



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.

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.

Group ID: RFGH

1. Your Personal Information

Form section for personal information including fields for 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, City, State, Zip, Home Phone, Cell Phone, Work Phone, Email Address, Gender, and Marital Status.

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

Form section for dependent information including checkboxes for Spouse and Domestic Partner, fields for First Name, Middle Name/MI, Last Name, Social Security No., Date of Birth, contact information, and a table for Dependent Children with columns for First Name, Middle Name/MI, Last Name, SSN (Optional), Gender, DOB, and Full-time Student.

Employer Completes this Section.

Form section for employer completion including fields for Billing Division or Location, Sort Group/Code, Payroll Cycle, Policy #(s), Average Hours Worked Per Week, Earnings, Actively at Work?, Occupation, Date of Employment, and Date of Rehire.

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

**3. Benefit Selection — Choose your benefits.**

Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions stated in the policy and certificate. (Spouse includes your Domestic Partner.)

Basic Group Insurance				
Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium (Bi-Weekly)
Class	Effective Date			
_____	____/____/____	Life & AD&D		Your Employer pays
_____	____/____/____	Long Term Disability (LTD)		Your Employer pays

Voluntary/Optional Group Insurance				
Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions as stated in the policy and certificate. (Spouse includes your Domestic Partner.)				
Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium (Bi-Weekly)
Class	Effective Date			
_____	____/____/____	Optional Life & AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$_____	\$_____
_____	____/____/____	Optional Life Only <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$_____	\$_____
_____	____/____/____	Optional Dependent (Spouse Only) Life & AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No* <i>You must be enrolled for Life &amp; AD&amp;D insurance in order to add spouse and/or child insurance.</i>	\$_____	\$_____
_____	____/____/____	Optional Dependent (Spouse Only) Life Only <input type="checkbox"/> Yes <input type="checkbox"/> No* <i>You must be enrolled for Life insurance in order to add spouse and/or child insurance.</i>	\$_____	\$_____
_____	____/____/____	Optional Dependent (Child Only) Life Only <input type="checkbox"/> Yes <input type="checkbox"/> No* <i>You must be enrolled for Life insurance in order to add spouse and/or child insurance.</i>	\$_____	\$_____
_____	____/____/____	Voluntary Short Term Disability (STD) <input type="checkbox"/> Yes <input type="checkbox"/> No* (STD)	Weekly Benefit Amount: \$_____	\$_____

\*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 CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH THE INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY. THE FALSITY OF ANY STATEMENT IN THIS APPLICATION SHALL NOT BAR THE RIGHT TO RECOVERY UNDER THE POLICY UNLESS SUCH FALSE STATEMENT WAS MADE WITH ACTUAL INTENT TO DECEIVE OR UNLESS IT MATERIALLY AFFECTED EITHER THE ACCEPTANCE OF THE RISK OR THE HAZARD ASSUMED BY THE INSURER.**

**CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.**

## 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**