Lincoln Financial Group®

Lincoln Life & Annuity Company of New York
Home Office: Syracuse, NY
toll free (800) 423-2765 www.LincolnFinancial.com

****MAIL THIS COMPLETED FORM WITH YOUR PREMIUM AND BILLING FEE PAYMENT TO:**
Lincoln Life & Annuity Company of New York, P.O. Box 7247-0347, Philadelphia, PA 19170-0347

APPLICATION FOR CONTINUATION OF COVERAGE For Voluntary Insurance Coverage

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 Port	Coverage Amount	Monthly Premium Amount*	Initial Effective Date	Termination Date	Prior Carrier Effective Date
Voluntary Employee Life/AD&D	☐ $_____	$_____	_____	_____	_____
Voluntary Spouse Life/AD&D	☐ $_____	$_____	_____	_____	_____
Voluntary Dependent Life	☐ $_____	$_____	_____	_____	_____
Voluntary LTD	☐ $_____	$_____	_____	_____	_____
STD	☐ $_____	$_____	_____	_____	_____

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:

GLA-03727 NY VOL 11/08