

# The Lincoln National Life Insurance Company

A Stock Company    Home Office Location: Fort Wayne, Indiana  
 Group Insurance Service Office: P.O. Box 2616, Omaha, NE 68103-2616

## ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: BAIRDANDW	GROUP POLICY #:	BILLING DIVISION OR LOCATION:
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### A. Applicant Information (Complete for ALL Enrollments)

Company Name (Please Print) <b>Baird &amp; Warner</b>			County	Employer ZIP	State
Applicant 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 (    )		Work Phone (    )

### Must Be Completed

Average Hours Worked Per Week:	Occupation:		
Annual Earnings: \$ _____	Date of Employment:	Rehire Date:	

### B. 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 Applicant Life Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>** Evidence of Insurability Required for Coverage Amounts over \$100,000</b>	<input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> Other: _____	\$
Voluntary Spouse Life Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>** Evidence of Insurability Required for Coverage Amounts over \$25,000</b>	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> Other: _____	\$
Voluntary Dependent Child Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 5,000 <input type="checkbox"/> 10,000	\$
Voluntary <b>Short Term</b> Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Weekly Benefit Amount \$ _____ \$500 Maximum Benefit	\$
Voluntary <b>Long Term</b> Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Benefit Amount \$ _____ \$5,000 Maximum Benefit	\$

**C. 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.

**E. Request for Coverages**

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

**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.

**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.

**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.

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 applicant is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Applicant Full Name: \_\_\_\_\_ Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Automatic Deduction and Notification Agreement

I hereby authorize **Realty Benefit Services, an affiliate of Dergalis Associates**, to access my checking and/or savings account solely for the purpose of paying premiums for the insurance benefits that I select. The deductions could include health, dental, vision, life and / or disability insurance premiums.

I understand that these deductions will be made periodically and I realize that changes in premiums may result in higher or lower deductions. I further understand that I shall incur additional charges in the event this debit is returned for any reason. In the event that **Realty Benefits Services** is unable to collect my premiums on the first business day of the month, I will be charged \$25.00.

## Notifications

I agree to provide signed written notice at least two weeks in advance in the event I wish to cancel, change or amend my current policies. I further agree to indemnify and hold harmless **Realty Benefit Services, an affiliate of Dergalis Associates**, for charges assessed on my account from my lending institution due to debits for services rendered. I agree to notify **Realty Benefit Services, an affiliate of Dergalis Associates**, in writing of any changes to my bank account. This notice will be at least two weeks in advance of any scheduled payment debits.

I understand that these services are being provided solely through arrangements with **Realty Benefit Services, an affiliate of Dergalis Associates**, my real estate firm and the insurance carrier. I am aware that I must notify **Dergalis Associates** in writing if I no longer work as a licensed Realtor with my current Real Estate firm. This notification is my responsibility, otherwise, **Dergalis Associates** will NOT be able to notify our COBRA administrator, to offer me COBRA benefits, if applicable. If I do NOT notify **Dergalis Associates** within 30 days of my termination, I realize I may continue to get billed for services and benefits that I am no longer eligible to receive and I may forfeit any benefits received or premiums I paid for these benefits beyond my termination date. **NO REFUNDS WILL BE PROVIDED FOR MY FAILURE TO NOTIFY DERGALIS ASSOCIATES OF TERMINATION OR SEPARATION FROM MY REAL ESTATE COMPANY.** I understand that any changes to or termination of my coverage will also affect the coverage I have elected for my dependents.

I have read and accept the terms of the above notification agreement.

SIGNATURE OF INSURED **X**

NAME OF INSURED \_\_\_\_\_ SS # \_\_\_\_\_

REALTY COMPANY \_\_\_\_\_ OFFICE NAME \_\_\_\_\_

WORK EMAIL \_\_\_\_\_ PERSONAL EMAIL \_\_\_\_\_

WORK PHONE \_\_\_\_\_ FAX # \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

SIGNATURE **X** \_\_\_\_\_ DATE \_\_\_\_\_

OF ACCOUNT OWNER\*

\*Note: Signature should be that of the owner of the checking account whose name appears on the check used for deductions.

**ATTACH VOIDED CHECK**

**ATTACH YOUR BUSINESS CARD**