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: STMARYCOL	GROUP POLICY #:	Billing Division or Location:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) Saint Mary's College			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:
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
	01/01/2017	Dental – High Plan ☐**Yes** ☐**No**	☐Employee Only ☐Family	**$**
	01/01/2017	Dental – Medium Plan ☐**Yes** ☐**No**	☐Employee Only ☐Family	**$**
	01/01/2017	Dental – Low Plan ☐**Yes** ☐**No**	☐Employee Only ☐Family	**$**

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

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

Are you or any of your eligible dependents covered by any other dental plan? ☐**YES (If YES, please list)** ☐**NO**

Name of Insured	Insurance Company Name/Phone and Policy Number	Employer	Coverage
			☐**Dental**
			☐**Dental**
			☐**Dental**

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: A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

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.

I understand that the vision care insurance benefit plan I have selected provides reimbursement for certain vision costs which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my provider or me for vision care expenses which I have incurred may not be covered by my vision care insurance benefit plan.

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