

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
 Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066
 Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

GROUP ID: SCMASC	GROUP POLICY #: 00040000100004174 VLIF	Billing Division or Location:	
Employee Information (Complete for ALL Enrollments)			
Employer Name/Company Name (Please Print) South Carolina Medical Association		County	Employer ZIP
State			
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 ()	Occupation
		Average Hours Worked Per Week:	
Completed By Employer			
Earnings: \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly		Date of Full-Time Employment:	Rehire Date:
Product Selection (Complete for ALL Enrollments)			
Voluntary 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.			
TYPE OF COVERAGE		AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life/AD&D Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____	\$ _____
Voluntary Spouse Life/AD&D Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No		\$ _____	\$ _____
Voluntary Dependent Child Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> \$10,000	\$ _____
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.			
Request for Coverages			
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:			
<input type="checkbox"/> REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company. 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.			
<input type="checkbox"/> NOT ENROLL myself in the Program. I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.			
<input type="checkbox"/> NOT ENROLL my dependents in the Program. I understand that if I apply 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: A PERSON COMMITS INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

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, 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 a dependent is in a period of limited activity on the date insurance would otherwise take effect.

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