



The Lincoln National Life Insurance Company
 PO Box 2616, Omaha, NE 68103-2616
 Phone: (800) 423-2765 Fax: (877) 573-6177

VOLUNTARY LIFE ENROLLMENT FORM FOR GROUP INSURANCE

Group Name: City of Chico		Group ID: CITYOFCHIC		Group Policy #: 10178696, 403002573, 40001000-17153		Billing Division/Location: HR	
EMPLOYEE INFORMATION (Complete for ALL Enrollments)							
Last Name		First Name		MI	Social Security Number		Date of Birth
Address					Home Telephone Number ()		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
City		State	Zip	Email Address		Marital Status	
SPOUSE INFORMATION (Includes Domestic Partner)							
Last Name		First Name		MI	Social Security Number		Date of Birth
Date of Marriage/Domestic Partnership		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female					
EMPLOYEE WORK INFORMATION							
Date of Hire		Rehire Date		Avg. Hours Worked per Week		Annual Salary	
Work Telephone Number ()		Occupation/Job Title					
PRODUCT SELECTION (Complete for ALL Enrollment)							
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.							
To apply the appropriate tobacco/non-tobacco rates, please answer the following questions:							
Has EMPLOYEE used any type of tobacco or nicotine in the past 12 months?				<input type="checkbox"/> No <input type="checkbox"/> Yes			
Has SPOUSE/DOMESTIC PARTNER used any type of tobacco or nicotine in the past 12 months?				<input type="checkbox"/> No <input type="checkbox"/> Yes			
Type of Coverage		Benefit Election*		Amount of Coverage			
Voluntary Life – Employee Evidence of Insurability required for coverage amounts over \$150,000.00		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$		Coverage must be elected in \$10,000 increments. Employee coverage selection may not exceed 5 times employee annual base salary.	
Voluntary AD&D – Employee		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$			
Voluntary Life – Spouse ** Evidence of Insurability required for coverage amounts over \$25,000.00		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$		Coverage must be elected in \$5,000 increments. Spouse coverage selection may not exceed 100% of employee's coverage selection.	
Voluntary AD&D – Spouse **		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$		Spouse coverage selection may not exceed 100% of employee's coverage selection.	
Voluntary Life – Dependent Child(ren) ** Maximum child coverage is \$10,000.00		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$		Coverage must be elected in \$2,000 increments.	
Voluntary AD&D – Dependent Child(ren) ** Maximum child coverage is \$10,000.00		<input type="checkbox"/> Yes <input type="checkbox"/> No		\$			
*Selecting Yes authorizes my employer to payroll deduct premium(s). By selecting No, application for coverage at a later date may require further medical information and/or physical exam, which will be at my own expense.							
** Employee must elect coverage in order to elect spouse/domestic partner and/or dependent child coverage							
BENEFICIARY INFORMATION (Must be completed for all Life/AD&D Enrollments)							
Primary Beneficiary Name and address				Relationship to Beneficiary		Social Security Number	
Contingent Beneficiary Name and Address				Relationship to Beneficiary		Social Security Number	
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 Beneficiary or Contingent Beneficiary, please attach a separate sheet of paper.							
SIGNATURE							
FRAUD WARNING: A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with intent to defraud (or knowing that he or she is helping to defraud) an insurance company. The falsity of any statement in this application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insured.							
Note: CA law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. The insurance requests 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 delay effective date will apply if the employee is not Actively at Work, or the dependent is in a period of limited activity on the date insurance would otherwise take effect.							
Employee Signature						Date	