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 Use Ink or Type	GROUP ID:	GROUP POLICY #:	Billing Division or Location:

A. Employee Information (Complete for ALL Enrollments)

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

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly $_____	Date of Full-Time Employment:	Rehire Date:

B. 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	☐ **Yes**	☐ **No***	$	$
		Dependent Life	☐ **Yes**	☐ **No***	$	$
		Optional Employee Life/AD&D	☐ **Yes**	☐ **No***	$	$
		Optional Spouse Life/AD&D	☐ **Yes**	☐ **No***	$	$
		Optional Child Life	☐ **Yes**	☐ **No***	$	$
		Short Term Disability	☐ **Yes**	☐ **No***	$	$
		Long Term Disability	☐ **Yes**	☐ **No***	$	$
		Dental	☐ **Yes**	☐ **No**	☐ Employee Only ☐ Employee/Spouse ☐ Employee/Children ☐ Employee/Spouse/Children	$
		Dental DHMO *Underwritten by National Pacific Dental, Inc.*	☐ Yes	☐ No	☐ Employee Only ☐ Employee/Spouse ☐ Employee/Children ☐ Employee/Spouse/Children	$

*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--

Please See Last Page for Beneficiary and Signature

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 ☐Yes ☐No Underwritten by National Pacific Dental, Inc.	☐Employee Only ☐Employee/Spouse ☐Employee/Children ☐Employee/Spouse/Children	$
Voluntary Vision ☐Yes ☐No Lincoln VisionConnect is underwritten by UnitedHealthcare Insurance Company, Hartford, CT, and United Healthcare Insurance Company of New York, Hauppauge, NY	☐Employee Only ☐Employee/Spouse ☐Employee/Children ☐Employee/Spouse/Children	$
Voluntary Accidental ☐Yes ☐No Death & Dismemberment (Standalone)	☐Employee Only ☐Employee and Family ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $350,000 ☐ $400,000 ☐ $450,000 ☐ $500,000	$

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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.			
Type of Coverage	**Selecting Yes authorizes my employer to payroll deduct premium(s).**	**Amount of Coverage** **Check One:**	**Weekly Premium**
Health Assessment - $50	☐Yes ☐No	☐Employee Only ☐Employee Plus Spouse ☐Employee Plus Child(ren) ☐Family	$ $ $ $
Sickness Hospital Confinement - $100	☐Yes ☐No	☐Employee Only ☐Employee Plus Spouse ☐Employee Plus Child(ren) ☐Family	$ $ $ $
Accident Sickness Disability - $2,000	☐Yes ☐No	☐Employee Only ☐Employee Plus Spouse	$ $
Accident Disability - $2,000	☐Yes ☐No	☐Employee Only ☐Employee Plus Spouse	$ $

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Please See Last Page for Beneficiary and Signature

Critical Illness 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.

To apply the appropriate tobacco/non-tobacco rates, please answer the following question:
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	Plan Option(s)	Amount of Coverage	Weekly Premium
Critical Illness ☐**Yes** ☐**No***	Employee	☐ $15,000 ☐ $25,000 ☐ $50,000	$
Base Plan includes: Wellness Category Heart Category Cancer Category Organ Category Quality of Life Category Child Category** 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.	Spouse* ***Spouse amount cannot exceed Employee amount. Child** ****Child amount cannot exceed 50% of Employee amount.	☐ $10,000 ☐ $20,000 ☐ $50,000 ☐ $10,000 ☐ $25,000	$ $

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*	Employee	☐ $15,000 ☐ $25,000 ☐ $50,000	$
	Spouse	☐ $10,000 ☐ $20,000 ☐ $50,000	$
	Child	☐ $10,000 ☐ $25,000	$
Cancer Category ☐Yes ☐No*	Employee	☐ $15,000 ☐ $25,000 ☐ $50,000	$
	Spouse	☐ $10,000 ☐ $20,000 ☐ $50,000	$
	Child	☐ $10,000 ☐ $25,000	$

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Please See Last Page for Beneficiary and Signature

C. Beneficiary Information (Complete ONLY for Life/AD&D or Accident with AD&D or Critical Illness)

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.

D. Dependent and Other Insurance Information (Complete only for Accident or Critical Illness or Dental/Vision Coverage)

	Last Name / SSN (Optional)	First Name	Middle Initial	Gender	Date of Birth	Full-time Student
Child						☐Yes ☐No
Child						☐Yes ☐No
Child						☐Yes ☐No
Child						☐Yes ☐No

DHMO INFORMATION (If Dental DHMO Coverage is selected, complete this section for each covered member)

Member Name	Provider	Provider Group Number	Dentist Name/City	Is Member an Existing Patient?
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

Are you or any of your eligible dependents covered by any other dental/vision plan? ☐YES (If YES, please list) ☐NO

Name of Insured	Insurance Company Name/Phone and Policy Number	Employer	Coverage
			☐**Dental** ☐**Vision**
			☐**Dental** ☐**Vision**
			☐**Dental** ☐**Vision**

E. Request for Coverages

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

☐ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby enroll for group insurance, for which I am eligible or may become eligible. If contributions are 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.

Please See Reverse for Signature

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:_____