



Mail, Fax or E-mail Completed Form to:
The Lincoln National Life Insurance Company
 c/o The Managing Agency Group, Inc.
 One Enterprise Drive, Suite 210
 Shelton, CT 06484
 Phone: 800-243-2534 ext. 3
 Fax: 203-924-0860
 E-Mail: phs@mag-eb.com

ENROLLMENT FORM FOR EMPLOYERS GROUP TRUST

Please use ink or type

GROUP POLICY#

A. Employee Information						
Employer Name/Company Name (Please Print)						State
Social Security Number	Last Name		First Name		MI	
Street Address		City	State	Zip	Date of Birth (mo day yr)	
Male	Marital Status:	Married	Divorced	Spouse Date of Birth	Home Phone	Work Phone
Female		Single	Widowed			
Completed By Employer						
Date of Full-Time Hire: (mo day yr)			Occupation:			
Earnings: \$	_____		Union	Exempt	Average Hours Worked Per Week:	
	Hourly	Monthly	Non-Union	Non-Exempt	Rehire Date: (mo day yr)	
	Weekly	Yearly				
B. Product Selection (Complete for ALL Enrollments)						
Note: Apply for or decline each coverage listed below. Not checking either box will be considered a declination of that coverage.						
Request	Decline					
	Group Life/AD& D					
	Dependent Life					
	Short Term Disability					
	Long Term Disability					
C. Beneficiary Information (Complete ONLY for Life/AD&D Enrollment)						
Primary Beneficiary's Last Name		First	MI	Relationship of Beneficiary	Social Security No.	
Street Address			City	State	ZIP	
Contingent Beneficiary's Last Name		First	MI	Relationship of Beneficiary	Social Security No.	
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. I understand receipt of any coverage greater than the guaranteed issue amount or application for coverage after the approved enrollment period first requires medical underwriting and written approval by Lincoln Financial Group.

Note: A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping defraud) an insurance company.

Employee Signature

Date Signed