

Lincoln Mutual Life and Casualty Insurance Company

203 10th St. N. / P.O. Box 1918
 Fargo, North Dakota 58107-1918

GROUP INSURANCE ENROLLMENT CARD

STATE		GROUP NUMBER		DIVISION NO.		SOCIAL SECURITY NUMBER																	
NAME - LAST			FIRST			MIDDLE			DATE OF BIRTH MM DD YY			ANNUAL SALARY											
ADDRESS						CITY			STATE		ZIP		SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		DEP LIFE YES <input type="checkbox"/> NO <input type="checkbox"/>		STD YES <input type="checkbox"/> NO <input type="checkbox"/>		LTD YES <input type="checkbox"/> NO <input type="checkbox"/>		SUPPLEMENTAL LIFE AMOUNT YES <input type="checkbox"/> NO <input type="checkbox"/>		
EFFECTIVE DATE M M D D Y Y			CLASS			FULL-TIME EMPLOYMENT DATE M M D D Y Y			MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED			EMPLOYER'S NAME						OCCUPATION					

PRIMARY BENEFICIARY'S NAME: _____ RELATIONSHIP: _____
 (EXAMPLE: "HELEN LOUISE JONES" - NOT "MRS. H.L. JONES")

CONTINGENT BENEFICIARY'S NAME: _____ RELATIONSHIP: _____

REQUEST THE GROUP INSURANCE TO WHICH I AM ENTITLED OR TO WHICH I MAY BECOME ENTITLED UNDER THE PROVISIONS OF THE GROUP POLICY OR POLICIES ISSUED BY THE INS. CO. AND I AUTHORIZE THE PROPER DEDUCTIONS, IF ANY, FROM MY EARNINGS AS MY CONTRIBUTIONS TOWARDS THE COST OF THIS INSURANCE.

EMER SIGN HERE → YOUR SIGNATURE DATE 29000332(6071) 11-94

X

TYPE OR PRINT HARD WITH BALLPOINT

COMPLETE ALL SPACES IN FULL.

THEN FORWARD COMPLETED ORIGINAL AND SECOND COPY TO YOUR GROUP LIFE INSURANCE SALES REPRESENTATIVE.

THIRD COPY IS TO BE RETAINED BY THE EMPLOYER.

COMPLETE AND RETAIN REVERSE SIDE OF THIRD COPY WHEN COVERAGE IS REFUSED.

REFUSAL FORM

NAME OF EMPLOYEE	LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER										
				<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>										
BRANCH OR PLANT														
DEPARTMENT		LOCATION	CITY	STATE										

FO _____
NAME OF EMPLOYER _____

The Group Benefit Plan provided by my employer has been explained to me thoroughly, and I understand it fully. I elect not to participate and understand that I will not be entitled to any benefits provided by the Plan. I make this election voluntarily and under no compulsion or duress.

X _____
SIGNATURE OF EMPLOYEE

_____ WITNESS _____ DATE