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: **LOUISTECHC**	GROUP POLICY #:	Billing Division or Location:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) **Louisiana Technical University**			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single		Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐Hourly ☐Monthly ☐Weekly ☐Yearly $_____	Date of Full-Time Employment:	Rehire Date:

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.

Class	Effective Date	Type of Coverage	Amount of Coverage	Total Premium
		Short Term Disability ☐**Yes** ☐**No***	**$**	**$**
		Long Term Disability ☐**Yes** ☐**No***	**$**	**$**

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	AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life/AD&D Insurance ☐**Yes** ☐**No***	**$**	**$**
Voluntary Spouse Life/AD&D Insurance ☐**Yes** ☐**No***	**$**	**$**
Voluntary Dependent Child Benefit ☐**Yes** ☐**No***	**$10,000**	**$**

Type of Coverage	Plan Option(s)	Amount of Coverage	
Critical Illness ☐**Yes** ☐**No*** **Base Plan includes:** Wellness Category Heart Category Cancer Category Organ Category Quality of Life Category Accident Benefit	Employee Spouse** **Spouse amount cannot exceed Employee amount. Child*** *** Children are automatically enrolled for 25% of the employee's elected amount.	☐ **$5,000** ☐ **$10,000** ☐ **$15,000** ☐ **$20,000** ☐ **$25,000** ☐ **$5,000** ☐ **$10,000** ☐ **$15,000**	

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	

D. Dependent and Other Insurance Information (Complete only for Critical Illness Coverage)

	Last Name / SSN (Optional)	First Name	Middle Initial	Gender	Date of Birth	Full-time Student
Spouse						
Child						☐Yes ☐No
Child						☐Yes ☐No
Child						☐Yes ☐No

E. 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 enroll 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.
- ☐ **NOT ENROLL myself in the Program.** I understand that if I enroll for coverage 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 Program.** I understand that if I enroll 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.

NOTE: 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, or its insurance partners, 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 an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name:_____ Employee Signature:_____ Date:_____