

The Lincoln National Life Insurance Company

P.O. Box 2616, Omaha, NE 68103-2616 Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please U	Jse Ink or Ty	Type GROUP ID: GRO			OUP POLICY #:			Billing Division or Location:			
A. En	ployee Info	rmati	ion (Comple	te for ALL Enr	ollmen	ts)		•			
Employ	er Name/Con	npany l	Name (Please	Print)			County	Employer	r ZIP	State	
Employee Last Name First Name M					Middle I	nitial	Social Security Number			Date of Birth	
Spouse	Last Name		First Na	ame	Middle I	nitial	Social Security	Number		Date of Birth	
Street A	ddress						City	St	tate	Zip	
Gender:	Male [Fem	ale Marital	Status: Marri	ed 🗌 S	Single	Home Phone			Work Phone	
Compl	eted By Em	ploye	r								
Average	e Hours Work	ted Per	Week:	Occupation:							
Earning \$	s: Hourly		Monthly [Weekly Yea	rly	Date of Fu	Ill-Time Employ	ment:	Rehir	re Date:	
B. Pro	oduct Select	tion (C	Complete for	ALL Enrollme	ents)						
				: Please mark the							
<u> </u>		ll cove		ts are subject to		tations aı					
Class	Effective Date		T	ype of Coverag	e			t of Cover	age	Total Premium	
		Basic	Group Life/A	D&D	Yes	□No*	\$			\$	
		Depe	nden <u>t</u> Life		Yes	□No*	\$			\$	
		Optio	onal Employee	Life/AD&D	Yes	□No*	\$			\$	
		Optio	onal Spouse Li	fe/AD&D	Yes	□No*	\$			\$	
		Optio	onal Child Life	;	Yes	□No*	\$			\$	
		Short	Term Disabil	ity	Yes	□No*	\$			\$	
		Long	Term Disabili	ity	Yes	□No*	\$			\$	
		Denta			□Yes	□No		/Spouse /Children /Spouse/Chi	ldren	\$	
		Unde	al DHMO rwritten by No al, Inc.	utional Pacific	□Yes	□No	Employee Employee	/Spouse	ldren	\$	

--Actual deductions may vary slightly from above illustrations due to rounding--

^{*}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.

VII 4 C NOTE	D1 1.4	1 1 0 1	· c				
Voluntary 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.							
Has Employee or Spouse used any type of tobacco or nicotine in the past 12 months? Employee: Yes No Spouse: Yes No							
TYPE OF COVERAGE		AMOUNT OF COVERAGE	TOTAL PREMIUM				
Voluntary Employee Life Insurance	☐Yes ☐No*	\$	\$				
Voluntary Employee Optional AD&D	Yes No*	Equal to Life Insurance Amount	\$				
Voluntary Spouse Life Insurance	Yes No*	\$	\$				
Voluntary Spouse Optional AD&D	Yes No*	Equal to Life Insurance Amount	\$				
Voluntary Dependent Child Benefit	Yes No*	\$	\$				
Voluntary Short Term Disability	Yes No*	Weekly Benefit Amount \$	\$				
Voluntary Long Term Disability	☐Yes ☐No*	Monthly Benefit Amount \$	\$				
Voluntary Dental	□Yes □No	☐ Employee Only ☐ Employee/Spouse ☐ Employee/Children ☐ Employee/Spouse/Children	\$				
Voluntary Dental DHMO Underwritten by National Pacific Dental, Inc.	□Yes □No	☐ Employee Only ☐ Employee/Spouse ☐ Employee/Children ☐ Employee/Spouse/Children	\$				
Voluntary Vision Lincoln VisionConnect is underwritten by UnitedHealthcare Insurance Company, Hartford, CT, and United Healthcare Insurance Company of New York, Hauppauge, NY	□Yes □No	Employee Only Employee/Spouse Employee/Children Employee/Spouse/Children	\$				
Voluntary Accidental Death & Dismemberment (Standalone)	□Yes □No	□ Employee Only □ Employee and Family □ \$100,000 □ \$150,000 □ \$200,000 □ \$250,000 □ \$300,000 □ \$350,000 □ \$400,000 □ \$450,000 □ \$500,000	\$				

^{*}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.

