

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
 Group Insurance Service Office: P.O. Box 2616, Omaha, NE 68103-2616
 Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID:	GROUP POLICY #:	Billing Division or Location:
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A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) FrankCrum			County Pinellas	Employer ZIP 33756	State Florida
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		Home Phone ()	Work Phone ()	

Completed By FrankCrum

Average Hours Worked Per Week:	Occupation:	
Earnings: <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly \$ _____	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Completed by Employee)

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 MONTHLY PREMIUM
Voluntary Employee Life Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$100,000	\$
Voluntary Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Weekly Benefit Amount \$ _____	\$
Voluntary Long Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Benefit Amount \$ _____	\$

C. Beneficiary Information (Complete Only for Life 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. 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 The Lincoln National Life Insurance Company. 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.

NOTICE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM OR APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Employee Signature: _____ Date: _____

Email Address: _____