Lincoln Financial®

Continuity of Coverage Form

The Lincoln National Life Insurance Company
8801 Indian Hills Drive
Omaha, NE 68114-4066
Toll Free (800) 423-2765
LincolnFinancial.com

Please complete this form to determine whether you are eligible for credit upon transfer from your previous employer's group dental plan also referred to as Continuity of Coverage. To avoid claim processing delays, this form should be completed and signed prior to your or your dependents effective date of coverage.

Provide the completed form to Lincoln Financial:

Toll-Free fax: 1-877-573-6177
Email to: lfgenrollments@lfg.com

Mail: Lincoln Financial
Attn: Group Protection
P.O. Box 2616
Omaha, NE 68103-2616

1. Your Information

Employee Name (First, Middle, Last) _____

Date of Birth: _____ /_____ /_____

2. Dependent Information - Complete this section, if applicable (attach a separate sheet, if needed)

Dependent Name (First, Middle, Last): _____

Date of Birth: _____ /_____ /_____

Dependent Name (First, Middle, Last): _____

Date of Birth: _____ /_____ /_____

Dependent Name (First, Middle, Last): _____

Date of Birth: _____ /_____ /_____

3. Previous Group Dental Plan

Previous Group Dental plan name: _____

Covered member name(s): _____

Your previous Dental coverage start date: _____ /_____ /_____

Your previous Dental coverage end date: _____ /_____ /_____

4. Signature

Your Full Name (Print): _____

Your Signature: _____ Date: _____ /_____ /_____

Your Telephone Number: (_____) _____ - _____

Your Address: _____
Street/PO Box City State Zip Code