



The Lincoln National Life Insurance Company

P.O. Box 2616, Omaha, NE 68103-2616

Phone: 800-423-2765 Fax: 877-573-6177

Here is your Enrollment Form.

Group ID: HSGSTANIS

Policy # 000400001000-31212 (Voluntary Life/AD&D)

Follow these steps to complete the form.

Print clearly in ink.

Step 1: Fill in or confirm your personal information.

Step 2: Fill in dependent information, if any.

Step 3: Select your benefits.

Step 4: Assign beneficiaries.

Step 5: Confirm enrollment.

Step 6: Sign, date & return the form.

1. Your Personal Information

Group/Employer/Participating Organization Name			County	Zip	State		
Your First Name			Middle Name/MI	Last Name	Social Security No.	Employee ID No.	Date of Birth
_____			_____	_____	____-____-____	_____	____/____/____
Street Address (Include Apt. or Suite No.)			City		State	Zip	
_____			_____		_____	_____	
Home Phone		Cell Phone		Work Phone		Email Address	
(____) ____-____		(____) ____-____		(____) ____-____		_____	
Gender: ☐ Male		☐ Female		Marital Status: ☐ Married		☐ Single	

2. Personal Information on Dependents — Complete if you are enrolling dependents.

☐ Spouse							
First Name		Middle Name/MI		Last Name		Social Security No.	Date of Birth
_____		_____		_____		____-____-____	____/____/____
Provide contact information if different than Your information above.							
Home Phone		Cell Phone		Work Phone		Email Address	
(____) ____-____		(____) ____-____		(____) ____-____		_____	
Dependent Children — List all children you are enrolling (attach a separate sheet, if needed).							
First Name	Middle Name/MI	Last Name	SSN (Optional)	Gender	DOB	Full-time Student	
_____	_____	_____	____-____-____	☐ Male ☐ Female	____/____/____	☐ Yes ☐ No	
_____	_____	_____	____-____-____	☐ Male ☐ Female	____/____/____	☐ Yes ☐ No	
_____	_____	_____	____-____-____	☐ Male ☐ Female	____/____/____	☐ Yes ☐ No	

Employer Completes this Section.

Billing Division or Location: _____

Sort Group/Code: _____ Payroll Cycle: _____

Policy #(s): # 000400001000-31212 _____

Average Hours Worked Per Week: _____ ☐ Full-time ☐ Part-time Occupation: _____

Earnings: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly \$ _____ Date of Employment: ____/____/____

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

Continue on Next Page. . .

Actively at Work? ☐ Yes ☐ No

Date of Rehire:_____/_____/_____

3. Benefit Selection — Continued. Choose your benefits.

Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium (Weekly)
Class	Effective Date			
_____	____/____/____	Voluntary Life & AD&D (Employee) ☐ Yes ☐ No*	\$ _____	\$ _____
_____	____/____/____	Voluntary Dependent (Spouse) Life & AD&D ☐ Yes ☐ No* <i>You must be enrolled for Life & AD&D insurance in order to add spouse and/or child insurance.</i>	\$ _____	\$ _____
_____	____/____/____	Voluntary Dependent (Child) Life Only ☐ Yes ☐ No* <i>You must be enrolled for Life insurance in order to add spouse and/or child insurance.</i>	\$ _____	\$ _____

*By selecting "No," application for insurance 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--

4. Select Your Beneficiaries — Choose who receives your insurance benefits.

Primary Beneficiary(ies)

The Primary Beneficiary is the person(s) you identify to receive insurance benefits upon your death.

If more than three Primary Beneficiaries, please attach a separate sheet of paper.
If multiple Primary Beneficiaries, total percentage of all combined must equal 100%.

First Name	Middle Initial	Last Name		
Street Address		City	State	Zip
Social Security Number	Date of Birth	Relationship to You	Percentage	Phone Number
- - - - -	/ /		%	() -

First Name	Middle Initial	Last Name		
Street Address		City	State	Zip
Social Security Number	Date of Birth	Relationship to You	Percentage	Phone Number
- - - - -	/ /		%	() -

First Name	Middle Initial	Last Name		
Street Address		City	State	Zip
Social Security Number	Date of Birth	Relationship to You	Percentage	Phone Number
- - - - -	/ /		%	() -

Contingent Beneficiary(ies) and Other Beneficiary Designations

A Contingent Beneficiary will receive benefits only if the Primary Beneficiary(ies) does not survive you. Please attach a separate sheet to identify a Contingent Beneficiary. If multiple Contingent Beneficiaries, total percentage of all combined must equal 100%.
To name a Beneficiary(ies) by product, attach a separate sheet identifying product and beneficiary.

5. Confirm Enrollment

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

- ☐ **ENROLL FOR INSURANCE for which I am or may become eligible** under the group policies issued by The Lincoln National Life Insurance Company, or its insurance partners. If contributions are required, I authorize my Employer to deduct premium from my pay.
- ☐ **NOT ENROLL myself in the group insurance offered.** I understand if I enroll for insurance 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 group insurance offered.** I understand if I enroll my dependents for insurance at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

Fraud Warning/State Disclosure(s)

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.

6. Sign and Return

I understand the group insurance requested will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners. A delayed effective date will apply if you are not Actively at Work/an Active Member. A delayed effective date may apply to your dependent, if he or she is confined in a hospital or health care facility or is in a period of limited activity on the date insurance would otherwise take effect.

I understand that the vision insurance I have elected 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 that I have incurred may not be covered by my vision care insurance benefit plan.

I understand the information provided is for enrollment in group insurance as offered by my Employer and will not be used for underwriting purposes.

The information provided is complete, true, and accurate to the best of my knowledge.

Your Full Name (Print): _____

Your Signature: **X** _____ Date ____/____/____

Complete and return this form.

(Be sure to sign and date the form to start your insurance.)

Questions? Call 800-423-2765