Lincoln Financial Group

The Lincoln National Life Insurance Company
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: 939909

1. Your Personal Information

Group/Employer/Participating Organization Name: Heritage University | County: Yakima | Zip: 98948 | State: WA

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** ☐ **Domestic Partner**

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
			- -	☐ 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: ___/___/___

Continue on Next Page. . .

3. Benefit Selection — Choose your benefits.

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 stated in the policy and certificate. (Spouse includes your Domestic Partner.)

Basic Group Insurance				
Employer Completes this section.		**Type of Insurance**	**Amount of Insurance**	**Total Premium**
Class	**Effective Date**			
_____	_____/_____/_____	Life & AD&D	$50,000	Your Employer pays
_____	_____/_____/_____	Long Term Disability (LTD)		Your Employer pays
Voluntary/Optional Group Insurance				
_____	_____/_____/_____	Voluntary Life Only ☐ **Yes** ☐ **No***	$_____	$_____
_____	_____/_____/_____	Voluntary Dependent (Spouse Only) Life Only ☐ **Yes** ☐ **No*** *You must be enrolled for Life insurance in order to add spouse and/or child insurance.*	$_____	$_____
_____	_____/_____/_____	Voluntary Dependent (Child Only) Life Only ☐ **Yes** ☐ **No*** *You must be enrolled for Life insurance in order to add spouse and/or child insurance.*	$_____	$_____
_____	_____/_____/_____	Voluntary Employee AD&D ☐ **Yes** ☐ **No**	$_____	$_____
_____	_____/_____/_____	Voluntary Dependent (Spouse Only) AD&D ☐ **Yes** ☐ **No** *You must be enrolled for AD&D insurance in order to add spouse and/or child insurance.*	$_____	$_____
_____	_____/_____/_____	Voluntary Dependent (Child Only) AD&D ☐ **Yes** ☐ **No** *You must be enrolled for AD&D insurance in order to add spouse and/or child insurance.*	$_____	$_____

*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.

Continue on Next Page. . .

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.

Continue on Next Page. . .

5. 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.

☐ **NOT ENROLL my dependents in the group insurance offered.** I understand if I enroll my dependents 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)

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

6. 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.)

Questions? Call 800-423-2765