Lincoln Financial Group℠

The Lincoln National Life Insurance Company, PO Box 2616, Omaha, NE 68103-2616
toll free (800) 423-2765
www.LincolnFinancial.com

Please fax to (877) 573-6177
Total Pages Faxed _____

GROUP INSURANCE CHANGE REQUEST

Employer: _____

Policy Number (List all affected policy numbers): _____

Group ID: _____ Insured's Name: _____ Social Security Number: _____

NAME/ADDRESS CHANGE (First, MI, Last):
From:
To:

BENEFICIARY CHANGE	
Primary Beneficiary:	Relationship:
Contingent Beneficiary:	Relationship:

NOTE: Contingent Beneficiary will receive benefits only if Primary Beneficiary does not survive you. If more than one Primary or Contingent Beneficiary is wanted, please attach a separate sheet of paper.

DEPENDENTS TO BE ADDED OR REMOVED

Check One		Name (First, MI, Last)	Date of Birth (Mo/Day/Yr)	Relationship (Spouse or Child)	Date of Marriage (Mo/Day/Yr)	Late Entrant (Yes or No)
Add	Remove					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					

If adding dependent outside eligibility period, please explain reason:

For foster or adopted child, show date or placement and any adoption decree.

NOTE: If dependents are late entrants for Life coverage, each dependent will need to complete an Evidence of Insurability form and submit it to The Lincoln National Life Insurance Company for review. If dependents are late entrants for Dental coverage, and were previously covered under another plan, please complete the back of this form.

CHANGES IN COVERAGE (For Changes to Accident Coverage see page 2.)

Effective Date of Change:_____ **Current Salary: $**_____

☐ 1. Increase Employee Coverage to $ _____

☐ 2. Add/Increase Spouse Coverage to $ _____

☐ 3. Add/Increase Child Coverage to $ _____

Indicate which coverage the above change is for (ex. Vol life, Optional life, Critical Illness, etc.): _____

Enrollment form must be attached for items 1 - 3. Evidence of Insurability may be required.

Effective Date of Change:_____

☐ 1. Reduce Employee Coverage to $ _____

☐ 2. Reduce Spouse Coverage to $ _____

Indicate which coverage the above change is for (ex. Vol life, Optional life, Critical Illness, etc.): _____

Date:	Insured's Signature:	Witness' Signature:

REQUEST FOR REPLACEMENT CERTIFICATION

☐ I am requesting a duplicate group insurance certificate.

REQUEST FOR REPLACEMENT IDENTIFICATION CARDS

☐ I am requesting duplicate group insurance identification cards.

REQUEST FOR REPLACEMENT GROUP DENTAL INSURANCE

Information Regarding Employee

1. Name of Employee Requesting Coverage:
2. Employer's Name and Address:
3. Employer's Policy Number:

Information Regarding Previous Plan

1. Termination Date of Previous Plan:
2. Reason for Termination of Previous Plan:

PLEASE COMPLETE THE FOLLOWING

Name of Employee or Dependent	Covered Under Previous Plan	Requesting Covering	Date of Birth	Social Security Number

I request Group Dental Insurance to be effective _____ which is the day after Dental coverage is provided through my previous group plan ends.

I previously refused or did not enroll for Dental coverage through my employer's group plan only because (I/my) dependents (was/were) covered for benefits through a previous group plan. We have now become ineligible for coverage under this plan. With respect to any part of the requested coverage which is non-contributory (paid entirely by my employer), I waive any rights I may have to coverage earlier than the above stated date.

Date: Employee Signature:

CHANGES IN ACCIDENT COVERAGE

Effective Date of Change: _____

1. Change Plan Type to:	☐ Select	☐ Choice	☐ Preferred	☐ Elite
2. Change Accident Coverage to:	☐ Employee Only	☐ Employee + Spouse	☐ Employee + Child	☐ Family
3. Change Optional Coverage to:	**Accident Disability** ☐ Employee Only	**Accident/Sickness Disability** ☐ Employee Only	**Sickness Hospital Confinement** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child ☐ Family	**Health Assessment Benefit** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child ☐ Family

Enrollment form must be attached for all changes.

Date: Employee Signature: