Lincoln Financial Group®

The Lincoln National Life Insurance Company
Domiciled in Indiana
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: Select your benefits.
Step 3: Confirm enrollment.
Step 4: Sign, date & return the form.

Group ID: WASHINGSD_____

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**
			___-___-____			___/___/____

2. Benefit Selection — Continued. Choose your benefits.

Voluntary/ Group Insurance
Mark the box for the 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.
Type of Insurance
Voluntary Short Term Disability (STD) ☐ **Yes** ☐ **No***

*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. 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. 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.

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.

FOR ACCIDENTAL DEATH & DISMEMBERMENT (AD&D), ACCIDENT, CRITICAL ILLNESS INSURANCE, OR HOSPITAL INDEMNITY: THE CERTIFICATE PROVIDES LIMITED BENEFITS. REVIEW YOUR CERTIFICATE CAREFULLY.

FOR DENTAL INSURANCE: THE CERTIFICATE PROVIDES DENTAL BENEFITS ONLY. REVIEW YOUR CERTIFICATE CAREFULLY.

4. 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. 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