Lincoln Financial Group®

Underwritten by: Lincoln National Life Insurance Company
A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha NE 68114-4066
(800) 423-2765 fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Your employer provided information used to create this enrollment form.	Group ID: **LANDRUMPRO**	Group Policy #:	Billing Division or Location:

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name **Landrum Professional Employer Services**	County	Employer ZIP	State
Employee First Name / Middle Initial / Last Name			Date of Birth
Street Address / City / State / Zip			
Gender:	Marital Status:	Home Phone ( )	Work Phone ( )

Employee Work Information (Complete for ALL Enrollments)

Average Work Week Hours:	Occupation:	Earnings annually:	Full-Time Employment Date:	Rehire Date:

Product Selection (Complete for ALL Enrollments)

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	Selecting yes authorizes my employer to payroll deduct premium(s)	Amount of Coverage	Weekly Premium
Voluntary Long Term Disability	☐Yes ☐No*	**Monthly Benefit Amount:**	
Voluntary Short Term Disability 24 week benefit	☐Yes ☐No*	**Weekly Benefit Amount:**	
Voluntary Short Term Disability 13 week benefit	☐Yes ☐No*	**Weekly Benefit Amount:**	

*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 illustration due to rounding --

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

The insurance requested on this enrollment form will not be effective until approved by the Home Office of Lincoln Financial Group Insurance Company, and the initial premium is paid to Lincoln Financial Group 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.

I understand by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage I have selected.

Employee Full Name: _____

Employee Signature: _____ Date: _____

Group ID: LANDRUMPRO

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Voluntary Long-Term Disability Insurance

Weekly Premium Calculation

John Doe is 33 and earns $2,500.00 Monthly.
$2,500.00 x 0.00111 = $2.78 Weekly premium

Attained Age	Premium Factors
Less than 30	0.00076
30 – 34	0.00111
35 – 39	0.00162
40 – 44	0.00233
45 – 49	0.00406
50 – 54	0.00528
55 – 59	0.00745
60 – 64	0.00651
65 – 69	0.00397
70 – 74	0.00268
75 - 80	0.00291

Bi-Weekly Premium Calculation

John Doe is 33 and earns $2,500.00 Monthly.
$2,500.00 x 0.002215 = $5.54 Bi-Weekly premium

Attained Age	Premium Factors
Less than 30	0.001523
30 – 34	0.002215
35 – 39	0.003231
40 – 44	0.004662
45 – 49	0.008123
50 – 54	0.010569
55 – 59	0.014908
60 – 64	0.013015
65 – 69	0.007938
70 – 74	0.005354
75 - 80	0.005815

Semi-Monthly Premium Calculation

John Doe is 33 and earns $2,500.00 Monthly.
$2,500.00 x 0.00240 = $6.00 Semi-Monthly premium

Attained Age	Premium Factors
Less than 30	0.00165
30 – 34	0.00240
35 – 39	0.00350
40 – 44	0.00505
45 – 49	0.00880
50 – 54	0.01145
55 – 59	0.01615
60 – 64	0.01410
65 – 69	0.00860
70 – 74	0.00580
75 - 80	0.00630

$_____ X _____ = $_____
Your Monthly Salary * Premium Factor Your (Weekly, Bi-weekly or Semi-monthly) Cost

*Maximum covered payroll is $8,333.33 Monthly