



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

OFFICE CODE:	Memo
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Please Use Ink or Type GROUP ID: REGSCHDIS17 GROUP POLICY #:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) Regional School District # 17		County Middlesex	State CT
Social Security Number	Last Name	First Name	MI
Street Address	City	State	Zip
Date of Birth			
<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Spouses Date of Birth	Home Phone
		Work Phone	

Completed By Employer

Effective Date:	Date of Full-Time Employment:	Occupation:
Earnings: \$ _____	<input type="checkbox"/> Union <input type="checkbox"/> Exempt	Average Hours Worked Per Week:
<input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly	<input type="checkbox"/> Non-Union <input type="checkbox"/> Non-Exempt	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Class	Effective Date	Basic Amount <i>Employer to Complete</i>	NOTE: Please mark each box if you are eligible for the listed coverage.		Dental
			Coverage	Amount	
		Per Contract	Group Life <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Single Dental
		Per Contract	Group AD&D <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> EE/Spouse
			Dependent Life <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> EE/Spouse/Children
			Optional Employee Life <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> EE/Children <input type="checkbox"/> One Child
			Optional Dependent Life <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 2 or More Children
			Optional AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No Coverage
			Long Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No		Effective: _____
			Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No		

C. 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.

D. Signature (Complete for ALL Enrollments)

I hereby apply 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. I reserve the right to revoke this deduction at any time on written notice.

Employee Signature

Date Signed

Dental Enrollment is on the back of this Enrollment Form.

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