⁻⁻Actual deductions may vary slightly from above illustrations due to rounding-

Accident Coverage NOTE: Please mark the box or boxes for each plan/benefits you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.							
Type of Coverage	Selecting Yes authorizes my employer to payroll deduct premium(s).	Amount of Coverage	Weekly Premium				
Accident	☐Yes ☐No If Yes, Select One: ☐Select ☐Choice ☐Preferred ☐Elite	☐Employee Only ☐Employee Plus Spouse ☐Employee Plus Child(ren) ☐Family	\$ \$ \$ \$				
The following Optional Benefits may be elected if Accident coverage is elected. Accident coverage for Dependents must be elected in order to elect any Dependent coverage for the Optional Benefits.							
			tional Denember				
Type of Coverage	Selecting Yes authorizes my employer to payroll deduct premium(s).	Amount of Coverage Check One:	Weekly Premium				
Type of Coverage Health Assessment - \$50	employer to payroll deduct						
	employer to payroll deduct premium(s).	Check One: Employee Only Employee Plus Spouse Employee Plus Child(ren)	Premium \$ \$ \$ \$				
Health Assessment - \$50	employer to payroll deduct premium(s). Yes No	Check One: Employee Only Employee Plus Spouse Employee Plus Child(ren) Family Employee Only Employee Plus Spouse Employee Plus Child(ren)	Premium \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$				

⁻⁻Actual deductions may vary slightly from above illustrations due to rounding--

All coverage amounts are subject to the limitations and exclusions as stated in the policy. To apply the appropriate iobaccor or actise, please amounts or actise, please amounts or actise, please amounts or active please amounts. Type of Coverage Plan Option(s) Amount of Coverage Weekly Premium Critical Illness Yes No. Employee Employee Employee Employee Employee Spouse. Sp		Critical Illness Coverage NOTE: Please mark the box or boxes for each plan/benefits you are applying for.						
Has Employee or Spouse used any type of tobacco or nicotine in the past 12 months? Employee	All coverage a	mounts are subject to the limitations and	exclusions as stated in the policy	٧.				
Type of Coverage	To apply the appropriate tobacc	o/non-tobacco rates, please answer the fo	llowing question:					
Type of Coverage	Has Employee or Spouse used any type of tobacco or nicotine in the past 12 months? Employee: Yes No							
Critical Illness Yes No* Employee \$15,000 \$25,000			Spouse:	Yes No				
Critical Illness Very No* Employee S15,000 S S25,000 S25	Type of Coverage	Plan Option(s)	Amount of Coverage	Weekly				
Yes No* Employee S15,000 S S25,000 S25,000 S50,000 S50,00				Premium				
Yes No* Employee S15,000 S S25,000 S25,000 S50,000 S50,00	Critical Illness							
Sase Plan includes: Wellness Category Heart Category Cancer Category Spouse *Spouse amount cannot exceed Employee \$10,000		Employee	\$15,000	\$				
Base Plan includes:		Employee	l · · · · · · · · · · · · · · · · ·	Ψ .				
Heart Category Organ								
Cancer Category Organ Category Quality of Life Category Quality of Life Category Quality of Life Category Child Category** Permanent Care Benefit** Permanent and Total Disability Benefit Accident Benefit Cocupational HIV/Occupational Hepatitis Benefitit** **Child amount cannot exceed 50% of Employee amount. The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit Plan Option(s) Amount of Coverage Weekly Premium Heart Category Spouse	• •							
Organ Category Quality of Life Category Child Category** Treatment Care Benefit*** Permanent and Total Disability Benefit Accident Benefit Occupational HIV/Occupational Hepatitis Benefit available for children. ***Not available for spouses or children. The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit. Optional Benefit Plan Option(s) Amount of Coverage Weekly Premium Heart Category Yes No* Employee Spouse S		Spouse*	\$10,000	\$				
Quality of Life Category Child Category** Treatment Care Benefit*** Permanent and Total Disability Benefit Accident Benefit Cocupational HIV/Occupational Hepatitis Benefit*** **Child Category covers Dependent children only. ***Not available for children. The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit. Optional Benefit Plan Option(s) Amount of Coverage Weekly Premium Heart Category Spouse Spo		*Spouse amount cannot exceed Employee	\$20,000					
Child Category** Permanent Care Benefit*** Permanent and Total Disability Benefit Accident Benefit Occupational HIV/Occupational Hepatitis Benefit only. ***Child Category covers Dependent children only. ***PNot available for spouses or children. ***PNot available for spouses or elected in order to elect any Dependent coverage for the optional Benefit. **Deptional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage is elected. **Optional Benefit* **Plan Option(s) **The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Benefit **Plan Option(s) **The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Benefit **Plan Option(s) **Employee **Employee **Spouse **Spou		amount.	\$50,000					
Treatment Care Benefit** Permanent and Total Disability Benefit Accident Benefit Occupational HIV/Occupational Hepatitis Benefit*** **Child Category covers Dependent children only. ***Not available for children. ***Not available for spouses or children. The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit. Optional Benefit Plan Option(s) Amount of Coverage Weekly Premium Heart Category Yes No* Employee Spouse Spous	Child Category**							
Permanent and Total Disability Benefit Accident Benefit Cecupational HIV/Occupational				\$				
Benefit Accident Benefit Occupational HIV/Occupational Hepatitis Benefit**** **Child Category covers Dependent children only. ***Not available for children. ***Not available for spouses or children. The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit. Optional Benefit Plan Option(s) Amount of Coverage Weekly Premium Heart Category Yes No* Employee Spouse Spo			\$25,000					
Occupational HIV/Occupational Hepatitis Benefit*** **Child Category covers Dependent children only. ***Not available for children. ***Not available for spouses or children. The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit. Optional Benefit Plan Option(s) Amount of Coverage Weekly Premium Heart Category Yes No* Employee Spouse Spouse Spouse Silo,000 Silo,000 Scoudo		Employee amount.						
### Stoke Part	Accident Benefit							
Child Category covers Dependent children only. *Not available for children. The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit. Optional Benefit Plan Option(s) Employee S15,000								
Dependent children only. ****Not available for children. ****Not available for spouses or children. The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit. Optional Benefit Plan Option(s) Amount of Coverage Weekly Premium Heart Category Yes No* Spouse Spouse Child Spouse Child Spouse Cancer Category Yes No* Spouse S	Hepatitis Benefit****							
Dependent children only. ****Not available for children. ****Not available for spouses or children. The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit. Optional Benefit Plan Option(s) Amount of Coverage Weekly Premium Heart Category Yes No* Spouse Spouse Child Spouse Child Spouse Cancer Category Yes No* Spouse S	**C1:14 C-4							
Not available for children. *Not available for spouses or children. The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit. Optional Benefit Plan Option(s) Amount of Coverage Weekly Premium Heart Category Yes No* Spouse Spouse Spouse Spouse Spouse Cancer Category Penployee Spouse S								
****Not available for spouses or children. The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit. Optional Benefit Plan Option(s) Amount of Coverage Weekly Premium Heart Category Yes No* Spouse Spouse Spouse Cancer Category Yes No* Employee Cancer Category Yes No* Spouse	*							
The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit. Amount of Coverage Weekly Premium Deptional Benefit Plan Option(s) Amount of Coverage Weekly Premium Heart Category Employee \$15,000 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$								
The following Optional Benefit(s) may be elected if Critical Illness coverage is elected. Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit. Optional Benefit Plan Option(s) Amount of Coverage Weekly Premium Heart Category Yes No* Spouse Spouse Spouse Child Spouse Cancer Category Yes No* Spouse Cancer Category Spouse Spouse Spouse Spouse Cancer Category Spouse Spous								
