Lincoln Financial Group®

Request For Portability/Extended Continuation

MAIL THIS COMPLETED FORM WITH YOUR PREMIUM PAYMENT TO:
The Lincoln National Life Insurance Company
Servicing Office: PO Box 4658 Carol Stream, IL 60197-4658

SECTION A – EMPLOYER *(must be completed by the Employer)*:

Instructions:

1. The Employee must submit this completed form no later than 31 days[1] from the date their employment ends. You must let the Employee know their Portability rights as soon as their employment ends. If we receive this form after 31 days[1], the request for Portability coverage may be denied.
2. Complete, sign and date Section A of the Portability form.
3. Provide the completed form to the Employee as soon as their employment ends.

[1]The deadline for receipt of the Portability form may vary by state, please refer to your policy.

Lincoln Financial is here to help! For questions, please contact us at 1-800-423-2765.
To avoid delay of benefits, please complete each section of this form.

Section A. Employer

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

Employee Information:

Employee Name:_____

Birthdate: _____/_____ / _____ Social Security #: _____-_____-_____

Address *(Street, City, State, Zip Code)*: _____

Phone Number: (_____) _____-_____ Sex at Birth: ☐ Male ☐ Female

Annual Earnings: $_____ *(please refer to your policy for the Earnings definition)*

Spouse[2] Information: *(Complete ONLY if Insured)*

Spouse Name:_____

Birthdate: _____/_____/_____ Social Security #: _____-_____-_____

Spouse Address *(Street, City, State, Zip Code)*: _____

Phone Number: (_____) _____-_____ Sex at Birth: ☐ Male ☐ Female

[2]Throughout this document, “Spouse” may include a domestic partner or civil union partner.

Dependent Child Information: *(Complete ONLY if Insured)*

If naming more than three children, please attach separate sheet of paper.

Child Name:_____ Birthdate: _____ / _____ / _____

Child Name:_____ Birthdate: _____ / _____ / _____

Child Name:_____ Birthdate: _____ / _____ / _____

Coverage Eligible to Port:

Check all coverage the insured employee is eligible to port/continue.

		Approved Coverage Amount	Monthly Premium Amount[3]	Plan/ Class	Effective Date under Group Policy	Termination Date	Prior Insurance Carrier Effective Date
Basic Employee Life/AD&D	☐	$ _____	$ _____	_____	___/___/_____	___/___/_____	___/___/_____
Basic Dependent Life/AD&D	☐	$ _____	$ _____	_____	___/___/_____	___/___/_____	___/___/_____
Voluntary Employee Life/AD&D	☐	$ _____	$ _____	_____	___/___/_____	___/___/_____	___/___/_____
Voluntary Spouse Life/AD&D	☐	$ _____	$ _____	_____	___/___/_____	___/___/_____	___/___/_____
Voluntary Child Life/AD&D	☐	$ _____	$ _____	_____	___/___/_____	___/___/_____	___/___/_____
Long-Term Disability	☐	$ _____	$ _____	_____	___/___/_____	___/___/_____	___/___/_____
Short-Term Disability	☐	$ _____	$ _____	_____	___/___/_____	___/___/_____	___/___/_____

		Coverage Amount/Tier	Monthly Premium Amount[3]	Termination Date
Accident	☐	_____	$ _____	___/___/_____
Accident Sickness Hospital Confinement Benefit	☐	_____	$ _____	___/___/_____
Employee Critical Illness	☐	$ _____	$ _____	___/___/_____
Spouse Critical Illness	☐	$ _____	$ _____	___/___/_____
Child Critical Illness	☐	$ _____	$ _____	___/___/_____

[3]Use current group rate to calculate "Monthly Premium Amount".

Date Last Worked: _____/_____/_____ **Date Premium Paid To:** _____/_____/_____

Reason Coverage has ended:
Check all that apply.

Portability

- ☐ Employment has ended
- ☐ Reduction in hours
- ☐ Retirement
- ☐ Loss of coverage because employer group policy ended
- ☐ Dependent Spouse or Child(ren) no longer eligible for coverage
- ☐ Unable to perform each of the main duties of **any** occupation due to sickness or injury
- ☐ Unable to perform each of the main duties of **own** occupation due to sickness or injury
- ☐ Other, please explain _____

Dependent Portability *(only applies to Life/AD&D, Accident or Critical Illness)*

- ☐ Loss of coverage due to employee's death
- ☐ Loss of coverage due to Divorce or Dissolution of Partnership
- ☐ Court Order of Dependent
- ☐ Other, please explain _____

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

Employer's Signature _____ **Printed Name**_____**Date** _____

SECTION B – EMPLOYEE *(must be completed by the Employee)*:

You have the choice to continue your insurance coverage even though you're no longer eligible for the employer-sponsored plan. By completing this Portability form, you choose to continue, or "port", your group coverage.

Instructions:

1. Complete, sign and date **Section B** of the Portability form.
2. Return the Portability form and payment to Lincoln Financial Group *(see Premium calculation section)*.
3. Lincoln Financial Group must receive the Portability form and payment no later than 31 days[4] after your employment has ended. If we receive this form after 31 days[4], the request for Portability coverage may be denied.

[4]Contact your employer for the certificate or deadline *(# of days)*.

Lincoln Financial is here to help! For questions, please contact us at 1-800-423-2765.
To avoid delay of benefits, please complete each section of this form.

Section B. Employee

Beneficiary Information: This section only applies to Basic and Voluntary Life/AD&D, Accident and Critical Illness coverage. If you name more than one Primary or Contingent Beneficiary for the Employee, Spouse and/or Child, please attach a separate sheet of paper.

- **Primary Beneficiary:** This is the person(s) who will receive the benefit payment at the time of your death.
- **Contingent Beneficiary:** Also known as a secondary beneficiary, this is the person(s) who will receive the benefit payment if the primary beneficiary dies before you. Naming a contingent beneficiary helps determine who should receive the benefit payment if you outlive your primary beneficiary.

If you name more than one primary or contingent beneficiary, make sure the beneficiary percentages add up to 100% for each type of beneficiary *(primary and contingent)*.

	Employee	**Spouse[2]**	**Child**
Primary Beneficiary Name			
Beneficiary Address			
Relationship			
Percentage			

	Employee	**Spouse[2]**	**Child**
Contingent Beneficiary Name			
Beneficiary Address			
Relationship			
Percentage			

[2]Throughout this document, "Spouse" may include a domestic partner or civil union partner.

Premium Payment: Use the section below to select the premium payment option that works best for you. If you choose to pay your statement by paper, you must pay your premium payment via check, money order or cashier's check. Remember to use the amount ($) noted in the Employer section under the "Monthly Premium Amount" column to calculate your premium.

Preferred Payment Method *(select one)*:

☐ Paper *(A $5.00 Billing Fee will be added to your statements on paper requests.)*

☐ ACH *(Automated Clearing House) (Complete "Authorization Agreement for Automatic Payment of Portability/Extended Continuation" section below for ACH requests.)*

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**

Preferred Payment Frequency *(select one)*: ☐ Monthly *(for ACH Only)* ☐ Quarterly ☐ Semi-Annually ☐ Annually

For Paper: Total Premium Amount Enclosed $ _____ *(please include the $5.00 Billing Fee)*

For ACH: Total Premium Amount to be charged $_____

I hereby authorize The Lincoln National Life Insurance Company to begin billing directly for my:
(check eligible coverages you would like to Port/Continue)

Life		Disability	Accident	Critical Illness
☐ Basic Employee Life/AD&D	☐ Voluntary Employee Life/AD&D	☐ Long-Term Disability	☐ Accident	☐ Employee Critical Illness
☐ Basic Dependent Life/AD&D	☐ Voluntary Spouse Life/AD&D	☐ Short-Term Disability	☐ Accident with Sickness Hospital Confinement	☐ Spouse Critical Illness
	☐ Voluntary Child Life/AD&D			☐ Child Critical Illness

If your email address is supplied, we will contact you through email.

Employee email address: _____

Spouse email address: _____

Signature of Insured Employee: _____ Date: _____

Signature of Insured Spouse: _____ Date: _____

If you chose the ACH payment method, please mail the completed form to the address noted below or return via email to clientservices@lfg.com.

If you chose to pay via check, money order or cashier's check, please mail the completed form, along with your premium payment to:

The Lincoln National Life Insurance Company
PO Box 4658
Carol Stream, IL 60197-4658

Please note: In the event of a conflict between this document and the certificate and/or policy, the certificate and/or policy will control.