

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
 Group Insurance Service Office: 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: ICSAHIL	GROUP POLICY #:	Billing Division or Location:
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A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) ICS			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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		Home Phone ()	Work Phone ()	

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> 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 <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$	Employer Paid
		Short Term Disability <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$	Employer Paid
		Long Term Disability <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$	Employer Paid
		Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Spouse/Children	\$

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.

TYPE OF COVERAGE	AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> 4X <input type="checkbox"/> 5X <input type="checkbox"/> 6X	\$
Voluntary Employee Optional AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No	Equal to Life Insurance Amount	\$
Voluntary Spouse Life Insurance Must elect employee coverage in order to elect spouse or child coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> .5X <input type="checkbox"/> 1X <input type="checkbox"/> 1.5X	\$
Voluntary Spouse Optional AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No	Equal to Life Insurance Amount	\$
Voluntary Dependent Child Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 10000	\$

C. 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.					
D. Dependent and Other Insurance Information (Complete only for Dental Coverage)					
	Last Name	First Name	Middle Initial	Gender	Date of Birth
Spouse:					
Children:					
Are you or any of your eligible dependents covered by any other dental plan? <input type="checkbox"/> YES (If YES, please list) <input type="checkbox"/> NO					
Name of Insured	Insurance Company Name & Phone and Policy Number		Employer		
E. Request for Coverages					
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:					
<input type="checkbox"/> REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company. I hereby apply 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.					
<input type="checkbox"/> NOT 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.					
<input type="checkbox"/> NOT 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 Group Insurance Service 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: _____