Optional Plan Options will equal the amount of the Base Plan(s) checked above. Critical Illness coverage for Dependents must be elected in order to elect any Dependent coverage for the optional benefit. Optional Benefit Plan Option(s) Amount of Coverage Premium Heart Category Storon Sto		na Ontional Danafit(a) man ha alastad if Cu						
Optional Benefit Plan Option(s) Amount of Coverage Weekly Premium Heart Category Employee \$15,000 \$ \$25,000 Yes No* \$10,000 \$ \$10,000 \$50,000 \$50,000 \$ \$10,000 \$50,000 \$10,000 \$ \$10,000 \$25,000 \$ \$10,000 \$ \$15,000 \$25,000 \$ \$15,000 \$ \$15,000 \$25,000 \$ \$15,000 \$ \$15,000 \$25,000 \$ \$10,000 \$ \$10,000 \$25,000 \$ \$25,000 \$ \$10,000 \$20,000 \$ \$50,000 \$ \$10,000 \$20,000 \$ \$20,000 \$ \$10,000 \$20,000 \$ \$10,000 \$ \$10,000 \$20,000 \$ \$10,000 \$ \$10,000 \$20,000 \$ \$10,000 \$ \$10,000 \$20,000 \$ \$10,000 \$ \$10,000 \$20,000 \$ \$10,000 \$10,000 \$20,000 \$20,000 \$10,000 \$20,000 \$20,000 \$10,000 \$20,000 \$20,000 \$20,000		ng Oblional Benefit(s) may be elected if Cr	ritical Illness coverage is elected.	•				
Heart Category	Optional Plan Options will equa			pendents must be				
Heart Category		al the amount of the Base Plan(s) checked about	ove. Critical Illness coverage for De	pendents must be				
Yes No* \$25,000 \$50,000 Spouse \$10,000 \$220,000 \$550,000 Child \$10,000 \$15,000 \$15,000 \$15,000 \$15,000 \$15,000 \$15,000 \$15,000 \$15,000 \$10,000	ele	all the amount of the Base Plan(s) checked abouted in order to elect any Dependent coverage	ove. Critical Illness coverage for De e for the optional benefit.	Weekly				
Spouse \$50,000 \$10,000 \$ \$20,000 \$50,000 \$ \$ \$10,000 \$ \$ \$ \$ \$ \$ \$ \$ \$	ele	all the amount of the Base Plan(s) checked abouted in order to elect any Dependent coverage	ove. Critical Illness coverage for De e for the optional benefit.	Weekly				
Spouse \$10,000 \$ \$20,000 \$50,000 \$ Child \$10,000 \$ \$25,000 \$ Cancer Category \$15,000 \$ \$25,000 \$ \$25,000 \$ \$50,000 \$ \$20,000 \$ \$50,000 \$ Child \$10,000 \$ \$10,000 \$	Optional Benefit	al the amount of the Base Plan(s) checked aborted in order to elect any Dependent coverage Plan Option(s)	ove. Critical Illness coverage for Dee for the optional benefit. Amount of Coverage	Weekly Premium				
\$20,000	Optional Benefit Heart Category	al the amount of the Base Plan(s) checked aborted in order to elect any Dependent coverage Plan Option(s)	ove. Critical Illness coverage for Dee for the optional benefit. Amount of Coverage \$15,000	Weekly Premium				
\$20,000	Optional Benefit Heart Category	al the amount of the Base Plan(s) checked aborted in order to elect any Dependent coverage Plan Option(s)	ove. Critical Illness coverage for Determine for the optional benefit. Amount of Coverage \$15,000 \$25,000	Weekly Premium				
Child □\$50,000 \$ Cancer Category Employee □\$15,000 \$ □Yes □No* □\$25,000 \$ Spouse □\$10,000 \$ □\$20,000 □\$50,000 \$ □\$10,000 \$ □\$10,000 \$ □\$10,000 \$	Optional Benefit Heart Category	If the amount of the Base Plan(s) checked aborded in order to elect any Dependent coverage Plan Option(s) Employee	ove. Critical Illness coverage for Dee for the optional benefit. Amount of Coverage \$15,000 \$25,000 \$50,000	Weekly Premium				
Child	Optional Benefit Heart Category	If the amount of the Base Plan(s) checked aborded in order to elect any Dependent coverage Plan Option(s) Employee	ove. Critical Illness coverage for Determinent of the optional benefit. Amount of Coverage \$15,000 \$25,000 \$50,000 \$10,000	Weekly Premium				
Cancer Category Employee \$15,000 \$ Yes □No* \$25,000 \$ Spouse \$10,000 \$ \$20,000 \$50,000 Child \$10,000 \$	Optional Benefit Heart Category	If the amount of the Base Plan(s) checked aborded in order to elect any Dependent coverage Plan Option(s) Employee	Section Coverage Coverage	Weekly Premium				
Cancer Category Employee \$15,000 \$ Yes □No* \$25,000 \$ Spouse \$10,000 \$ \$20,000 \$50,000 Child \$10,000 \$	Optional Benefit Heart Category	If the amount of the Base Plan(s) checked aborded in order to elect any Dependent coverage Plan Option(s) Employee	Section Coverage Coverage	Weekly Premium				
Cancer Category □ \$15,000 \$ □ Yes □No* □ \$25,000 □ \$50,000 Spouse □ \$10,000 \$ □ \$20,000 □ \$50,000 \$ Child □ \$10,000 \$	Optional Benefit Heart Category	Plan Option(s) Employee Spouse	S15,000	Weekly Premium \$				
Yes No* \$25,000 \$50,000 Spouse \$10,000 \$\$22,000 \$\$50,000 \$50,000 \$\$10,000 \$	Optional Benefit Heart Category	Plan Option(s) Employee Spouse	S15,000	Weekly Premium \$				
Spouse	Optional Benefit Heart Category Yes No*	If the amount of the Base Plan(s) checked aborded in order to elect any Dependent coverage Plan Option(s) Employee Spouse Child	S15,000	Weekly Premium \$				
Spouse	Optional Benefit Heart Category Yes No* Cancer Category	If the amount of the Base Plan(s) checked aborded in order to elect any Dependent coverage Plan Option(s) Employee Spouse Child	S15,000	Weekly Premium \$				
□ \$20,000 □ \$50,000 Child □ \$10,000 \$	Optional Benefit Heart Category Yes No* Cancer Category	If the amount of the Base Plan(s) checked aborded in order to elect any Dependent coverage Plan Option(s) Employee Spouse Child	S15,000	Weekly Premium \$				
□ \$20,000 □ \$50,000 Child □ \$10,000 \$	Optional Benefit Heart Category Yes No* Cancer Category	If the amount of the Base Plan(s) checked aborded in order to elect any Dependent coverage Plan Option(s) Employee Spouse Child	S15,000	Weekly Premium \$				
☐ \$50,000 ☐ \$10,000 \$	Optional Benefit Heart Category Yes No* Cancer Category	If the amount of the Base Plan(s) checked aborded in order to elect any Dependent coverage Plan Option(s) Employee Child Employee	S15,000	Weekly Premium \$ \$ \$				
Child \$10,000 \$	Optional Benefit Heart Category Yes No* Cancer Category	If the amount of the Base Plan(s) checked aborded in order to elect any Dependent coverage Plan Option(s) Employee Child Employee	S15,000	Weekly Premium \$ \$ \$				
	Optional Benefit Heart Category Yes No* Cancer Category	If the amount of the Base Plan(s) checked aborded in order to elect any Dependent coverage Plan Option(s) Employee Child Employee	S15,000	Weekly Premium \$ \$ \$				
	Optional Benefit Heart Category Yes No* Cancer Category	If the amount of the Base Plan(s) checked aborded in order to elect any Dependent coverage Plan Option(s) Employee Child Employee	S15,000	Weekly Premium \$ \$ \$				
<u> </u>	Optional Benefit Heart Category Yes No* Cancer Category	If the amount of the Base Plan(s) checked aborted in order to elect any Dependent coverage Plan Option(s) Employee Spouse Child Employee Spouse	Store Critical Illness coverage for December Coverage	Weekly Premium \$ \$ \$ \$				

