



The Lincoln National Life Insurance Company
Group Insurance Service Office
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: STAFCONS

1. Your Personal Information

Form 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 for dependent information including a Spouse section with fields for First Name, Middle Name/MI, Last Name, Social Security No., Date of Birth, Home Phone, Cell Phone, Work Phone, Email Address, and a Dependent Children section with columns for First Name, Middle Name/MI, Last Name, SSN (Optional), Gender, DOB, and Full-time Student.

Employer Completes this Section.

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

Basic Group Insurance

Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium (Weekly)
Class	Effective Date			
<input type="checkbox"/>	___/___/___	Life & Accidental Death & Dismemberment (AD&D)		Your Employer pays
<input type="checkbox"/>	___/___/___	Life Only		Your Employer pays
<input type="checkbox"/>	___/___/___	Dependents (Spouse & Children) Life Only <input type="checkbox"/> Yes <input type="checkbox"/> No* <i>You must be enrolled for Life insurance to add your spouse & children.</i>		\$ _____
<input type="checkbox"/>	___/___/___	Short Term Disability (STD)		Your Employer pays
<input type="checkbox"/>	___/___/___	Long Term Disability (LTD)		Your Employer pays
<input type="checkbox"/>	___/___/___	Dental <input type="checkbox"/> Yes <input type="checkbox"/> No <i>By selecting No, you may be subject to late entrant or benefit waiting periods on certain services if you enroll at a later date.</i>	<input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Spouse/Children	\$ _____
<input type="checkbox"/>	___/___/___	Vision <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Lincoln VisionConnect is underwritten by UnitedHealthcare Insurance Company, Hartford, CT, and United Healthcare Insurance Company of New York, Hauppauge, NY</i>	<input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Spouse/Children	\$ _____

*By selecting "No," enrolling for insurance at a later date may require further medical information and/or a physical exam, which will be at your own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

3. Benefit Selection — Continued. Choose your benefits.

To apply the appropriate tobacco/non-tobacco rates, please answer the following question:

In the past 12 months, have You or Your Spouse smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?

You: Yes No
 Your Spouse: Yes No

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.

Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium (Weekly)
Class	Effective Date			
<input type="checkbox"/>	___/___/___	Optional Life & Accidental Death & Dismemberment (AD&D) <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$ _____	\$ _____
<input type="checkbox"/>	___/___/___	Optional Life Only <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$ _____	\$ _____
<input type="checkbox"/>	___/___/___	Optional Dependent (Spouse Only) Life & Accidental Death & Dismemberment (AD&D) <input type="checkbox"/> Yes <input type="checkbox"/> No* <i>You must be enrolled for Life & Accidental Death & Dismemberment (AD&D) insurance in order to add spouse and/or child insurance.</i>	\$ _____	\$ _____
<input type="checkbox"/>	___/___/___	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>	\$ _____	\$ _____
<input type="checkbox"/>	___/___/___	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>	\$ _____	\$ _____
<input type="checkbox"/>	___/___/___	Optional Employee Accidental Death & Dismemberment (AD&D) <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	\$ _____
<input type="checkbox"/>	___/___/___	Optional Employee & Family Accidental Death & Dismemberment (AD&D) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>You must be enrolled for Accidental Death & Dismemberment (AD&D) insurance in order to add spouse and/or child insurance.</i>	\$ _____	\$ _____
<input type="checkbox"/>	___/___/___	Buy-Up Short Term Disability (STD) <input type="checkbox"/> Yes <input type="checkbox"/> No*	Weekly Benefit Amount: \$ _____	\$ _____
<input type="checkbox"/>	___/___/___	Buy-Up Long Term Disability (LTD) <input type="checkbox"/> Yes <input type="checkbox"/> No*	Monthly 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--

