Lincoln Financial Group

Lincoln Life & Annuity Company of New York

Home Office: 100 Madison St., Ste 1860, Syracuse, NY 13202
All Group Insurance questions and correspondences sent to:
Group Insurance Service Office
P.O. Box 2616, Omaha, NE 68103-2616
Phone (800) 423-2765 Fax (877) 573-6177

Here is your Enrollment Form.

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.

Group ID: BEmus-BL-273592

1. Your Personal Information

Group/Employer/Participating Organization Name _____ County _____ Zip _____ State _____

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. Personal Information on Dependents — Complete if you are enrolling dependents.

☐ **Spouse**

First Name _____ Middle Name/MI _____ Last Name _____ Social Security No. ___-___-___ Date of Birth ___/___/___

Provide contact information if different than Your information above.

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

Dependent Children – List all children you are enrolling (attach a separate sheet, if needed).

First Name	Middle Name/MI	Last Name	SSN (Optional)	Gender	DOB	Full-time Student
			___-___-___	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No
			___-___-___	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No
			___-___-___	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No

Employer Completes this Section.

Billing Division or Location: _____
Sort Group/Code: _____ Payroll Cycle: _____
Policy #(s): _____

Average Hours Worked Per Week: _____ ☐ Full-time ☐ Part-time Occupation: _____
Earnings: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly $_____ Date of Employment: ___/___/___
Actively at Work? ☐ Yes ☐ No Date of Rehire: ___/___/___

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3. Benefit Selection — Continued. Choose your benefits.

To apply the appropriate tobacco/non-tobacco rates, please answer the following question:

In the past 12 months, have You or Your Spouse smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?

You: ☐ **Yes** ☐ **No**
Your Spouse: ☐ **Yes** ☐ **No**

Voluntary/Optional Group Insurance

Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions as stated in the policy and certificate.

Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium (Weekly)
Class	Effective Date			
_____	____/____/____	Optional Life & AD&D ☐ **Yes** ☐ **No***	$_____	$_____
_____	____/____/____	Optional Life Only ☐ **Yes** ☐ **No***	$_____	$_____
_____	____/____/____	Optional Dependent (Spouse Only) Life & AD&D ☐ **Yes** ☐ **No*** *You must be enrolled for Life & AD&D insurance in order to add spouse and/or child insurance.*	$_____	$_____
_____	____/____/____	Optional Dependent (Spouse Only) Life Only ☐ **Yes** ☐ **No*** *You must be enrolled for Life insurance in order to add spouse and/or child insurance.*	$_____	$_____
_____	____/____/____	Optional Dependent (Child Only) Life Only ☐ **Yes** ☐ **No*** *You must be enrolled for Life insurance in order to add spouse and/or child insurance.*	$_____	$_____
_____	____/____/____	Optional Employee AD&D ☐ **Yes** ☐ **No**	$_____	$_____
_____	____/____/____	Optional Employee & Family AD&D ☐ **Yes** ☐ **No** *You must be enrolled for AD&D insurance in order to add spouse and/or child insurance.*	$_____	$_____
_____	____/____/____	Buy-Up Short Term Disability (STD) ☐ **Yes** ☐ **No***	Weekly Benefit Amount: $_____	$_____
_____	____/____/____	Buy-Up Long Term Disability (LTD) ☐ **Yes** ☐ **No***	Monthly Benefit Amount: $_____	$_____

*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--

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3. Benefit Selection — Continued. Choose your benefits.

Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium (Weekly)
Class	Effective Date			
_____	____/____/____	Accident ☐ Yes ☐ No	☐ Employee ☐ Employee/ Spouse ☐ Employee/ Children ☐ Employee/ Spouse/Children	$_____
_____	____/____/____	Critical Illness ☐ Yes ☐ No* *You must be enrolled for Critical Illness insurance in order to add spouse and/or child insurance.*	You: $_____ Spouse: $_____ Child: $_____	$_____
_____	____/____/____	Voluntary Dental ☐ Yes ☐ No	☐ Employee ☐ Employee/ Spouse ☐ Employee/ Children ☐ Employee/ Spouse/Children	$_____
_____	____/____/____	Voluntary Vision ☐ Yes ☐ No *Lincoln VisionConnect is underwritten by United Healthcare Insurance Company of New York, Hauppauge, NY*	☐ Employee ☐ Employee/ Spouse ☐ Employee/ Children ☐ Employee/ Spouse/ Children	$_____

*By selecting "No," enrolling for insurance at a later date may require further medical information and/or a physical exam, which will be at your own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

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4. Select Your Beneficiaries — Choose who receives your insurance benefits.

Primary Beneficiary(ies)
The Primary Beneficiary is the person(s) you identify to receive insurance benefits upon your death.

If more than three Primary Beneficiaries, please attach a separate sheet of paper.
If multiple Primary Beneficiaries, total percentage of all combined must equal 100%.

First Name _____ Middle Initial _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number ___-___-___ Date of Birth ___/___/___ Relationship to You _____ Percentage _____% Phone Number (___) ___-___

First Name _____ Middle Initial _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number ___-___-___ Date of Birth ___/___/___ Relationship to You _____ Percentage _____% Phone Number (___) ___-___

First Name _____ Middle Initial _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number ___-___-___ Date of Birth ___/___/___ Relationship to You _____ Percentage _____% Phone Number (___) ___-___

Contingent Beneficiary(ies) and Other Beneficiary Designations

A Contingent Beneficiary will receive benefits only if the Primary Beneficiary(ies) does not survive you. Please attach a separate sheet to identify a Contingent Beneficiary. If multiple Contingent Beneficiaries, total percentage of all combined must equal 100%. To name a Beneficiary(ies) by product, attach a separate sheet identifying product and beneficiary.

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