

ENROLLMENT FORM FOR GROUP INSURANCE

Your employer provided information used to create this enrollment form.

Group ID: WICHIRO	Group Policy #:	Billing Division or Location:
-----------------------------	-----------------	-------------------------------

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name	County	Employer ZIP	State
Employee First Name / Middle Initial / Last Name			Date of Birth
Street Address / City / State / Zip			
Gender:	Marital Status:	Home Phone ()	Work Phone ()

Employee Work Information (Complete for ALL Enrollments)

Average Work Week Hours:	Occupation:	Full-Time Employment Date:	Rehire Date:
--------------------------	-------------	----------------------------	--------------

Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for all coverages you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage	Amount of Coverage	Premium
		Basic Group Life/AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No	1.00 Times annual salary to a maximum amount of \$200,000	
		Long Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	60% to \$10,000 max.	

*By selecting no, application for coverage 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 illustration due to rounding -

Beneficiary Information (Complete ONLY for Life 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.

NOTE: A PERSON COMMITS 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.

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 Full Name: _____

Employee Signature: _____ Date: _____

Group ID: Control:
 * *