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

OFFICE CODE:	Memo

Please Use Ink or Type | GROUP ID: | GROUP POLICY #:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print)	County	State CA

Social Security Number	Last Name	First Name	MI

Street Address	City	State	Zip	Date of Birth

☐ Male ☐ Female	Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Spouses Date of Birth	Home Phone ( )	Work Phone ( )

Completed By Employer

Effective Date:	Date of Full-Time Employment:	Occupation:

Earnings: $_____ ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly	☐ Union ☐ Exempt ☐ Non-Union ☐ Non-Exempt	Average Hours Worked Per Week: Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Class	Effective Date	Basic Amount *Employer to Complete*	**NOTE**: Please mark each box if you are eligible for the listed coverage. Coverage	Amount	Dental
			Group Life ☐ Yes ☐ No		☐ Single Dental
			Group AD&D ☐ Yes ☐ No		☐ EE/Spouse
			Dependent Life ☐ Yes ☐ No		☐ EE/Spouse/Children
			Optional Employee Life ☐ Yes ☐ No		☐ EE/Children ☐ One Child ☐ 2 or More Children
			Optional Dependent Life ☐ Yes ☐ No		☐ No Coverage
			Optional AD&D ☐ Yes ☐ No		
			Long Term Disability ☐ Yes ☐ No		Effective:_____
			Short Term Disability ☐ Yes ☐ No		

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. Signature (Complete for ALL Enrollments)

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. I reserve the right to revoke this deduction at any time on written notice.

_____ Employee Signature

_____ Date Signed

Dental Enrollment is on the back of this Enrollment Form.

Waiver of Coverage: Please sign and date this form where indicated below.

Please Use Ink or Type | GROUP ID:

E. Dependent and Other Insurance Information (Complete ONLY for Dental Enrollment)

List Dependents to be Covered for Dental Benefits (if applicable)

	Last Name	First Name	MI	Sex	Birth Date
EMPLOYEE:					
SPOUSE:					
CHILDREN:					

Are you or any of your eligible dependents covered by any other dental plan? ☐ Yes ☐ No If YES, please list:

Name of Insured	Insurance Company Name & Phone Number	Employer

Is coverage through other dental plan? ☐ Single ☐ Family

F. WAIVER OF COVERAGE (Complete ONLY for Waiver of Group Insurance Coverage)

The group program has been offered to me, and after carefully considering its benefits, I have decided:

(Please indicate your choice)
- ☐ (a) not to enroll myself or dependents in the Program
- ☐ (b) not to enroll my dependents in the Program

I understand that if I desire to participate in the Program at some future date, my coverage or my dependents' coverage will not be effective until after Evidence of Insurability is submitted and approved. I understand if a physical examination or further medical information is required, it will be at my own expense.

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Employee Signature _____ Date Signed _____