

MAIL THIS COMPLETED FORM WITH YOUR PREMIUM AND BILLING CHARGE PAYMENT TO:
 The Lincoln National Life Insurance Company, P.O. Box 0821, Carol Stream, IL 60132-0821

PORTABILITY FORM FOR VOLUNTARY LIFE AND VOLUNTARY LTD GROUP INSURANCE

Employer: Please complete and sign the upper section of this form. Please give the form to the employee to complete the lower section.

Employee: Please complete and sign the lower section of this form. Return the completed form with the premium due PLUS the billing charge to the address shown on the bottom of this form. We must receive this form within 31 days of "Date Employment Terminated" as shown on this form.

This section to be completed by EMPLOYER

Group Name: _____ **Group Policy Number:** _____ **Group ID:** _____

Employee Information:

Employee Name: _____ Birthdate: ___/___/___ Social Security #: _____ - _____ - _____

Address (Street, City, State, Zip Code): _____

Phone Number: (_____) _____

Spouse Information: (Complete ONLY if Insured)

Spouse's Name: _____ Birthdate: _____ Social Security #: _____ - _____ - _____

Coverage Eligible to Port	Coverage Amount	Monthly Premium Amount*	Initial Effective Date	Termination Date
Voluntary Employee Life/AD&D	<input type="checkbox"/> \$ _____	\$ _____	_____	_____
Voluntary Spouse Life/AD&D	<input type="checkbox"/> \$ _____	\$ _____	_____	_____
Voluntary Dependent Life	<input type="checkbox"/> \$ _____	\$ _____	_____	_____
Voluntary LTD	<input type="checkbox"/> \$ _____	\$ _____	_____	_____

Date Last Worked: _____ **Date Premium Paid To:** _____

***Use current group rates to calculate Monthly Premium Amount.**

Reason for Termination of Employment (Check ALL that apply)

- Retirement (voluntary termination of employment initiated by employee by meeting age, length of service and/or any other criteria for retirement from the organization)
- Unable to perform each of the main duties of **any** occupation due to sickness or injury.
- Resignation (voluntary termination of employment initiated by employee)
- Dismissal (involuntary termination of employment initiated by employer)
- Other, please explain _____

Employer's Signature _____ Printed Name _____ Date _____

Company Phone Number:(_____) _____ **Group Fax #:** _____

This section to be completed by EMPLOYEE

Beneficiary Information (Life/AD&D Insurance). If naming more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

Employee's Primary Beneficiary: _____ Employee's Contingent Beneficiary: _____

Relationship: _____ Relationship: _____

Beneficiary's Address: _____ Contingent Beneficiary's Address: _____

Employee's quarterly premium: \$ _____ + \$5.00 Billing Fee = Total Amount Enclosed: \$ _____
 (Monthly premium x 3)

Spouse's quarterly premium: \$ _____ + \$5.00 Billing Fee = Total Amount Enclosed: \$ _____
 (Monthly premium x 3)

Child(ren)'s quarterly premium: \$ _____ (No Billing Fee) = Total Amount Enclosed: \$ _____
 (Monthly premium x 3)

I hereby authorize The Lincoln National Life Insurance Company to begin billing directly for my: (check all applicable coverages)

- Voluntary Employee Life
- Voluntary Employee Life and AD&D
- Voluntary Dependent Life
- Voluntary Spouse Life
- Voluntary Spouse Life and AD&D
- Voluntary LTD

Signature of Insured Employee: _____ Date: _____

Signature of Insured Spouse: _____ Date: _____

Employee e-mail address: _____