Lincoln Financial Group®

Application for Portability

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

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 Page 2** 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 & payment 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 #: _____ - _____ - _____ Gender: ☐ Male ☐ Female

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/Plan	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	☐	$ _____	$ _____	_____	_____	_____
Voluntary Accident	☐ Yes ☐ No		$ _____	_____	_____	_____
Long Term Disability	☐	$ _____	$ _____	_____	_____	_____
Short Term Disability	☐	$ _____	$ _____	_____	_____	_____

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: _____ **Date:** _____

Printed Name: _____

Company Phone Number: (____) _____ **Employer's Email Address:** _____

This section to be completed by EMPLOYEE. For questions on completing this section, please contact us at 800-423-2765.

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: _____

Beneficiary's Address: _____

Relationship: _____

Employee's Contingent Beneficiary: _____

Contingent Beneficiary's Address: _____

Relationship: _____

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 Accident

☐ Voluntary Spouse Life ☐ Voluntary Spouse Life and AD&D ☐ Voluntary LTD

☐ LTD ☐ STD

Signature of Insured Employee: _____ Date: _____

Signature of Insured Spouse: _____ Date: _____

Employee e-mail address: _____

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