**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

| OFFICE CODE: | Memo |
|---|---|

Please Use Ink or Type | GROUP ID: | GROUP POLICY #:

### A. Employee Information (Complete for ALL Enrollments)

| Employer Name/Company Name (Please Print) | County | State |
|---|---|---|
| Caledonia Central Supervisory Union - Barnet Danville Peacham Walden | Caledonia | Vermont |

| Social Security Number | Last Name | First Name | MI |
|---|---|---|---|
| | | | |

| Street Address | City | State | Zip | Date of Birth |
|---|---|---|---|---|
| | | | | |

| ☐ Male ☐ Female | Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed | Spouses Date of Birth | Home Phone | Work Phone |
|---|---|---|---|---|
| | | | | |

**Completed By Employer**

| Effective Date: | Date of Full-Time Employment: | Occupation: |
|---|---|---|
| | | |

| Earnings: $________ ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly | ☐ Union ☐ Exempt ☐ Non-Union ☐ Non-Exempt | Average Hours Worked Per Week: |
|---|---|---|
| | | Rehire Date: |

### B. Product Selection (Complete for ALL Enrollments)

NOTE: Please mark each box if you are eligible for the listed coverage.

| Class | Effective Date | Basic Amount *Employer to Complete* | Coverage | | | Amount | Dental |
|---|---|---|---|---|---|---|---|
| | | | Group Life | ☒ Yes | ☐ No | | ☐ Single Dental |
| | | | Group AD&D | ☒ Yes | ☐ No | | ☐ EE/Spouse |
| | | | Dependent Life | ☐ Yes | ☐ No | | ☐ EE/Spouse/Children |
| | | | Optional Employee Life | ☐ Yes | ☐ No | | ☐ EE/Children ☐ One Child |
| | | | Optional Dependent Life | ☐ Yes | ☐ No | | ☐ 2 or More Children ☐ No Coverage |
| | | | Optional AD&D | ☐ Yes | ☐ No | | |
| | | | Long Term Disability | ☒ Yes | ☐ No | | Effective:________ |
| | | | Short Term Disability | ☐ Yes | ☐ No | | |

### C. Beneficiary Information (Complete ONLY for Life or AD&D 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. Signature (Complete for ALL Enrollments)

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. I reserve the right to revoke this deduction at any time on written notice.

______________________________ Employee Signature

______________ Date Signed

Dental Enrollment is on the back of this Enrollment Form.

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