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: LOYOUNIVST	GROUP POLICY #:	Billing Division or Location:

Completed By Employer

Average Hours Worked Per Week:	Occupation:

Earnings: ☐ Hourly ☐ Biweekly ☐ Annually $_____	Date of Full-Time Employment:	Rehire Date:

Employer Name/Company Name (Please Print)	County	Employer ZIP	State
Loyola University New Orleans	Orleans	70118	Louisiana

A. Employee Information (Complete for ALL Enrollments)

Employee Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Gender: ☐Male ☐Female	Marital Status: ☐Married ☐Single	Home Phone ( )	Work Phone ( )

Street Address	City	State	Zip

Spouse Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Dependent(s) Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

B. Product Selection (Complete for ALL Enrollments)

Basic 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. Maximum Benefit: 250,000. Employee age reduction at 70.

Class	Effective Date	Type of Coverage			Amount of Coverage	Premium
		Long Term Disability 60% Base Salary Max $10,000/mo.	☒Yes	☐No	☐Pre-tax Premium/Taxable Benefit ☐Post-Tax Premium/Non-Taxable Benefit	Employer Paid
		Basic Group Life/AD&D	☒Yes	☐No	1x Base Salary	Employer Paid
		Basic Dependent Life Eligible Spouse & Dependent Children (age > 1 year, age 14 days-1 year $1500, under 14 days no coverage)	☐Yes	☐No	$5000	Employer Pays $1.73 & Employee Pays $0.85

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. Employee coverage reduces at age 70. Spouse coverage ends at employee age 70.

TYPE OF COVERAGE			AMOUNT OF COVERAGE	
Voluntary Employee Life Insurance	☐Yes	☐No	☐1x ☐2x 3x☐ Base Salary Guaranteed issue $250,000. Maximum coverage $500,000.	
Voluntary Spouse Life Insurance	☐Yes	☐No	☐ 50% of Employee Voluntary Coverage Guaranteed issue $20,000. Maximum coverage $250,000.	
Voluntary Dependent Life Insurance	☐Yes	☐No	$10,000 Benefit, age reduction for 14days-6months $250.00 benefit	
Voluntary Employee AD&D Insurance If yes: ☐ Employee Only OR ☐Family	☐Yes	☐No	☐1x ☐2x ☐3x ☐4x ☐5x ☐6x ☐7x ☐8x ☐9x ☐10x Base Salary Maximum coverage $500,000. All Voluntary AD&D coverage ends at employee age 99.	

C. Beneficiary Information

1. Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Share % -				
2. Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Share % -				
TOTAL 100%				
1. Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Share % -				
2. Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Share % -				
TOTAL 100%				

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. 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 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 understand that if I apply for Voluntary coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense. I understand that if I apply for Voluntary 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 PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR **BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

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:_____

******Spousal Waiver for Beneficiary******

Community Property State Consent for residents of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin. If you are married, live in a community property state, and name someone other than your spouse as beneficiary, you must have your spouse sign below to waive his or her rights to any community property interest in the benefit.

As the Insured's spouse, I do hereby consent to the beneficiary designation(s) indicated on this form and waive any rights that I may have to the proceeds of such insurance under applicable community property laws.

Spouse Full Name: _____ Spouse Signature: _____ Date: _____