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

Your employer provided information used to create this enrollment form.

Group ID:	Group Policy #:	Billing Division or Location:
PUBLICRM	000010106770, 000400001000-08728	**1138664**

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name	County	Employer ZIP	State
Public Risk Management of Florida – Hendry County Board of Commissioners			
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
Date of Marriage/Civil Union/Domestic Partnership	Date of Family Status Change		

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	Bi-Weekly Premium
		Basic Group Life/AD&D	☒ Yes	☐ No	$	Employer Paid
		Dependent Life	☐ Yes	☐ No	**Spouse $5,000, Child $2,500**	**$.72**

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	Bi-Weekly Premium
Voluntary Employee Life + AD&D Evidence of Insurability Required for Coverage Amounts Over $100,000	☐ Yes ☐ No* *Employees must elect coverage in order to elect spouse and/or dependent coverage*	☐ $20,000 ☐ $40,000 ☐ $60,000 ☐ $80,000 ☐ $100,000 ☐ OTHER $ _____	Life+AD&D
Voluntary Spouse Life + AD&D Evidence of Insurability Required for Coverage Amounts Over $50,000	☐ Yes ☐ No* *Spouse coverage selection may not exceed 50% of the Employee amount selected*	☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ OTHER $ _____	
Voluntary Dependent Child Benefit	☐ Yes ☐ No*	☐ $10,000	$0.92

*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 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.				

NOTE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM OR AN 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 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: _____

Group ID: Control:

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