Lincoln Financial Group

The Lincoln National Life Insurance Company
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: Confirm enrollment.
Step 5: Sign, date & return the form.

Group ID: CGSUNRISE

1. Your Personal Information

Group/Employer/Participating Organization Name: Sunrise Cooperative, Inc. | County | Zip | State: OH

Your First Name | Middle 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 | Social Security No. ___-___-___ | Date of Birth ___/___/___

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	SSN (Optional)	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: ___/___/___

3. Benefit Selection — Choose your benefits.

To apply the appropriate tobacco/non-tobacco rates, please answer the following question:

In the past 12 months, have You or Your Spouse smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?

You: ☐ **Yes** ☐ **No**
Your Spouse: ☐ **Yes** ☐ **No**

Voluntary/Optional Group Insurance

Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions as stated in the policy and certificate.

Employer Completes this section.		**Type of Insurance**	**Amount of Insurance**	**Total Premium (Weekly)**
Class	**Effective Date**			
_____	_____/_____/_____	Voluntary Short Term Disability (STD) ☐ **Yes** ☐ **No***	Weekly Benefit Amount: $_____	$_____
_____	_____/_____/_____	Accident ☐ **Yes** ☐ **No**	☐ Employee ☐ Employee/ Spouse ☐ Employee/ Children ☐ Employee/ Spouse/Children	$_____
_____	_____/_____/_____	Critical Illness ☐ **Yes** ☐ **No*** *You must elect be enrolled for Critical Illness insurance in order to add spouse and/or child insurance.*	You: $_____ Spouse: $_____ Child: $_____	$_____

*By selecting "No," enrolling for insurance at a later date may require further medical information and/or a physical exam, which will be at your own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

4. 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 The Lincoln National Life Insurance Company, 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)

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

5. Sign and Return

I understand the group insurance requested will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, 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 that the vision insurance I have elected provides reimbursement for certain vision costs which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my provider or me for vision care expenses that I have incurred may not be covered by my vision care insurance benefit plan.

I understand the information provided is for enrollment in group insurance as offered by my Employer and will not be used for underwriting purposes.

The information provided is complete, true, and accurate to the best of my knowledge.

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