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

Here is your Enrollment Form.

Follow these steps to complete the form.
Print clearly in ink.
Step 1: Fill in or confirm your personal information.
Step 2: Fill in dependent information, if any.
Step 3: Select your benefits.
Step 4: Assign beneficiaries.
Step 5: Confirm enrollment.
Step 6: Sign, date & return the form.

Group ID: KEANU

1. Your Personal Information

Group/Employer/Participating Organization Name | County | Zip | State

Kean University

Your First Name | Middle Name/MI | Last Name | Social Security No. | Employee ID No. | Date of Birth

Street Address (Include Apt. or Suite No.) | City | State | Zip

Home Phone | Cell Phone | Work Phone | Email Address

( ) - | ( ) - | ( ) - |

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single Civil Union: ☐ Yes ☐ No

2. Personal Information on Dependents — Complete if you are enrolling dependents.

☐ **Spouse** ☐ **Civil Union Partner**

First Name | Middle Name/MI | Last Name | Social Security No. | Date of Birth

Provide contact information if different than Your information above.

Home Phone | Cell Phone | Work Phone | Email Address

( ) - | ( ) - | ( ) - |

Dependent Children – List all children you are enrolling (attach a separate sheet, if needed).

First Name	Middle Name/MI	Last Name	SSN (Optional)	Gender	DOB	Full-time Student
			- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No
			- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No
			- -	☐ Male ☐ Female	/ /	☐ Yes ☐ No

Employer Completes this Section.

Billing Division or Location:

Sort Group/Code: Payroll Cycle:

Policy #(s):

Average Hours Worked Per Week: ☐ Full-time ☐ Part-time Occupation:

Earnings: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly $ Date of Employment: / /

Actively at Work? ☐ Yes ☐ No Date of Rehire: / /

Continue on Next Page. . .

3. Benefit Selection — Choose your benefits.

Employer Completes this section.		Type of Insurance	Amount of Insurance	Total Premium (Weekly)
Class	**Effective Date**			
_____	_____/_____/_____	Voluntary Life Only ☐ **Yes** ☐ **No***	$_____	$_____
_____	_____/_____/_____	Voluntary Dependent (Spouse or Civil Union Partner Only) Life Only ☐ **Yes** ☐ **No*** *You must be enrolled for Life insurance in order to add spouse* or civil union partner *and/or child insurance.*	$_____	$_____
_____	_____/_____/_____	Voluntary Dependent (Child Only) Life Only ☐ **Yes** ☐ **No*** *You must be enrolled for Life insurance in order to add spouse* or civil union partner *and/or child insurance.*	$_____	$_____
_____	_____/_____/_____	Voluntary Employee AD&D ☐ **Yes** ☐ **No**	$_____	$_____
_____	_____/_____/_____	Voluntary Dependent AD&D (Spouse or Civil Union Partner Only) ☐ **Yes** ☐ **No** *You must be enrolled for AD&D insurance in order to add spouse* or civil union partner *and/or child insurance.*	$_____	$_____

*By selecting "No," application for insurance 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--

4. Select Your Beneficiaries — Choose who receives your insurance benefits.

Primary Beneficiary(ies)
The Primary Beneficiary is the person(s) you identify to receive insurance benefits upon your death.

If more than three Primary Beneficiaries, please attach a separate sheet of paper.
If multiple Primary Beneficiaries, total percentage of all combined must equal 100%.

First Name Middle Initial Last Name

____

Street Address ____________ City ____________ State ______ Zip ______

Social Security Number ______-_____-________
Date of Birth _____/_____/_____
Relationship to You ____________
Percentage ____________%
Phone Number (____) _____-_______

First Name Middle Initial Last Name

____

Street Address ____________ City ____________ State ______ Zip ______

Social Security Number ______-_____-________
Date of Birth _____/_____/_____
Relationship to You ____________
Percentage ____________%
Phone Number (____) _____-_______

First Name Middle Initial Last Name

____

Street Address ____________ City ____________ State ______ Zip ______

Social Security Number ______-_____-________
Date of Birth _____/_____/_____
Relationship to You ____________
Percentage ____________%
Phone Number (____) _____-_______

Contingent Beneficiary(ies) and Other Beneficiary Designations

A Contingent Beneficiary will receive benefits only if the Primary Beneficiary(ies) does not survive you. Please attach a separate sheet to identify a Contingent Beneficiary. If multiple Contingent Beneficiaries, total percentage of all combined must equal 100%. To name a Beneficiary(ies) by product, attach a separate sheet identifying product and beneficiary.

Continue on Next Page. . .

5. Confirm Enrollment

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

☐ **ENROLL FOR INSURANCE for which I am or may become eligible** under the group policies issued by The Lincoln National Life Insurance Company, or its insurance partners. If contributions are required, I authorize my Employer to deduct premium from my pay.

☐ **NOT ENROLL myself in the group insurance offered.** I understand if I enroll for insurance 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 group insurance offered.** I understand if I enroll my dependents for insurance at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

Fraud Warning/State Disclosure(s)

ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

ANY REFERENCE TO CIVIL UNION PARTNER MEANS YOUR CIVIL UNION PARTNER TO THE EXTENT RECOGNIZED BY THE STATE IN WHICH YOU RESIDE, AND INCLUDES PARTNERS IN SAME-SEX RELATIONSHIPS FORMED OUTSIDE OF NEW JERSEY THAT GO BY A DIFFERENT NAME BUT WHICH PROVIDE SUBSTANTIALLY ALL OF THE RIGHTS AND BENEFITS OF MARRIAGE. ANY REFERENCE TO DOMESTIC PARTNER MEANS YOUR DOMESTIC PARTNER WHETHER SAME OR OPPOSITE SEX, REGARDLESS OF REGISTRATION, AND INCLUDES PARTNERS IN SAME-SEX RELATIONSHIPS FORMED OUTSIDE OF NEW JERSEY THAT GO BY A DIFFERENT NAME BUT WHICH PROVIDE SOME BUT NOT ALL OF THE RIGHTS AND OBLIGATIONS OF MARRIAGE.

6. Sign and Return

I understand the group insurance requested will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners. A delayed effective date will apply if you are not Actively at Work/an Active Member. A delayed effective date may apply to your dependent, if he or she is confined in a hospital or health care facility or is in a period of limited activity on the date insurance would otherwise take effect.

I understand that the vision insurance I have elected provides reimbursement for certain vision costs which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my provider or me for vision care expenses that I have incurred may not be covered by my vision care insurance benefit plan.

I understand the information provided is for enrollment in group insurance as offered by my Employer and will not be used for underwriting purposes.

The information provided is complete, true, and accurate to the best of my knowledge.

Your Full Name (Print): _____

Your Signature: X_____ **Date** _____/_____/_____

Complete and return this form.

(Be sure to sign and date the form to start your insurance.)

Questions? Call 800-423-2765