3. Benefit Selection — Continued. Choose your benefits.

Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium (Weekly)
Class	Effective Date			
<u> </u>	<u> </u> / <u> </u> / <u> </u>	Voluntary Life & Accidental Death & Dismemberment (AD&D) <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$ <u> </u>	\$ <u> </u>
<u> </u>	<u> </u> / <u> </u> / <u> </u>	Voluntary Life Only <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$ <u> </u>	\$ <u> </u>
<u> </u>	<u> </u> / <u> </u> / <u> </u>	Voluntary Dependent (Spouse Only) <input type="checkbox"/> Yes <input type="checkbox"/> No* Life & Accidental Death & Dismemberment (AD&D) <i>You must be enrolled for Life & Accidental Death & Dismemberment (AD&D) insurance in order to add spouse and/or child insurance.</i>	\$ <u> </u>	\$ <u> </u>
<u> </u>	<u> </u> / <u> </u> / <u> </u>	Voluntary 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>	\$ <u> </u>	\$ <u> </u>
<u> </u>	<u> </u> / <u> </u> / <u> </u>	Voluntary 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>	\$ <u> </u>	\$ <u> </u>
<u> </u>	<u> </u> / <u> </u> / <u> </u>	Voluntary Employee Accidental Death & Dismemberment (AD&D) <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ <u> </u>	\$ <u> </u>
<u> </u>	<u> </u> / <u> </u> / <u> </u>	Voluntary Employee & Family Accidental Death & Dismemberment (AD&D) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>You must be enrolled for Accidental Death & Dismemberment (AD&D) insurance in order to add spouse and/or child insurance.</i>	\$ <u> </u>	\$ <u> </u>
<u> </u>	<u> </u> / <u> </u> / <u> </u>	Voluntary Short Term Disability (STD) <input type="checkbox"/> Yes <input type="checkbox"/> No*	Weekly Benefit Amount: \$ <u> </u>	\$ <u> </u>
<u> </u>	<u> </u> / <u> </u> / <u> </u>	Voluntary Long Term Disability (LTD) <input type="checkbox"/> Yes <input type="checkbox"/> No*	Monthly Benefit Amount: \$ <u> </u>	\$ <u> </u>

*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--

3. Benefit Selection — Continued. Choose your benefits.

Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium (Weekly)
Class	Effective Date			
<u> </u>	<u> </u> / <u> </u> / <u> </u>	Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Spouse/Children	\$ <u> </u>
<u> </u>	<u> </u> / <u> </u> / <u> </u>	Critical Illness <input type="checkbox"/> Yes <input type="checkbox"/> No* <i>You must be enrolled for Critical Illness insurance in order to add spouse and/or child insurance.</i>	You: \$ <u> </u> Spouse: \$ <u> </u> Child: \$ <u> </u>	\$ <u> </u>
<u> </u>	<u> </u> / <u> </u> / <u> </u>	Voluntary Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Spouse/Children	\$ <u> </u>
<u> </u>	<u> </u> / <u> </u> / <u> </u>	Voluntary Vision <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Lincoln VisionConnect is underwritten by UnitedHealthcare Insurance Company, Hartford, CT, and United Healthcare Insurance Company of New York, Hauppauge, NY</i>	<input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Spouse/Children	\$ <u> </u>

*By selecting "No," enrolling for insurance at a later date may require further medical information and/or a physical exam, which will be at your own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

3. Benefit Selection — Continued. Complete if you are enrolling for Dental/Vision insurance.

Are you or any of your eligible dependents covered by another dental/vision plan? Yes (If Yes, please list) No

Name of Insured	Insurance Company Name, Phone and Policy No.	Employer	Coverage
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Dental <input type="checkbox"/> Vision

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		
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Street Address		City	State	Zip	
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	
Social Security Number	Date of Birth	Relationship to You	Percentage	Phone Number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

First Name		Middle Initial	Last Name		
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Street Address		City	State	Zip	
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	
Social Security Number	Date of Birth	Relationship to You	Percentage	Phone Number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

First Name		Middle Initial	Last Name		
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Street Address		City	State	Zip	
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	
Social Security Number	Date of Birth	Relationship to You	Percentage	Phone Number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

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)

ANY PERSON WHO, WITH THE INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY HAVE VIOLATED THE STATE LAW.

THE UNDERSIGNED APPLICANT CERTIFIES THAT THE APPLICANT HAS READ, OR HAD READ TO HIM OR HER, THE COMPLETED APPLICATION AND THAT THE APPLICANT REALIZES THAT ANY FALSE STATEMENT OR MISREPRESENTATION IN THE APPLICATION MAY RESULT IN THE LOSS OF COVERAGE UNDER THE POLICY.

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