The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: MEPRCO	GROUP POLICY #:	Billing Division or Location:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) Metromont Prestress Company			County	Employer ZIP	State
Employee 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: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single		Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week: 40	Occupation:		
Earnings: ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly $_____		Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Basic 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.

Class	Effective Date	Type of Coverage			Amount of Coverage	Total Premium
		Basic Group Life/AD&D	☒ Yes	☐ No*	$	Employer Paid
		Optional Employee Life	☐ Yes	☐ No*	$	$
		Optional Spouse Life	☐ Yes	☐ No*	$	$
		Optional Child Life	☐ Yes	☐ No*	$	$
		Long Term Disability	☒ Yes	☐ No*	$	Employer Paid

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 This section for for Vol. AD&D coverage only. If not electing, check NO and leave the rest of this section blank. If electing, check YES and list the amount of coverage desired		AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Accidental Death & Dismemberment (Standalone)	☐ Yes ☐ No	☐ Employee Only ☐ Employee and Family	$

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

--Actual deductions may vary slightly from above illustrations due to rounding—

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

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 (Please select one)
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 enroll 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 enroll 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 enroll 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.

NOTE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

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, or its insurance partners, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name:_____ Employee Signature:_____ Date:_____

Please print a copy of this form, sign and date, and return to your Human Resources representative.