IMPORTANT: This is fixed indemnity policy,
NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov online** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

The Lincoln National Life Insurance Company
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: _____

1. Your Personal Information

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

Home Phone | Cell Phone | Work Phone | Email Address

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

2. Personal Information on Dependents — Complete if you are enrolling dependents.

☐ **Spouse**

First Name | Middle Name/MI | Last Name | Social Security No. | Date of Birth

Provide contact information if different than Your information above.

Home Phone | Cell Phone | Work Phone | Email Address

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

First Name	Middle Name/MI	Last Name	SSN (Optional)	Gender	DOB	Full-time Student
				☐ Male ☐ Female		☐ Yes ☐ No
				☐ Male ☐ Female		☐ Yes ☐ No
				☐ Male ☐ Female		☐ Yes ☐ No

Employer Completes this Section.

Billing Division or Location: _____

Sort Group/Code: _____ Payroll Cycle: _____

Policy #(s): _____

Average Hours Worked Per Week: _____ ☐ Full-time ☐ Part-time Occupation: _____

Earnings: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly $_____ Date of Employment: ____/____/____

Actively at Work? ☐ Yes ☐ No Date of Rehire: ____/____/____

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Continue on Next Page. . .

3. **Benefit Selection — Continued. Choose your benefits.**

Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium (Weekly)
Class	Effective Date			
_____	____/____/____	Accident ☐ Yes ☐ No	☐ Employee ☐ Employee/ Spouse ☐ Employee/ Children ☐ Employee/ Spouse/Children	$_____
_____	____/____/____	Critical Illness ☐ Yes ☐ No* *You must be enrolled for Critical Illness insurance in order to add spouse and/or child insurance.*	You: $_____ Spouse: $_____ Child: $_____	$_____
_____	____/____/____	Voluntary Dental ☐ Yes ☐ No	☐ Employee ☐ Employee/ Spouse ☐ Employee/ Children ☐ Employee/ Spouse/Children	$_____
_____	____/____/____	Voluntary Vision ☐ Yes ☐ No *Lincoln VisionConnect is underwritten by UnitedHealthcare Insurance Company, Hartford, CT, and United Healthcare Insurance Company of New York, Hauppauge, NY*	☐ Employee ☐ Employee/ Spouse ☐ Employee/ Children ☐ Employee/ Spouse/Children	$_____
_____	____/____/____	Hospital Indemnity ☐ Yes ☐ No *You must be enrolled for Hospital Indemnity insurance in order to add spouse and/or child insurance.*	☐ Employee ☐ Employee/ Spouse ☐ Employee/ Children ☐ 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--

Continue on Next Page. . .

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
			☐ Dental ☐ Vision
			☐ Dental ☐ Vision
			☐ Dental ☐ Vision
			☐ Dental ☐ 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

Street Address | City | State | Zip

Social Security Number | Date of Birth | Relationship to You | Percentage | Phone Number

___-___-___ | ___/___/___ | _____ | _____% | (___) ___-____

First Name | Middle Initial | Last Name

Street Address | City | State | Zip

Social Security Number | Date of Birth | Relationship to You | Percentage | Phone Number

___-___-___ | ___/___/___ | _____ | _____% | (___) ___-____

First Name | Middle Initial | Last Name

Street Address | City | State | Zip

Social Security Number | Date of Birth | Relationship to You | Percentage | Phone Number

___-___-___ | ___/___/___ | _____ | _____% | (___) ___-____

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.

Continue on Next Page. . .

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)

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 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