



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: GUADCOUNTY

Your Personal Information

Group/Employer/Participating Organization Name			County	Zip	State
<u>Guadalupe County</u>					
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: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single			

Employer Completes this Section.

Billing Division or Location: _____

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: ____/____/____

2. 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.	Effective Date	Type of Insurance	Total Premium (Weekly)
	____/____/____	Life & AD&D	\$20,000 Your Employer pays

3. 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
<hr/>		
Street Address	City	State Zip
<hr/>		
Social Security Number	Date of Birth	Relationship to You Percentage Phone Number
<hr/>	<hr/>	<hr/>

First Name	Middle Initial	Last Name
<hr/>		
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<hr/>		
Social Security Number	Date of Birth	Relationship to You Percentage Phone Number
<hr/>	<hr/>	<hr/>

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

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.

4. 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 KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

5. 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.

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