Lincoln Financial Group

Lincoln Life & Annuity Company of New York

Home Office: 100 Madison St., Ste 1860, Syracuse, NY 13202
All Group Insurance questions and correspondences sent to:
Group Insurance Service Office
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: DAEMEN2_____

1. Your Personal Information

Group/Employer/Participating Organization Name: Daemen College | County | Zip | State

Your First 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

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

☐ **Spouse**

First Name | Middle Name/MI | Last Name

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	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 Only) Life Only ☐ **Yes** ☐ **No*** *You must be enrolled for Life insurance in order to add spouse and/or child insurance.*	$_____	$_____
_____	_____/_____/_____	Voluntary Dependent (Child Only) Life Only ☐ **Yes** ☐ **No*** *You must be enrolled for Life insurance in order to add spouse 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 Lincoln Life & Annuity Company of New York, 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)

THIS WARNING DOES NOT APPLY TO APPLICATION FOR LIFE INSURANCE:

ACCIDENT AND HEALTH INSURANCE FRAUD. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED $5000 AND THE STATED VALUE OF THE CLAIM FOR EACH VIOLATION.

ACCELERATED DEATH BENEFIT INFORMATION. THIS BENEFIT IS INCLUDED WITH EMPLOYEE LIFE INSURANCE, AT NO ADDITIONAL PREMIUM CHARGE OR COST OF INSURANCE CHARGE. NO LIEN, DISCOUNT, OR ADMINISTRATIVE CHARGE IS ASSOCIATED WITH THIS BENEFIT. RECEIPT OF ACCELERATED DEATH BENEFITS MAY AFFECT ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS AND MAY BE TAXABLE. FOR THIS REASON, EMPLOYEES SHOULD CONSULT THEIR PERSONAL TAX ADVISORS BEFORE CLAIMING THIS BENEFIT.

FOR CRITICAL ILLNESS AND ACCIDENT INSURANCE: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

INSURANCE FOR SHORT TERM DISABILITY, LONG TERM DISABILITY, AND/OR CRITICAL ILLNESS MAY CONTAIN A PRE-EXISTING CONDITION EXCLUSION. PLEASE SEE YOUR CERTIFICATE FOR MORE INFORMATION.

6. Sign and Return

I understand the group insurance requested will not be effective until approved by the Group Insurance Service Office of Lincoln Life & Annuity Company of New York, 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 the information provided is for enrollment in group insurance as offered by my Employer and will not be used for underwriting purposes.

By signing below, you agree that all statements made above are to the best of your knowledge and belief.

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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