LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK

Home Office: 100 Madison St., Ste 1860, Syracuse, NY 13202
All Group Insurance questions and correspondence send to:
Group Insurance Service Office
8801 Indian Hills Drive
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: CLCSD	GROUP POLICY #:	Billing Division or Location:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) Central Lyon Community School			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single		Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐Hourly ☐Monthly ☐Weekly ☐Yearly $_____	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage	Amount of Coverage	Total Premium
		Long Term Disability ☐**Yes** ☐**No***	$	$

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

TYPE OF COVERAGE		AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life Insurance	☐**Yes** ☐**No***	$	$
Voluntary Employee Optional AD&D	☐**Yes** ☐**No***	Equal to Life Insurance Amount	$
Voluntary Spouse Life Insurance	☐**Yes** ☐**No***	$	$
Voluntary Spouse Optional AD&D	☐**Yes** ☐**No***	Equal to Life Insurance Amount	$
Voluntary Dependent Child Benefit	☐**Yes** ☐**No***		$

*By selecting No, application for coverage 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--

Please See Last Page for Beneficiary and Signature

C. Beneficiary Information (Complete ONLY for Life/AD&D)

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

Accelerated Death Benefit Information: This benefit is included with your Life insurance, at no additional premium charge. The Death Benefit payable to your Beneficiary upon your death will be reduced by any Accelerated Death Benefits received plus an interest charge. Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs and may be taxable. For this reason, you should consult your personal tax advisor before claiming this benefit.

D. Request for Coverages

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

- ❑ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by Lincoln Life & Annuity Company of New York.** I hereby enroll for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
- ❑ **NOT ENROLL myself in the Program.** I understand that if I enroll for coverage 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 Program.** I understand that if I enroll for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

ACCIDENT & HEALTH INSURANCE FRAUD: Any person who knowingly and with intent to defraud any insurance company or other person:

(1) files an application for insurance or a statement of claim containing any materially false information; or

(2) conceals, for the purpose of misleading, information concerning any fact material thereto;

commits a fraudulent insurance act, which is a crime. Such person shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation.

THIS WARNING DOES NOT APPLY TO APPLICATION FOR LIFE INSURANCE.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of Lincoln Life & Annuity Company of New York, or its insurance partners, and the initial premium is paid to Lincoln Life & Annuity Company of New York. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect. **By signing below, you agree that all statements made above are to the best of your knowledge and belief.**

Employee Full Name:_____ Employee Signature:_____

Date:_____