

# THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

Enrollment/Change Form for the University of Florida #30-0004300

Name: \_\_\_\_\_ UF ID #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Employment: \_\_\_\_\_ Hours worked weekly: \_\_\_\_\_

**TOBACCO USER? Employee:**  Yes  No **Spouse:**  Yes  No

## ENROLLMENT

New Enrollee  Add Spouse  Add Child  Open Enrollment Increase/Year: 20\_\_\_\_

### Amount of insurance applied for with this application:

Employee: \$ \_\_\_\_\_ Spouse: \$ \_\_\_\_\_ Child(ren)\*: \$ \_\_\_\_\_

(Issue amounts: Initial guarantee of \$100,000 for employees, \$50,000 for spouses, and \$25,000 for children. Additional amounts may be added by medical application for employees and spouses. Open enrollment: \$10,000 employees; \$5,000 spouses; \$5,000 per child.)

\*Youngest **eligible** child's name \_\_\_\_\_ and date of birth: \_\_\_\_\_

\*Is this child a full-time student between the ages of 19 and 23?  Yes  No

\*Is this child handicapped?  Yes  No

## INCREASE COVERAGE AMOUNTS BEYOND GUARANTEE ISSUE (by medical application\*)

\*Attach one medical application for each person applying for additional insurance.

Employee: \$ \_\_\_\_\_ Spouse: \$ \_\_\_\_\_ Child(ren): \$ \_\_\_\_\_

## DECREASE COVERAGE Reduce amounts by:

Employee: \$ \_\_\_\_\_ Spouse: \$ \_\_\_\_\_ Child(ren): \$ \_\_\_\_\_

Drop Spouse  Drop Child

## CANCEL COVERAGE Yes

**BENEFICIARIES** You may name any beneficiary at any time by making a written request. Please consult legal counsel prior to naming a minor child (under age 18). Attach separate sheet for multiple beneficiaries.

New  Change  Add to current beneficiary/beneficiaries

Primary Beneficiary \_\_\_\_\_ % Relationship: \_\_\_\_\_

Primary Beneficiary \_\_\_\_\_ % Relationship: \_\_\_\_\_

Contingent Beneficiary \_\_\_\_\_ % Relationship: \_\_\_\_\_

Contingent Beneficiary \_\_\_\_\_ % Relationship: \_\_\_\_\_

## EMPLOYEE AUTHORIZATION

I hereby apply for the above insurance and authorize deduction of premiums from my salary. I understand that it **is my responsibility** to notify University Benefits of changes in the eligibility status of dependent spouse and children prior to the requested effective date of change.

Employee's Signature \_\_\_\_\_

Date \_\_\_\_\_

Work Phone # \_\_\_\_\_

Home Phone # \_\_\_\_\_

NOTICE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM, OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

### TO BE COMPLETED BY UNIVERSITY BENEFITS

Total amount of Insurance including this application:

Employee: \$ \_\_\_\_\_ Spouse: \$ \_\_\_\_\_ Child(ren): \$ \_\_\_\_\_ Effective Date: \_\_\_\_\_

Return completed form to University Benefits, 903 W. University Avenue, Gainesville, FL 32601  
or by campus mail to P. O. Box 115007