Lincoln Financial Group®

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

OFFICE CODE:	Memo

Please Use Ink or Type | GROUP ID: TASBGARSN | GROUP POLICY #: 01-0077483

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print)	County	State
Garrison ISD - TASB - Risk Management Fund	Nacogdoches	Texas

Social Security Number	Last Name	First Name	MI

Street Address	City	State	Zip	Date of Birth

☐ Male ☐ Female	Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Spouses Date of Birth	Home Phone	Work Phone

Completed By Employer

Effective Date:	Date of Full-Time Employment:	Occupation:

Earnings: $_____ ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly	☐ Union ☐ Exempt ☐ Non-Union ☐ Non-Exempt	Average Hours Worked Per Week:
		Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Class	Effective Date	Basic Amount *Employer to Complete*	NOTE: Please mark each box if you are eligible for the listed coverage. Coverage			Amount	Dental
		$20,000	Group Life	☒ Yes	☐ No		☐ Single Dental
		$20,000	Group AD&D	☒ Yes	☐ No		☐ EE/Spouse
			Dependent Life	☐ Yes	☐ No		☐ EE/Spouse/Children
			Optional Employee Life	☐ Yes	☐ No		☐ EE/Children ☐ One Child ☐ 2 or More Children
			Optional Dependent Life	☐ Yes	☐ No		☐ No Coverage
			Optional AD&D	☐ Yes	☐ No		
			Long Term Disability	☐ Yes	☐ No		Effective:_____
			Short Term Disability	☐ Yes	☐ No		

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.

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.*

_____ Employee Signature

_____ Date Signed

Dental Enrollment is on the back of this Enrollment Form.

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