

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

CONTINUATION OF COVERAGE FORM FOR GROUP LIFE INSURANCE

TO AVOID DELAY OF BENEFITS, PLEASE COMPLETE ALL QUESTIONS.

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 top** of this form. We must receive this form within 31 days of "Date Employment Terminated."

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 Continue	Coverage Amount	Monthly Premium Amount*	Initial Effective Date	Termination Date	Prior Carrier Effective Date
Basic Employee Life <input type="checkbox"/>	\$ _____	\$ _____	_____	_____	_____
Basic Employee AD&D <input type="checkbox"/>	\$ _____	\$ _____	_____	_____	_____
Dependent Life <input type="checkbox"/>	\$ _____	\$ _____	_____	_____	_____
Optional Employee Life <input type="checkbox"/>	\$ _____	\$ _____	_____	_____	_____
Optional Employee AD&D <input type="checkbox"/>	\$ _____	\$ _____	_____	_____	_____
Optional Dependent Life <input type="checkbox"/>	\$ _____	\$ _____	_____	_____	_____

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

***To calculate Monthly Premium Amount, see Rate Sheet included on page 2.**

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 **one or more** duties of his/her **regular** occupation or unable to perform such duties on a full-time basis 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)

- Employee Life Optional Employee Life
- Employee Life and AD&D Optional Employee Life and AD&D
- Dependent Life Optional Dependent Life

Signature of Insured Employee: _____ **Date:** _____

Signature of Insured Spouse: _____ **Date:** _____

Employee e-mail address: _____

**BASIC LIFE AND OPTIONAL LIFE CONTINUATION
PREMIUM CALCULATION**

AGE	RATES PER \$1,000 OF COVERAGE
<30	0.13
30-34	0.14
35-39	0.20
40-44	0.32
45-49	0.54
50-54	0.80
55-59	1.20
60-64	1.98
65-69	3.57
70-74	5.04
75-80	10.90

To calculate your monthly premium amount, please follow these instructions:

	EMPLOYEE	SPOUSE
1. List your benefit amount	\$ _____	\$ _____
2. Divide by \$1,000	/\$1,000	/\$1,000
	SUBTOTAL \$ _____	\$ _____
3. Multiply by the rate in the above table for your age	X _____	X _____
	MONTHLY PREMIUM \$ _____	\$ _____

**ACCIDENTAL DEATH & DISMEMBERMENT
PREMIUM CALCULATION**

For Accidental Death & Dismemberment rates, use current group monthly premium.

**DEPENDENT LIFE
PREMIUM CALCULATION**

Dependent Life rates are \$2.00 per \$10,000 of coverage.