LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK

Group Insurance Service Office
P.O. Box 2616, Omaha NE 68103-2616
(800) 423-2765

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID:	GROUP POLICY #:	Billing Division or Location:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print)			County	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: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single		Home Phone ( )	Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:	☐ Union ☐ Non-Union	☐ Exempt ☐ Non-Exempt
Earnings: ☐ Hourly ☐ Monthly ☐ Weekly ☐ 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	☒Yes	☐No	$	Employer Paid
		Basic Group Life Only	☒Yes	☐No	$	Employer Paid
		Basic Group Life/AD&D	☐Yes	☐No	$	$
		Basic Group Life Only	☐Yes	☐No	$	$
		Dependent Life	☐Yes	☐No	$	$
		Optional Employee Life/AD&D	☐Yes	☐No	☐_____ ☐_____ ☐_____ ☐_____ ☐_____	$
		Optional Employee Life Only	☐Yes	☐No	☐_____ ☐_____ ☐_____ ☐_____ ☐_____	$
		Optional Employee Life/AD&D	☐Yes	☐No	$	$
		Optional Employee Life Only	☐Yes	☐No	$	$
		Optional Dependent Life	☐Yes	☐No	$	$
		Short Term Disability	☒Yes	☐No	$	Employer Paid
		Short Term Disability	☐Yes	☐No	$	$
		Long Term Disability	☒Yes	☐No	$	Employer Paid
		Long Term Disability	☐Yes	☐No	$	$
		Long Term Disability Base	☒Yes	☐No	$	Employer Paid
		Long Term Disability Buy/Up	☐Yes	☐No	$	$
		Dental	☐Yes	☐No	☐Employee Only ☐Employee/Spouse ☐Employee/Children ☐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	☒**Yes**	☐**No**	$	$
Voluntary Employee Optional AD&D	☐**Yes**	☐**No**	Equal to Life Insurance Amount	$
Voluntary Spouse Life Insurance	☐**Yes**	☐**No**	$	$
Voluntary Spouse Optional AD&D	☐**Yes**	☐**No**	Equal to Life Insurance Amount	$
Voluntary Dependent Child Benefit	☐**Yes**	☐**No**		$
Has Employee or Spouse used any type of tobacco in the past 12 months? Employee: ☐ Yes ☐No Spouse: ☐Yes ☐No				
Voluntary Employee Life Insurance	☐**Yes**	☐**No**	☐_____ ☐_____ ☐_____ ☐_____ ☐_____ ☐_____	$
Voluntary Spouse Life Insurance	☐**Yes**	☐**No**	☐_____ ☐_____ ☐_____	$
Voluntary Dependent Child Benefit	☐**Yes**	☐**No**		$
Voluntary Short Term Disability	☐**Yes**	☐**No**	**Elimination Period:** ☐ 1 Day Injury/8 Day Sickness ☐ 8 Day Injury/8 Day Sickness ☐ 15 Day Injury/15 Day Sickness **Benefit Duration:** ☐ 13 Week Benefit ☐ 26 Week Benefit **Weekly Benefit Amount $**_____	$
Voluntary Short Term Disability	☐**Yes**	☐**No**	**Weekly Benefit Amount $**_____	$
Voluntary Long Term Disability	☐**Yes**	☐**No**	**Elimination Period:** ☐ 90 Days ☐ 180 Days **Benefit Duration:** ☐ 2 Years ☐ 5 Years ☐ To Age 65 **Benefit Percentage:** ☐ 50% of Salary ☐ 60% of Salary **Monthly Benefit Amount $**_____	$
Voluntary Long Term Disability	☐**Yes**	☐**No**	**Monthly Benefit Amount $**_____	$
Voluntary Dental	☐**Yes**	☐**No**	☐**Employee Only** ☐**Employee/Spouse** ☐**Employee/Children** ☐**Employee/Spouse/Children**	$
Voluntary Accidental Death & Dismemberment (Standalone)	☐**Yes**	☐**No**	☐**Employee Only** ☐**Employee and Family** ☐ **$100,000** ☐ **$150,000** ☐ **$200,000** ☐ **$250,000** ☐ **$300,000** ☐ **$350,000** ☐ **$400,000** ☐ **$450,000** ☐ **$500,000**	
Voluntary Vision Care	☐**Yes**	☐**No**	* To enroll in Voluntary Vision Care, you must purchase at least one other product offered to you.	**$2.00**

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.

Accelerated Death Benefit Information: This benefit is included with your Life insurance, at no additional premium charge. The Death Benefit payable to your Beneficiary upon your death will be reduced by any Accelerated Death Benefits received plus an interest charge. Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs and may be taxable. For this reason, you should consult your personal tax advisor before claiming this benefit.

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? ☐ YES (If YES, please list) ☐ 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:

- ❑ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by Lincoln Life & Annuity Company of New York.** 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.
- ❑ **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.
- ❑ **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.

ACCIDENT & HEALTH INSURANCE FRAUD: Any person who knowingly and with intent to defraud any insurance company or other person:

(1) files an application for insurance or a statement of claim containing any materially false information; or

(2) conceals, for the purpose of misleading, information concerning any fact material thereto;

commits a fraudulent insurance act, which is a crime. Such person shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each violation.

The insurance requested on this enrollment form will not be effective until approved by the group insurance service office of Lincoln Life & Annuity Company of New York, and the initial premium is paid to Lincoln Life & Annuity Company of New York. 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.

Signature of Employee:_____ Date Signed:_____