

****MAIL THIS COMPLETED FORM WITH YOUR PREMIUM AND BILLING CHARGE PAYMENT TO:**
 The Lincoln National Life Insurance Company, P.O. Box 0821, Carol Stream, IL 60132-0821

APPLICATION FOR PORTABILITY

TO AVOID DELAY OF BENEFITS, PLEASE COMPLETE ALL QUESTIONS.

Employer: Please complete and sign the upper section of this form. Please give the form to the employee to complete the lower section.

Employee: Please complete and sign the lower section of this form. Return the completed form with the premium due PLUS the billing charge to the address shown on the top** of this form. We must receive this form within 31 days of "Date Employment Terminated."

This section to be completed by EMPLOYER

Group Name: _____ **Group Policy Number:** _____ **Group ID:** _____

Employee Information:

Employee Name: _____ **Birthdate:** ___/___/___ **Social Security #:** _____ - _____ - _____

Address (Street, City, State, Zip Code): _____

Phone Number: (_____) _____

Spouse Information: (Complete ONLY if Insured)

Spouse's Name: _____ **Birthdate:** _____ **Social Security #:** _____ - _____ - _____

Coverage Eligible to Port	Coverage Amount	Monthly Premium Amount*	Initial Effective Date	Termination Date	Prior Carrier Effective Date
Voluntary Employee Life/AD&D <input type="checkbox"/>	\$ _____	\$ _____	_____	_____	_____
Voluntary Spouse Life/AD&D <input type="checkbox"/>	\$ _____	\$ _____	_____	_____	_____
Voluntary Dependent Life <input type="checkbox"/>	\$ _____	\$ _____	_____	_____	_____
Voluntary LTD <input type="checkbox"/>	\$ _____	\$ _____	_____	_____	_____
STD <input type="checkbox"/>	\$ _____	\$ _____	_____	_____	_____

Date Last Worked: _____ **Date Premium Paid To:** _____

***Use current group rates to calculate Monthly Premium Amount.**

Reason for Termination of Employment (Check ALL that apply)

- Retirement (voluntary termination of employment initiated by employee by meeting age, length of service and/or any other criteria for retirement from the organization)
- Unable to perform each of the main duties of **any** occupation due to sickness or injury.
- Resignation (voluntary termination of employment initiated by employee)
- Dismissal (involuntary termination of employment initiated by employer)
- Other, please explain _____

Employer's Signature _____ **Printed Name** _____ **Date** _____

Company Phone Number: (_____) _____ **Group Fax #:** _____

This section to be completed by EMPLOYEE

Beneficiary Information (Life/AD&D Insurance). If naming more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

Employee's Primary Beneficiary: _____ **Employee's Contingent Beneficiary:** _____

Relationship: _____ **Relationship:** _____

Beneficiary's Address: _____ **Contingent Beneficiary's Address:** _____

Employee's quarterly premium: \$ _____ + \$5.00 Billing Fee** = Total Amount Enclosed: \$ _____
 (Monthly premium x 3)

Spouse's quarterly premium: \$ _____ + \$5.00 Billing Fee** = Total Amount Enclosed: \$ _____
 (Monthly premium x 3)

Child(ren)'s quarterly premium: \$ _____ (No Billing Fee) = Total Amount Enclosed: \$ _____
 (Monthly premium x 3)

I hereby authorize The Lincoln National Life Insurance Company to begin billing directly for my: (check all applicable coverages)

- Voluntary Employee Life
- Voluntary Employee Life and AD&D
- Voluntary Dependent Life
- Voluntary Spouse Life
- Voluntary Spouse Life and AD&D
- Voluntary LTD

Signature of Insured Employee: _____ **Date:** _____

Signature of Insured Spouse: _____ **Date:** _____

Employee e-mail address: _____