Lincoln Financial Group®

APPLICATION FOR PORTABILITY
Accident and Critical Illness

****MAIL THIS COMPLETED FORM WITH YOUR PREMIUM AND BILLING CHARGE PAYMENT TO:**
The Lincoln National Life Insurance Company
1H-20 PO BOX 7894 Fort Wayne, IN 46801-7800

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 to the address shown on the top of this form. We must receive this form and payment within 31 days of the date insurance ends.

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: _____ Gender: ☐ Male ☐ Female

Spouse Information: **(Complete ONLY if Insured)**

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

Coverage Eligible to Port		Coverage Amount/Plan	Monthly Premium Amount*	Initial Effective Date	Termination Date
Accident	☐ Yes ☐ No	$_____	_____	_____	_____
Critical Illness	☐ $_____	$_____	_____	_____	_____
Date Last Worked:	_____		_____	_____	_____
*Use current group rates to calculate Monthly Premium Amount.			_____	_____	_____

Employer's Signature: _____ Printed Name: _____ Date: _____

Company Phone Number: _____ Employer's Email Address: _____

This section to be completed by EMPLOYEE

Beneficiary Information. If naming more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

Employee's Primary Beneficiary: _____

Relationship: _____

Beneficiary's Address: _____

Employee's Contingent Beneficiary: _____

Relationship: _____

Contingent Beneficiary's Address: _____

Employee's quarterly premium: $ _____ = Total Amount Enclosed: $ _____
(Monthly premium x 3)

Spouse's quarterly premium: $ _____ = Total Amount Enclosed: $ _____
(Monthly premium x 3)

Child(ren)'s quarterly premium: $ _____ = 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)

☐ Critical Illness ☐ Accident

Signature of Insured Employee: _____ Date: _____

Signature of Insured Spouse: _____ Date: _____

Employee e-mail address: _____

Employee phone number: _____

If e-mail address supplied, we will contact you through email. **Did you remember to include your payment?**