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: 1159754

1. Your Personal Information

Group/Employer/Participating Organization Name: Asbury University
County ______ Zip ______ State ______

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: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

Employer Completes this Section.

Billing Division or Location: ______

Sort Group/Code: ______ Payroll Cycle: ______

Policy #(s): ______

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: ____/___/____

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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.

Voluntary Group Insurance				
Employer Completes this section.		**Type of Insurance**	**Amount of Insurance**	**Total Premium**
Class	**Effective Date**			
______	_____/_____/_____	Voluntary Life Only ☐ **Yes** ☐ **No***	$______________	$______________
______	_____/_____/_____	Voluntary Dependent (Spouse Only) Life Only ☐ **Yes** ☐ **No*** *You must be enrolled for Life insurance in order to add spouse and/or child insurance.*	$______________	$______________
______	_____/_____/_____	Voluntary Dependent (Child Only) Life Only ☐ **Yes** ☐ **No*** *You must be enrolled for Life insurance in order to add spouse and/or child insurance.*	$______________	$______________
______	_____/_____/_____	Voluntary Employee AD&D only ☐ **Yes** ☐ **No**	$______________	$______________
______	_____/_____/_____	Voluntary Employee & Family AD&D ☐ **Yes** ☐ **No** *You must be enrolled for AD&D insurance in order to add spouse and/or child insurance.*	$______________	$______________

*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—

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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

Street Address | City | State | Zip

Social Security Number ______-_____-_________ | Date of Birth _____/_____/_____ | Relationship to You ____________ | Percentage ____________% | Phone Number (____) ____-________

First Name | Middle Initial | Last Name

Street Address | City | State | Zip

Social Security Number ______-_____-_________ | Date of Birth _____/_____/_____ | Relationship to You ____________ | Percentage ____________% | Phone Number (____) ____-________

First Name | Middle Initial | Last Name

Street Address | City | State | Zip

Social Security Number ______-_____-_________ | Date of Birth _____/_____/_____ | Relationship to You ____________ | Percentage ____________% | Phone Number (____) ____-________

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.

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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 AND WITH THE INTENT TO DEFRAUD AN INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

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 that the vision insurance I have elected provides reimbursement for certain vision costs which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my provider or me for vision care expenses that I have incurred may not be covered by my vision care insurance benefit plan.

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