY #:	Billing Division or Location:
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Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print)			County	Employer ZIP	State Texas
Employee 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 ()	Occupation	Average Hours Worked Per Week:	

Completed By Employer

Earnings: \$	Date of Full-Time Employment:	Rehire Date:
<input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly		

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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$	Employer Paid
		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 <small>* Maximum Optional Spouse Amount of Coverage cannot exceed 50% of Optional Employee Amount</small>	\$	\$
		Optional Child Life <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$10,000	\$

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.

Request for Coverages

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

- "I **APPLY FOR THE GROUP BENEFITS** indicated above and, if my application is approved by The Lincoln National Life Insurance Company, I authorize deductions from my pay for any required contributions. I know my coverage will not take effect unless I am actively at work and coverage on my dependent(s) will not take effect unless he/she is performing the usual and customary duties of activities of a healthy individual of the same age and sex."
- "**WAIVER OF COVERAGE: I do NOT want to enroll myself in the Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense."
- "**WAIVER OF COVERAGE: I do NOT want to enroll my dependents in the Program.** I understand that if I apply 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: 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 The Lincoln National Life Insurance Company, 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 a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name: _____ Employee Signature: _____ Date: _____