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
Homefull			Montgomery	45402	Ohio
Employee Last Name	First Name	Middle Initial	Social Security Number		Date & State of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date & State 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	$

*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 Information

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 adding spouse/dependent to life/AD&D)

	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

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.

NOTE: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

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:_____