Lincoln Financial Group
PO BOX 2108, Greensboro, NC 27420
Ph: (800) 487-1485 Fax: (800) 819-1987

ENROLLMENT FORM FOR GROUP INSURANCE

Your employer provided information used to create this enrollment form.	Group ID: **MTSBAHELEN**	Group Policy #: ----------	School location

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name **Helena School District #1**		County L & C	Employer ZIP **59601**	State **Montana**
Employee First Name / Middle Initial / Last Name		Social Security Number		Date of Birth
Street Address / City / State / Zip				
Gender:	Marital Status:	Home Phone ( )		Work Phone ( )
Spouse First Name / Middle Initial / Last Name		Spouse Social Security Number		Date of Birth

Employee Work Information (Complete for ALL Enrollments)

Avg. Work Week Hrs:	Occupation:	Earnings annually:**$**	Employment Date:	Rehire Date

Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Mandatory for employees who work 15 hours or more per week.

Class	Effective Date	Type of Coverage	Amount of Coverage		Monthly Premium
	10/1/2019	Basic-Group Life/AD&D	**$25,000___ $27.60** **$50,000___ $55.20**		**$2.30** **$4.60**

Complete optional coverage election Only is you wish to elect additional life coverage above the Basic Coverage selected.

Optional Coverage NOTE: Please mark the box(es) for each coverage you are applying for. All coverage amounts subject to limitations and exclusions as stated in policy.

Type of Coverage	Selecting yes authorizes my employer to payroll deduct premium(s)	Amount of Coverage	Monthly Premium	
Optional Employee Life + AD&D Evidence of Insurability Required for Coverage Amounts Over $100,000 ***Employees must elect optional life coverage in order to elect spouse and/or dependent coverage***	☐**Yes** ☐**No***	☐ $20,000 ☐ $40,000 ☐ $60,000 ☐ $80,000 ☐ $100,000	**Life+AD&D**	
Optional Spouse Life + AD&D Evidence of Insurability Required for Coverage Amounts Over $50,000 ***Employees must elect optional life coverage in order to elect spouse and/or dependent coverage*** ***Spouse coverage selection may not exceed 50% of the Employee optional amount selected.***	☐**Yes** ☐**No***	☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000		
Optional Dependent Child Benefit ***Employees must elect optional life coverage in order to elect spouse and/or dependent coverage***	☐**Yes** ☐**No***	☐ $10,000	$1.00	

*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

Please See Reverse for Beneficiary and Signature.

Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)				
Primary Beneficiary's Last Name First MI			Relationship	Social Security Number
Street Address	City	State	Zip Code	Date of Birth
Contingent Beneficiary's Last Name First MI			Relationship	Social Security Number
Street Address	City	State	Zip Code	Date of Birth
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.				

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 Home Office of Jefferson Pilot Financial Insurance Company, and the initial premium is paid to Jefferson Pilot Financial 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 (Printed): ____

Employee Signature: ____ Date: ______________

Group ID: MTSB Control: 0001