The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: 888-408-7300

Here is your Enrollment Form.

Div-Serial: 09-LF1991

Follow these steps to complete the form.
Print clearly in ink.
Step 1: Fill in or confirm your personal information.
Step 2: Fill in dependent information, if any.
Step 3: Select your benefits.
Step 4: Assign beneficiaries.
Step 5: Confirm enrollment.
Step 6: Sign, date & return the form.

1. Your Personal Information

Group/Employer/Participating Organization Name	County	Zip	State
Youngstown State University	Mahoning	44555	OH

Your First Name	Middle Name/MI	Last Name	Social Security No.	Employee ID No.	Date of Birth
			___-___-___		___/___/___

Street Address (Include Apt. or Suite No.)	City	State	Zip

Home Phone	Cell Phone	Work Phone	Email Address
(___) ___-	(___) ___-	(___) ___-	

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

2. Benefit Selection

Type of Insurance		
Supplemental Long-Term Disability (LTD)	☐ **Yes**	☐ **No***

*By selecting "No," application for insurance 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 illustrations due to rounding.

3. Confirm Enrollment

This group insurance has been offered to me and after careful consideration of the benefits, I have decided to:

☐ **ENROLL FOR INSURANCE for which I am or may become eligible** under the group policies issued by The Lincoln National Life Insurance Company, or its insurance partners. If contributions are required, I authorize my Employer to deduct premium from my pay.

☐ **NOT ENROLL myself in the group insurance offered.** I understand if I enroll for insurance at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

Fraud Warning/State Disclosure(s)

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

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

4. Sign and Return

I understand the group insurance requested will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners. A delayed effective date will apply if you are not Actively at Work/an Active Member. A delayed effective date may apply to your dependent if he or she is confined in a hospital or health care facility or is in a period of limited activity on the date insurance would otherwise take effect.

I understand the information provided is for enrollment in group insurance as offered by my Employer and will not be used for underwriting purposes.

The information provided is complete, true, and accurate to the best of my knowledge.

Your Full Name (Print): _____

Your Signature: X_____ **Date** _____/_____/_____

Complete and return this form.

(Be sure to sign and date the form to start your insurance).