

**MAIL THIS COMPLETED FORM WITH YOUR PREMIUM AND BILLING CHARGE PAYMENT TO:

The Lincoln National Life Insurance Company, P.O. Box 0821, Carol Stream, IL 60132-0821

APPLICATION FOR PORTABILITY

TO AVOID DELAY OF BENEFITS, PLEASE COMPLETE ALL QUESTIONS.

Employer: Please complete and sign the upper section of this form. Please give the form to the employee to complete the lower section. Employee: Please complete and sign the lower section of this form. Return the completed form with the premium due PLUS the billing charge to the address shown on the top** of this form. We must receive this form & payment within 31 days of "Date Employment Terminated."

This section to be completed b	y EMPLOYER				
			Group Policy		
Group Name:		Number:	Group ID:		
Employee Information:		D: 4.1.	0 : 10	*	
Employee Name:				urity #:	
Address (Street, City, State, Zip C					
Phone Number: ()		Geno	der: □ Male □	Female	
Spouse Information: (Complet	e ONLY if Insured)				
Spouse's Name:		Birthdate://	Social Sec	urity #:	
Coverage Eligible to Port	Coverage Amount/Plan	Monthly Premium Amount*	Initial Effective Date		Prior Carrier Effective Date
Voluntary Employee Life/AD&	D 🗆 \$	<u> </u>			
Voluntary Spouse Life/AD&D		\$			
Voluntary Dependent Life		\$			
Voluntary LTD		\$			
Voluntary Accident		\$			
Long Term Disability		\$			
Short Term Disability					
·	☐ \$ \$ Date Premium Paid To:				
*Use current group rates to calcu					
 □ Unable to perform each of t □ Resignation (voluntary termin □ Dismissal (involuntary termin □ Other, please explain 	nation of employment init ation of employment init	iated by employee) iated by employer)	or injury.		
Employer's Signature		Printed Nan	ne		Date
Company Phone Number: ()				
This section to be completed b	y EMPLOYEE				
Beneficiary Information (Life/AD& Employee's Primary Beneficiar Relationship:	y:	Employee's (Contingent Benefic	iary:	
Beneficiary's Address:		1			
Employee's quarterly premium:		+ \$5.00 Billing Fee** =			
Spouse's quarterly premium:	\$(Monthly premium x 3)	+ \$5.00 Billing Fee**	Total Amount End	closed: \$	
Child(ren)'s quarterly premium:	\$(Monthly premium x 3)	(No Billing Fee) = Tot	al Amount Enclose	<u>ed:</u> \$	
I hereby authorize The Lincoln ☐ Voluntary Employee Life ☐ Voluntary Spouse Life ☐ LTD	National Life Insuranc ☐ Voluntary Employ ☐ Voluntary Spouse ☐ STD	ee Life and AD&D	ng directly for my: Voluntary Depend Voluntary LTD		
Signature of Insured Employee:				_ Date:	
Signature of Insured Spouse: _				_ Date:	
Employee e-mail address:				_	
If a mail address supplied we will	contact you through ama	Did you remember to inc	ludo vour novment	9	

If e-mail address supplied, we will contact you through email. Did you remember to include your payment?

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. GLA-03727