

ENROLLMENT FORM FOR GROUP INSURANCE

Your employer provided information used to create this enrollment form.

Group ID: LANECC	Group Policy #: 000010086742	Billing Division or Location:
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Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name Lane Community College	County Lane	Employer ZIP 97405	State Oregon
Employee First Name / Middle Initial / Last Name	Social Security Number		Date of Birth
Street Address / City / State / Zip			
Gender:	Marital Status:	Home Phone ()	Work Phone ()
Spouse First Name / Middle Initial / Last Name	Spouse Social Security Number	Spouse Date of Birth	

Employee Work Information (Complete for ALL Enrollments)

Average Hours/Week:	Occupation:	Earnings: \$	Full-Time Employment Date:	Rehire Date:
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Product Selection (Complete for ALL Enrollments) All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Basic Coverage NOTE: Please mark the box for all coverage(s) you are applying for.

Effective Date	Type of Coverage	Amount of Coverage	Premium
1/1/2010	Long Term Disability - Buy Up <input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly gross salary x 66.67%, max \$6700	

Management Premium: .024 X Monthly Salary

Classified Premium: .030 X Monthly Salary

Voluntary Coverage

NOTE: Please mark the box for all coverage(s) you are applying for. Selecting yes authorizes my employer to deduct premium(s) via payroll deduction. By selecting no, an application for coverage at a later date may require further medical information and/or physical exam, which will be at my own expense.

Type of Coverage	Amount of Coverage	Premium
Voluntary Employee Life Only Voluntary Employee Life + AD&D	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> Other: \$	
Voluntary Spouse Life Only Voluntary Spouse Life + AD&D	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> Other: \$	
Voluntary Dependent Child Life Only	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000	

Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

The insurance requested on this enrollment form will not be effective until approved by the Home Office of Lincoln National Life Insurance Company, and the initial premium is paid to Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Signature: _____ Date: _____