# Voluntary Group Benefits Enrollment Form

***Accident, Critical Illness, Hospital Indemnity Insurance***

- **Complete the entire form to elect coverage.**
- **To decline coverage, complete Step 1, then skip to Step 5. Be sure to sign and date in Step 6.**

## 1. Your Personal Information

Employer Name | Site Location

Last Name | First Name | Middle Initial | Social Security No.

Street Address (Include Apt. or Suite No.) | City | State | Zip

Date of Birth | Contact Phone | Email Address

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

## 2. Your Dependent's Information

*Only complete if you are enrolling dependents.*

☐ Spouse Gender: ☐ Male ☐ Female

Last Name | First Name | Middle Initial | Social Security No.

Date of Birth | Contact Phone | Email Address

**Dependent Children - List all children you are enrolling (attach a separate sheet, if needed).**

| Last Name | First Name | Middle Name | SSN | Gender | DOB |
|---|---|---|---|---|---|
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### 3. Benefit Selection – Choose your benefits.

| Employer completes this section. Class | Effective Date | Type of Insurance | Coverage Level | Monthly Rate |
|---|---|---|---|---|
| | | **Accident** ☐ Yes ☐ No<br>*You must enroll in Accident insurance in order to add insurance for spouse, and/or child(ren).* | ☐ Employee<br>☐ Employee/Spouse<br>☐ Employee/Child(ren)<br>☐ Employee/Family | $ |
| | | **Critical Illness** ☐ Yes ☐ No<br>*You must enroll in Critical Illness insurance in order to add insurance for spouse, and/or child(ren).* | ☐ Employee<br>☐ Spouse<br>☐ Child(ren) | $<br>$<br>$ |
| | | **Hospital Indemnity** ☐ Yes ☐ No<br>*You must enroll in Hospital Indemnity insurance in order to add insurance for spouse, and/or child(ren).* | ☐ Employee<br>☐ Employee/Spouse<br>☐ Employee/Child(ren)<br>☐ Employee/Family | $ |

### Accident - Monthly Rates

| Coverage | Monthly flat rate |
|---|---|
| Employee only | $11.43 |
| Employee + spouse | $18.97 |
| Employee + child(ren) | $20.98 |
| Employee + family | $28.36 |

*Child(ren) coverage includes all children, up to age 26.

### Critical Illness - Monthly Rates

Employee/Spouse Coverage: elect an amount of $10,000, $20,000 or $30,000. If the employee enrolls, you may also elect $5,000, $10,000, or $15,000 in child coverage, up to 100% of your elected employee benefit amount. Calculate the cost and enter the monthly rate above. Use the ***employee age*** for both employee and spouse calculations.

Formula:

- I elect to enroll myself in Critical Illness: Elected Benefit Amount ÷ $1,000 x Rate = Monthly Cost
- I elect to enroll my spouse in Critical Illness: Elected Benefit Amount ÷ $1,000 x Rate = Monthly Cost

| Employee Age | Monthly rate per $1,000 |
|---|---|
| Under 24 | $0.238 |
| 25-29 | $0.333 |
| 30-34 | $0.453 |
| 35-39 | $0.669 |
| 40-44 | $0.998 |
| 45-49 | $1.453 |
| 50-54 | $2.069 |
| 55-59 | $2.754 |
| 60-64 | $3.905 |
| 65-69 | $5.510 |
| Above 70 | $9.569 |

- I elect to enroll my child(ren) up to age 26, in critical illness: Elected Benefit Amount ÷ $1,000 x $.0.526 = Monthly Cost. This cost covers all children enrolled.

### Hospital Indemnity - Monthly Rates

| Coverage | Monthly flat rate |
|---|---|
| Employee only | $13.86 |
| Employee + spouse | $30.14 |
| Employee + child(ren) | $20.91 |
| Employee + family | $38.69 |

*Child(ren) coverage includes all children, up to age 26.

## 4. Beneficiary Designation

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies), please indicate their full name, address, social security number, relationship, date of birth, and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. Following are examples of the most common designations:

**Primary:**

- Mary J. Doe, Wife (not Mrs. John Doe).

**Contingent:**

- Joseph W. Doe, Son and Jane Doe, Daughter, in equal shares (50%).
- Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts (for example, "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."). Beneficiary designation may be changed upon written request.

| | Full Name | Address | SSN | Relationship | D.O.B. | % |
|---|---|---|---|---|---|---|
| Primary | | | | | | |
| | | | | | | |
| | | | | | | |
| Contingent | | | | | | |
| | | | | | | |
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## 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 or my dependents in the group insurance offered. I understand if I enroll for insurance at a later date, and if a physical examination or other medical information is required, it will be at my own expense.

**A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.**

## 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 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.

NAME: Last, First, MI

Your Signature (type full name or sign after printing):

Date: