**The Lincoln National Life Insurance Company**
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

GRAY SECTIONS TO BE COMPLETED BY EMPLOYER

# ENROLLMENT FORM FOR DENTAL & VISION INSURANCE

## A. Employee Information (Complete for ALL Enrollments)

| Employee 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 ( ) |
|---|---|---|---|
| | | | |

## B. Product Selection (Complete for ALL Enrollments)

| Class | Effective Date | Type of Coverage | Amount of Coverage | Total Premium |
|---|---|---|---|---|
| | | Dental ☐Yes ☐No | ☐Employee Only<br>☐Employee + 1<br>☐Employee + 2 or More | $ |
| | | Voluntary Vision Care ☐Yes ☐No | ☐Employee Only<br>☐Employee + Spouse<br>☐Employee + Employee Children<br>☐Family | $ |

## C. Dependent and Other Insurance Information (Complete only for Dental and/or Vision)

| | Last Name | First Name | Middle Initial | Gender | Date of Birth |
|---|---|---|---|---|---|
| Spouse: | | | | | |
| Children: | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Are you or any of your eligible dependents covered by any other dental plan? ☐ YES (If YES, please list) ☐ NO

| **Name of Insured** | Insurance Company Name & Phone and Policy Number | **Employer** |
|---|---|---|
| | | |
| | | |

| GROUP ID: OZAUKEE | GROUP POLICY #: | Billing Division or Location: | DOH | WKLY HOURS |
|---|---|---|---|---|
| | | | | |

| Employer Name/Company Name (Please Print) | County: | Employer ZIP: | State |
|---|---|---|---|
| Ozaukee County | Ozaukee | 53074 | WI |

I hereby apply 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.

NOTE: A PERSON COMMITS INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name:_____ Employee Signature:_____ Date:_____