Lincoln Financial Group®

Underwritten by: Lincoln National Life Insurance Company
A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha NE 68114-4066
(800) 423-2765 fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Your employer provided information used to create this enrollment form.	Group ID: **LANECC**	Group Policy #: 000010086742	Billing Division or Location:

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name	County	Employer ZIP	State
Lane Community College	Lane	97405	Oregon

Employee First Name / Middle Initial / Last Name	Social Security Number	Date of Birth

Street Address / City / State / Zip

Gender:	Marital Status:	Home Phone ( )	Work Phone ( )

Spouse First Name / Middle Initial / Last Name	Spouse Social Security Number	Spouse Date of Birth

Employee Work Information (Complete for ALL Enrollments)

Average Hours/Week:	Occupation:	Earnings: **$**	Full-Time Employment Date:	Rehire Date:

Product Selection (Complete for ALL Enrollments)

All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Basic Coverage NOTE: Please mark the box for all coverage(s) you are applying for.

Effective Date	Type of Coverage			Amount of Coverage	Premium
	Basic Group Life	☒Yes	☐No	$50,000	Employer Paid
	Dependent Life	☐Yes	☐No	$2,000 – Spouse $2,000 – Child (six months to age 25) $1,000 – Child (newborn to six months)	
	Long Term Disability - Core	☒Yes	☐No	Monthly gross salary x 66.67%, max $2000	$14.00
	Long Term Disability - Buy Up	☐Yes	☐No	Monthly gross salary x 66.67%, max $6700	

Voluntary Coverage

NOTE: Please mark the box for all coverage(s) you are applying for. Selecting yes authorizes my employer to deduct premium(s) via payroll deduction. By selecting no, an application for coverage at a later date may require further medical information and/or physical exam, which will be at my own expense.

Type of Coverage		Amount of Coverage	Premium
Voluntary Employee Life Only Voluntary Employee Life + AD&D	☐Yes ☐No ☐Yes ☐No **Employees must elect coverage in order to elect spouse and/or dependent coverage**	☐$10,000 ☐$20,000 ☐$40,000 ☐$60,000 ☐$80,000 ☐$100,000 ☐Other: $	
Voluntary Spouse Life Only Voluntary Spouse Life + AD&D	☐Yes ☐No ☐Yes ☐No	☐$5,000 ☐$10,000 ☐$20,000 ☐$30,000 ☐Other: $	
Voluntary Dependent Child Life Only	☐Yes ☐No	☐$2,500 ☐$5,000 ☐$7,500 ☐$10,000	

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.

The insurance requested on this enrollment form will not be effective until approved by the Home Office of Lincoln National Life Insurance Company, and the initial premium is paid to Lincoln National Life Insurance Company. 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.

Employee Signature: _____ Date: _____