



**MAIL THIS COMPLETED FORM WITH YOUR PREMIUM AND BILLING CHARGE PAYMENT TO:
The Lincoln National Life Insurance Company
P.O. Box 0821 Carol Stream, IL 60132-0821

TO AVOID DELAY OF BENEFITS, PLEASE COMPLETE ALL QUESTIONS.

Employer: Please complete and sign the upper section of this form. Please give the form to the employee to complete the lower section. **Employee:** Please **complete and sign Page 2** of this form. Return the completed form with the premium due PLUS the billing charge to the address shown on the top" of this form. **We must receive this form & payment within 31 days of "Date Employment Terminated."**

This section to be completed by EMPLOYER

Group Name:			p Policy ber:	Group	ID:	
Employee Information:						
Employee Name:						
Birthdate://		Social Security	/ #:		Gender: Ma	ale 🗆 Female
Address (Street, City, State, Zip C	code):	-				
Phone Number: ()						
Spouse Information: (Co	mplete	ONLY if Insured	d)			
Spouse's Name:						
Birthdate://			· #:			
Coverage Eligible to Port		Coverage Amount/Plan	Monthly Premium Amount*		Termination Date	Prior Carrier Effective Date
Voluntary Employee Life/AD&D	□\$_		\$		· ·	
Voluntary Spouse Life/AD&D	\square \$ _		\$			
Voluntary Dependent Life			_ \$			
Voluntary LTD	\square \$ _		\$			
Voluntary Accident	☐ Yes	□ No	\$			
Long Term Disability			_ \$			
Short Term Disability	\square \$ _		_ \$		_	
	Date Premium Paid To:					
*Use current group rates to calculate	e Monthly	Premium Amount	•			
Reason for Termination of Er	nploym	ent (Check ALL	that apply)			
☐ Retirement (voluntary termi criteria for retirement from t			nitiated by employee	by meeting age,	length of service	and/or any other
☐ Unable to perform each of t	he main	duties of any or	ccupation due to sick	ness or injury.		
☐ Resignation (voluntary term	ination o	of employment in	nitiated by employee))		
☐ Dismissal (involuntary termi	nation o	f employment in	nitiated by employer)			
☐ Other, please explain						
Employer's Signature:					Date:	
Printed Name:						
Company Phone Number: ()		Employer's Em	nail Address:		

This section to be completed by EMPLOYEE. For questions on completing this section, please contact us at 800-423-2765.

Beneficiary Information (Life/Alsheet of paper.	D&D Insurance). If naming more than one	e Primary or Contingent Beneficial	ry, please attach a separate
Employee's Primary Beneficia	ary:		
Beneficiary's Address:			
Relationship:			
Employee's Contingent Benef	ficiary:		
Contingent Beneficiary's Addr	ess:		
Relationship:			
Employee's quarterly premiur	n: \$+ \$5.00 Billing (Monthly premium x 3)	g Fee ^{··} = Total Amount Enclosed:	\$
Spouse's quarterly premium:	\$	g Fee ^{··} = Total Amount Enclosed:	\$
Child(ren)'s quarterly premium	: \$(No Billing Fe (Monthly premium x 3)	e) = Total Amount Enclosed:	\$
I hereby authorize The Lincol	n National Life Insurance Company to b	egin billing directly for my: (chec	k all applicable coverages)
☐ Voluntary Employee Life	\square Voluntary Employee Life and AD&D	\square Voluntary Dependent Life	\square Voluntary Accident
☐ Voluntary Spouse Life	\square Voluntary Spouse Life and AD&D	\square Voluntary LTD	
□LTD	□STD		
Signature of Insured Employe	e:	Date: _	
Signature of Insured Spouse:		Date: _	
Employee e-mail address:			

If e-mail address supplied, we will contact you through email. Did you remember to include your payment?