

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.)

Eligible dependents must meet the definition under the U.S. IRS Code and not be serving in the armed forces.* This policy covers unmarried children from 14 days old* to age 19. Coverage may continue from age 19 through 25 if enrolled as a full time or part time student in an accredited educational institution. Dependents totally and permanently disabled and who became disabled prior to reaching age 19 may also continue coverage on the plan.

*Refer to plan brochure for more details or contact the Benefits office.

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.