**The Lincoln National Life Insurance Company**
Group Insurance Service Office
8801 Indian Hills Drive, Omaha, NE 68114
Phone: 800-423-2765 Fax: 877-573-6177

# APPLICATION FOR GROUP INSURANCE

**is made to THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (the Company).**

## A. Group Name & Address

**Applicant's Full Legal Name** (exactly as to be shown in Group Policy)

**Main Office Address** (physical location and group situs state)

Street Address | City | State | Zip

E-Mail Address (if available) | Phone | Fax

## B. Requested Insurance

**The following Group Insurance is applied for as specified in the sold case proposal(s). Complete the requested Effective Date for each.**

| Group Insurance | Requested Effective Date | Group Insurance | Requested Effective Date |
|---|---|---|---|
| ☐ Life & AD&D | ___/___/___ | ☐ Voluntary Life | ___/___/___ |
| ☐ Short Term Disability (STD) | ___/___/___ | ☐ Voluntary Life & AD&D | ___/___/___ |
| ☐ Long Term Disability (LTD) | ___/___/___ | ☐ Voluntary AD&D | ___/___/___ |
| ☐ Dental | ___/___/___ | ☐ Voluntary Short Term Disability | ___/___/___ |
| ☐ Accident | ___/___/___ | ☐ Voluntary Long Term Disability | ___/___/___ |
| ☐ Critical Illness | ___/___/___ | ☐ Voluntary Dental | ___/___/___ |
| ☐ Hospital Indemnity | ___/___/___ | | |

## C. Business Information

**Nature of Business** (Please specify) | **Years in Business** | **Federal Tax ID No.**

**Business is Organized as** (Select one)

☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Non-Profit Organization
☐ Labor Union ☐ Association ☐ Trust ☐ Other_____

**Financial Risk** (If Yes to any part, please explain below.)

Has Applicant ever filed for bankruptcy? ☐ Yes ☐ No
Does Applicant anticipate ceasing or materially reducing active business operations? ☐ Yes ☐ No
Has Applicant opted out (or do they anticipate opting out) of Workers' Compensation? ☐ Yes ☐ No

Explanation:_____

**Binder** payment submitted: Amount $_____(if applicable)

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

## D. Replacement Insurance

Will all or part of this insurance **replace** any similar insurance? **If Yes, provide details of the prior plan below and enclose a copy of each inforce contract to be replaced.** ☐ Yes ☐ No

| Insurance Type | Prior Carrier Name | Prior Plan Effective Date | Termination Date |
|---|---|---|---|
| | | ___/___/___ | ___/___/___ |
| | | ___/___/___ | ___/___/___ |
| | | ___/___/___ | ___/___/___ |
| | | ___/___/___ | ___/___/___ |
| | | ___/___/___ | ___/___/___ |
| | | ___/___/___ | ___/___/___ |

## E. Fraud Warning/State Disclosure(s)

**FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM:**

**ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.**

## F. Agreement

The Applicant applies for group insurance. The information in this Application is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance. Omission or misstatement of known information on this Application could affect the validity of any insurance issued and cause the denial of an otherwise valid claim. The Applicant understands that the requested group insurance will:

(a) be issued only if the requested insurance is legally permissible;
(b) be issued under a group Policy or Policies in the language customarily used by the Company;
(c) be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
(d) be subject to all exclusions, limitations, and other provisions of the Policy; and
(e) take effect on the date determined by the Company, in accord with the provisions of the Policy.

The Applicant understands that no agent or broker has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an employee is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms, and will be subject to any Active Work requirement. The Applicant agrees not to:

(a) collect or pay premiums (other than the Binder Premium, if any) for such insurance, before receiving the Company's notice of approval; or
(b) distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

If dental insurance is requested, the Applicant agrees to provide employees and dependents notice of any applicable continuation rights, required by federal COBRA law or any similar state continuation law. Premium rate quotes were based on data submitted to the Company. Final premium rates will be determined by the actual composition of the group. This application and the Binder payment, if any, constitutes the consideration for any Policy issued. After receipt of the Policy, payment of the premium is deemed acceptance of the Policy's terms and provisions, including its exhibits, riders, endorsements, or amendments, if any. If this Application is approved, it will be made a part of any Policy issued.

Writing Agent
Or Broker's Signature_____

Typed or Printed Name_____

License Number_____ State_____

Signed by Applicant's Authorized Representative:

Signature_____

Typed or Printed Name_____

Title_____

State Signed_____ Date___/___/_____
Must be signed prior to Effective Date

## *PARTICIPATION AGREEMENT*

## *The Lincoln National Life Insurance Company (herein called the Company)*

*Complete only if applying for coverage under The Lincoln National Life Insurance Company Voluntary Insurance Trust.*

**Note: Do not complete in AK, AL, FL, ME, MN, MS, NY, SD, TX, VT, WA or WI.**

Application is hereby made to become a Participating Employer under The Lincoln National Life Insurance Company's Voluntary Insurance Trust, based on the following statements plus the attached application for group insurance coverage. The Group Employer named below (herein called the Employer) understands that if Voluntary Group Term Life and AD&D or Disability Income insurance is requested and approved, such Employer will become a Participating Employer under The Lincoln National Life Insurance Company Voluntary Insurance Trust, situsued in Kansas City, Missouri. The Employer agrees to the terms of the Trust Agreement, each group policy issued to the Trust under which the Employer's employees become insured, and any amendments to them. The Employer understands that group certificates will be supplied and agrees to distribute them to each employee enrolled in the program. After receipt of the group certificates, payment of premium is deemed acceptance of the policy's terms.

The Employer agrees to be responsible for all premiums payable with respect to any of my employees who will be insured under the policy. The Employer agrees to honor and administer on a timely basis the written payroll deduction request of each participant, in the amount required to pay the necessary premium to keep coverage in-force. Payroll deductions will be remitted to the Company on a timely basis, in accord with the billing schedule agreed upon. The Employer agrees to promptly furnish the Company any information reasonably required to administer the coverage and claims under it.

The Employer understands that participation in the program may be terminated at any time by giving prior written notice to the Company. The effective date of termination will be the date the notice is received by the Company's Group Insurance Service Office, or on any later date stated in the notice. The Employer understands that the Company may terminate the Employer's participation based on the following circumstances:

a) at the end of the grace period during which the required premium has not been paid;
b) on any premium due date on which participation in the program falls below a minimum level of 10 employees;
c) on any premium due date when the Employer has failed to perform any duties related to the policy in good faith;
d) on any premium due date after the premium rate has been in effect for at least 12 months (or any longer Rate Guarantee period agreed upon by the Company).

**The Employer understands that the Company may change any premium rate:**

a) when there is a change in the terms of the policy, or in the factors bearing on the risk assumed;
b) when the policy liability is changed as a result of a change in federal, state or local law;
c) when a division, subsidiary or affiliate is added, removed, or relocated;
d) when the number of insured employees has changed by 25% or more since the Rate Guarantee period began;
e) on any premium due date after the expiration of the Rate Guarantee period agreed upon by the Company.

**SIGNATURE**

**I have read and understand the agreement above and will comply with the agreement as stated. I have reviewed, understand and agree to the proposal, rate structure, and enrollment strategy presented to me by the Company representative. I understand that no agent, broker or field representative has any right to bind the requested coverage, alter the terms of the policies or enrollment materials, adjust any claim for benefits, or waive any of the Company's rights or requirements.**

**Group Employer Name & ID** _____

_____ _____

Printed Name of Authorized Company Officer | Signature of Authorized Company Officer

_____ _____

Title | Date