



Underwritten by: Lincoln National Life Insurance Company
 DecisionHR 100 Carillon Pkwy; Suite 350
 St. Petersburg, FL 33716
 Phone: (888)828-5511 Fax: (727) 572-6827

Effective Date:

ENROLLMENT FORM FOR GROUP INSURANCE

Please use Ink or Type

Group ID: DECISIONHR	Group Policy #: BL-823607	Billing Division or Location:
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Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) Decision HR /			County	Employer ZIP	State
Employee First Name / Middle Initial / Last Name			Social Security Number		Date of Birth
Street Address / City / State / Zip					
Gender:	Marital Status:	Home Phone ()		Work Phone ()	
Spouse First Name / Middle Initial / Last Name			Spouse Social Security Number		Spouse Date of Birth

Employee Work Information (Complete for ALL Enrollments)

Average Work Week Hours:	Occupation:	Earnings: \$	Full-Time Employment Date:	Rehire Date:
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Product Selection (Complete for ALL Enrollments)

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage 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)	Amount of Coverage	Premium
Voluntary Employee Life Only	<input type="checkbox"/> Yes <input type="checkbox"/> No* <i>Employees must elect coverage in order to elect spouse and/or dependent coverage</i>	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> OTHER \$ _____	
Voluntary Spouse Life Only	<input type="checkbox"/> Yes <input type="checkbox"/> No* <i>Spouse coverage selection may not exceed 50% of the Employee amount selected</i>	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> OTHER \$ _____	
Voluntary Dependent Child Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No*	<input type="checkbox"/> \$10,000	
Voluntary Short Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No*	Weekly Benefit Amount: \$	
Option 1 Voluntary Long Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No*	Monthly Benefit Amount: \$	
Option 2 Voluntary Long Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No*	Monthly Benefit Amount: \$	

*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 Beneficiary	of	Social Security Number
Street Address			City	State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship Beneficiary	of	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.					

Request for Coverage
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:
<input type="checkbox"/> REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company. I hereby apply 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.
<input type="checkbox"/> NOT ENROLL myself in the Program. I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
<input type="checkbox"/> NOT ENROLL my dependents in the Program. I understand that if I apply 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.

NOTICE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM OR APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

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 : _____