

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 & payment 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: (____) _____ Gender: Male Female

Spouse Information: (Complete ONLY if Insured)

Spouse's Name: _____ Birthdate: ____/____/____ Social Security #: _____ - _____ - _____

Coverage Eligible to Port	Coverage Amount/Plan	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"/>	\$ _____	\$ _____	_____	_____	_____
Voluntary Accident <input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____	_____	_____	_____
Long Term Disability <input type="checkbox"/>	\$ _____	\$ _____	_____	_____	_____
Short Term Disability <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: (____) _____ **Employer's Email Address:** _____

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 Accident
- Voluntary Spouse Life Voluntary Spouse Life and AD&D Voluntary LTD
- LTD STD

Signature of Insured Employee: _____ Date: _____

Signature of Insured Spouse: _____ Date: _____

Employee e-mail address: _____

If e-mail address supplied, we will contact you through email. **Did you remember to include your payment?**