EGB Employers Group Benefits

Submit

ENROLLMENT FORM FOR EMPLOYERS GROUP BENEFITS TRUST

Group Number:

Please use ink or type

A. Employee Information

Employer Name/Company Name (Please Print) **State**

Social Security Number **Last Name** **First Name** **MI**

Street Address **City** **State** **Zip** **Date of Birth (mo day yr)**

☐ **Male** **Marital Status:** ☐ **Married** ☐ **Divorced** **Spouse Date of Birth** **Home Phone** **Work Phone**

☐ **Female** ☐ **Single** ☐ **Widowed**

Completed By Employer

Date of Full-Time Hire: (mo day yr) **Occupation:**

Yearly Earnings: $ _____ ☐ **Union** ☐ **Exempt** **Average Hours Worked Per Week:**

☐ **Non-Union** ☐ **Non-Exempt** **Rehire Date: (mo day yr)**

B. Product Selection (Complete for ALL Enrollments)

Note: Apply for or decline each coverage listed below. Not checking either box will be considered a declination of that coverage.

Request	Decline	
☐	☐	**Group Life/AD& D**
☐	☐	**Dependent Life**
☐	☐	**Short Term Disability**
☐	☐	**Long Term Disability**

C. Beneficiary Information (Complete ONLY for Life/AD&D Enrollment)

Primary Beneficiary's Last Name **First** **MI** **Relationship of Beneficiary** **Social Security No.**

Street Address **City** **State** **ZIP**

Contingent Beneficiary's Last Name **First** **MI** **Relationship of Beneficiary** **Social Security No.**

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.

D. Signature (Complete for All Enrollments)

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. I reserve the right to revoke this deduction at any time on written notice. I understand receipt of any coverage greater than the guaranteed issue amount or application for coverage after the approved enrollment period first requires medical underwriting and written approval by The Lincoln National Life Insurance Company.

Note: A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping defraud) an insurance company.

_____ _____

Employee Signature **Date Signed**