^{*}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.

⁻⁻Actual deductions may vary slightly from above illustrations due to rounding--

C. Beneficiary Infor	mation	(Complete ONL)	Y for Life/AD	&D or Acc	ident wit	h AD&D	or Critica	al Illne	ess)
Primary Beneficiary's La	ast Name	First	MI	Relationsh	nip of Bene	eficiary	Social Secu	ırity Nu	ımber
Street Address				City		1	State		Zip
Contingent Beneficiary's	Last Na	me First	MI	Relationsh	nip of Bene	eficiary	Social Secu	ırity Nu	ımber
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.									
		• •							
D. Dependent and O Coverage)	ther Ins	surance Informat	tion (Complete	e only for A	Accident	or Critica	al Illness o	or Den	tal/Vision
		Last Name	First Na	ame	Middle	Gender	Date of	Birth	Full-time
	S	SN (Optional)			Initial				Student
Child									☐Yes ☐No
Child									☐Yes ☐No
Child									☐Yes ☐No
Child									☐Yes ☐No
DHMO INFORMATIO	ON (If De	ental DHMO Cove	rage is selected.	complete t	his section	for each	rovered me	ember)	
Member Name		Provider Provider	Provider (tist Name		Is	Member an
			Numb	er					ting Patient?
								L	Yes No
									Yes No
									Yes No
									Yes No
Are you or any of your	eligible	dependents covere	d by any other	dental/visio	n plan?	YES (If	YES, pleas	e list)	□NO
Name of Insure	d		Company Nam Policy Numbe			Emp	oloyer		Coverage
			1 oney 1 turns						☐Dental ☐Vision
									☐Vision☐Dental☐
									□ Vision
E. Request for Cover	rages								
This coverage has been of	offered to	me and after carefu	ul consideration	of the benef	its, I have	decided to:			
REQUEST COVEL Life Insurance Con	npany. I	hereby enroll for gr	roup insurance, f	or which I a					
required, I authorize my employer to deduct premiums from my salary. NOT ENROLL myself in the Program. I understand that if I enroll for coverage 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 Program. I understand that if I enroll 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 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.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners, 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 an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

I understand that the vision care insurance benefit plan I have selected provides reimbursement for certain vision costs which are more
fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my
provider or me for vision care expenses which I have incurred may not be covered by my vision care insurance benefit plan.

Employee Full Name:	Employee Signature:	Date: