



Request for Portability/Extended Continuation
Group Accident, Critical Illness, Hospital Indemnity

Mail this completed form with your initial, quarterly premium payment to:
The Lincoln National Life Insurance Company
PO BOX 4658
Carol Stream IL 60197-4658

To avoid delay of benefits, please complete all questions.

Employer: Please complete and sign the Employer portion of this form. Please give the form to the employee to complete the Employee portion.

Employee: Please complete and sign the Employee portion of this form. Return the completed form with the premium due plus the billing charge (if applicable) to the return address provided on this form. We must receive this form & payment within 31 days of your coverage termination date.

(This section to be completed by the Employer)

Group ID: _____ Group Name: _____ Group Policy Number(s): _____

Employee Information:

Employee Name: _____ Birthdate: ___/___/___

Social Security #: ___/___/___ Gender: [] Male [] Female

Address (Street, City, State, Zip Code): _____ Phone Number:(____) ____ - ____

Spouse Information: (Complete ONLY if Insured)

Spouse Name: _____ Birthdate: ___/___/___

Social Security #: ___/___/___ Gender: [] Male [] Female

Spouse Address: (Street, City, State, Zip Code) _____ Phone Number:(____) ____ - ____

Dependent Child Information: (Complete ONLY if Insured)

Child Name: _____ Birthdate: ___/___/___

Child Name: _____ Birthdate: ___/___/___

Child Name: _____ Birthdate: ___/___/___

Child Name: _____ Birthdate: ___/___/___

Coverages Eligible to Port

Table with 4 columns: Coverage, Amount/Tier, Monthly Premium Amount, Termination Date. Rows include Accident, Accident w/Sickness Hospital Confinement Benefit, Employee Critical Illness, Spouse Critical Illness, Child Critical Illness, Hospital Indemnity.

1Use current group rates to calculate Monthly Premium Amount.

Date Last Worked: ___/___/___ Date Premium Paid To: ___/___/___

Portability/ Extended Continuation is not available when insurance terminates solely because of Your Spouse, Life Partner, or Child ceasing to be an eligible Dependent; Your organization ceasing to be a Participating Organization; nonpayment of Premiums; or Policy termination. Please refer to the Certificate of Coverage for Portability/Extended Continuation Eligibility requirements.

Employer's Signature: _____ Date: _____

Printed Name: _____

Company Phone Number:(____) ____ - ____ Employer's Email Address: _____

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

(This section to be completed by the Employee)

Employee's quarterly premium: \$ _____ + \$5.00 Billing Fee² = Total Amount Enclosed: \$ _____
(Monthly premium x 3)

Preferred Billing Method: Paper² ACH

Preferred Billing Frequency: Monthly (ACH Only) Quarterly Semi-Annually Annually

² If Paper delivery is requested, a \$5.00 Billing Fee will be added to your statements

Authorization Agreement for Automatic Payment of Portability/Extended Continuation (ACH) (Complete ONLY if ACH is selected payment method)

Which day of the month would you like Lincoln to draft your payment? (Please note that initial premiums will be drafted once your request is approved)

(select any day between the 1st thru the 28th) _____

Bank and Account Information

Bank name: _____

Bank routing number: _____

Bank account number: _____

Type of bank account (select one): Checking Savings

I authorize Lincoln Financial Group to collect premiums via ACH upon receipt of this request and continuing thereafter, for payment of my direct billed insurance policy premium. I understand that both Lincoln and its financial institution reserve the right to terminate this payment plan or my direct billed coverage. If I change my financial institution or my account number, or wish to discontinue this agreement, I agree to provide 30 days written notice to Lincoln Financial Group. Lincoln Financial Group assumes no liability for bank charges on these debits.

I agree to the "Authorization Agreement for Payment of Portability/Extended Continuation" terms

I hereby authorize The Lincoln National Life Insurance Company to begin billing directly for my: (check all applicable coverages)

- Accident Accident with Sickness Hospital Confinement Benefit
- Employee Critical Illness Spouse Critical Illness Child Critical Illness
- Hospital Indemnity

Employer's Signature: _____ Date: _____

Signature of Insured Spouse: _____ Date: _____

Employee e-mail address: _____

Spouse e-mail address: _____

If your e-mail address is supplied, we will contact you through email. **Did you remember to include your payment?**