Lincoln Financial Group®

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: **NAMICIN**	GROUP POLICY #: 000404002291-00000 000405033179-00000	Billing Division or Location:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) NAMIC Group Insurance Trust			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: ☐Male ☐Female	Marital Status: ☐Married ☐Single		Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly $____________	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Accident Coverage NOTE: Please mark the box or boxes for each plan/benefit you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Type of Coverage (Selecting yes authorizes my employer to payroll deduct premium(s))	**Plan Option(s)**	**Amount of Coverage**	**Total Premium**
Accident ☐**Yes** ☐**No**	**Choice Plan**	☐ Employee Only ☐ Employee/Spouse ☐ Employee/Children ☐ Employee/Family	

Critical Illness Coverage NOTE: Please mark the box or boxes for each plan/benefit you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Type of Coverage (Selecting yes authorizes my employer to payroll deduct premium(s))	**Plan Option(s)**	**Amount of Coverage**	**Total Premium**
Has Employee or Spouse used any type of tobacco in the past 12 months?		Employee: ☐Yes ☐No Spouse: ☐Yes ☐No	
Critical Illness ☐**Yes** ☐**No** Base Plan Includes: Heart Category Cancer Category Organ Category Quality of Life Category Accident Rider	Employee	☐ **$5,000** ☐ **$10,000** ☐ **$15,000** ☐ **$20,000** ☐ **$25,000**	
	Spouse* *Spouse amount cannot exceed Employee amount	☐ **$5,000** ☐ **$10,000** ☐ **$15,000** ☐ **$20,000** ☐ **$25,000**	
	Child	☐ **Benefit equals 25% of the Employee's approved amount**	

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

See last page/reverse for beneficiary information and signature

C. Beneficiary Information (Complete ONLY for Accident and Critical Illness 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.

D. Dependent and Other Insurance Information (Complete only for Accident and Critical Illness Coverage)

	Last Name	First Name	Middle Initial	Gender	Date of Birth
Spouse:					
Children:					

E. Request for Coverages

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

- ❑ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby enroll for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
- ❑ **NOT ENROLL myself in the Program.** I understand that if I enroll for coverage 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 Program.** I understand that if I enroll for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTE: 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 OT DEFRAUD) AN INSURANCE COMPANY.

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