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.

Group ID: CASF2

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: Confirm enrollment.
Step 5: Sign, date & return the form.

1. Your Personal Information

Group/Employer/Participating Organization Name: The Caswell Family Medical Center, Inc
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: __/__/__

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

Continue on Next Page. . .

3. Benefit Selection — Choose your benefits.

Basic Group Insurance				
Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium
Class	Effective Date			
______	_____/_____/_____	Dental ☐ Yes ☐ No *By selecting No, you may be subject to late entrant or benefit waiting periods on certain services if you enroll at a later date.*	☐ 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.

3. Benefit Selection — Continued. Complete if you are enrolling for Dental insurance.

Are you or any of your eligible dependents covered by another dental plan? ☐ Yes (If Yes, please list) ☐ No

Name of Insured	Insurance Company Name, Phone and Policy No.	Employer	Coverage
____________________	____________________________________	__________	☐ Dental
____________________	____________________________________	__________	☐ Dental
____________________	____________________________________	__________	☐ Dental
____________________	____________________________________	__________	☐ Dental

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)

ANY PERSON WHO, WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE AN INSURER OR INSURANCE CLAIMANT: (1) PRESENTS OR CAUSES TO BE PRESENTED A WRITTEN OR ORAL STATEMENT, INCLUDING COMPUTER-GENERATED DOCUMENTS AS PART OF, IN SUPPORT OF, OR IN OPPOSITION TO, A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY, KNOWING THAT THE STATEMENT CONTAINS FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR MATTER MATERIAL TO A CLAIM, OR (2) ASSISTS, ABETS, SOLICITS, OR CONSPIRES WITH ANOTHER PERSON TO PREPARE OR MAKE ANY WRITTEN OR ORAL STATEMENT THAT IS INTENDED TO BE PRESENTED TO AN INSURER OR INSURANCE CLAIMANT IN CONNECTION WITH, IN SUPPORT OF, OR IN OPPOSITION TO, A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY, KNOWING THAT THE STATEMENT CONTAINS FALSE OR MISLEADING INFORMATION CONCERNING A FACT OR MATTER MATERIAL TO THE CLAIM IS GUILTY OF A CLASS H FELONY.

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.

If an Agent assisted in the completion of this enrollment form, the agent must sign below.
I, the Agent, certify that I have truly and accurately recorded on the enrollment form the information supplied by the applicant.

Agent's Signature:____ **Date**______/_____/______

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

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