

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: CACPC	GROUP POLICY #: 000010080420; 000010026514	Billing Division or Location: 137444
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A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) Community Action Committee of Pike County			County Pike	Employer ZIP 45661	State Ohio
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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		Home Phone ()		Work Phone ()

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly \$ _____	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
		Basic Group Life/AD&D <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No*	\$	Employer Paid
		Long Term Disability <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No*	\$	Employer Paid

C. Beneficiary Information (Complete ONLY for Life/AD&D or Accident with AD&D)

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.

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: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

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.

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