Lincoln Financial Group®

**MAIL THIS COMPLETED FORM WITH YOUR PREMIUM AND BILLING CHARGE PAYMENT TO:
The Lincoln National Life Insurance Company, P.O. Box 0821, Carol Stream, IL 60132-0821

CONTINUATION OF COVERAGE FORM FOR GROUP LIFE INSURANCE

TO AVOID DELAY OF BENEFITS, PLEASE COMPLETE ALL QUESTIONS.

Employer: Please complete and sign the upper section of this form. Please give the form to the employee to complete the lower section.

Employee: Please complete and sign the lower section of this form. Return the completed form with the premium due PLUS the billing charge to the address shown on the top** of this form. **We must receive this form & payment within 31 days of "Date Employment Terminated."**

This section to be completed by EMPLOYER

Group Name: Samford University **Group Policy Number**: 000010236836 **Group ID:** SAMFORDUNV

Employee Information:

Employee Name: ______ Birthdate: ___/___/___ Social Security #: ___-___-___

Address (Street, City, State, Zip Code): ______

Phone Number: (___) ______ Gender: ☐ Male ☐ Female

Spouse Information: (Complete ONLY if Insured)

Spouse's Name: ______ Birthdate: ______ Social Security #: ___-___-___

Coverage Eligible to Continue		Coverage Amount	Monthly Premium Amount*	Initial Effective Date	Termination Date	Prior Carrier Effective Date
Basic Employee Life	☐	$	$			
Basic Employee AD&D	☐	$	$			
Dependent Life	☐	$	$			
Optional Employee Life	☐	$	$			
Optional Employee AD&D	☐	$	$			
Optional Dependent Life	☐	$	$			

Date Last Worked: ______ **Date Premium Paid To:** ______

***To calculate Monthly Premium Amount, see Rate Sheet included on page 2.**

Reason for Termination of Employment (Check ALL that apply)

☐ Retirement (voluntary termination of employment initiated by employee by meeting age, length of service and/or any other criteria for retirement from the organization)

☐ Unable to perform **one or more** duties of his/her **regular** occupation or unable to perform such duties on a full-time basis due to sickness or injury.

☐ Resignation (voluntary termination of employment initiated by employee)

☐ Dismissal (involuntary termination of employment initiated by employer)

☐ Other, please explain ______

Employer's Signature ______ Printed Name ______ Date ______

Company Phone Number: (___) ______ **Group Fax #:** ______

This section to be completed by EMPLOYEE

Beneficiary Information (Life/AD&D Insurance). If naming more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

Employee's Primary Beneficiary: ______ Employee's Contingent Beneficiary: ______

Relationship: ______ Relationship: ______

Beneficiary's Address: ______ Contingent Beneficiary's Address: ______

Employee's quarterly premium: $______ + $5.00 Billing Fee** = Total Amount Enclosed: $______
(Monthly premium x 3)

Spouse's quarterly premium: $______ + $5.00 Billing Fee** = Total Amount Enclosed: $______
(Monthly premium x 3)

Child(ren)'s quarterly premium: $______ (No Billing Fee) = Total Amount Enclosed: $______
(Monthly premium x 3)

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

☐ Employee Life ☐ Employee Life and AD&D ☐ Dependent Life

☐ Optional Employee Life ☐ Optional Employee Life and AD&D ☐ Optional Dependent Life

Signature of Insured Employee: ______ Date: ______

Signature of Insured Spouse: ______ Date: ______

Employee e-mail address: ______

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

BASIC LIFE AND OPTIONAL LIFE CONTINUATION
PREMIUM CALCULATION

AGE	RATES PER $1,000 OF COVERAGE
<30	0.13
30-34	0.14
35-39	0.20
40-44	0.32
45-49	0.54
50-54	0.80
55-59	1.20
60-64	1.98
65-69	3.57
70-74	5.04
75-80	10.90

To calculate your monthly premium amount, please follow these instructions:

	EMPLOYEE	SPOUSE
1. List your benefit amount	$____________	$____________
2. Divide by $1,000	/$1,000	/$1,000
SUBTOTAL	$____________	$____________
3. Multiply by the rate in the above table for your age	X____________	X____________
MONTHLY PREMIUM	$____________	$____________

ACCIDENTAL DEATH & DISMEMBERMENT
PREMIUM CALCULATION

For Accidental Death & Dismemberment rates, use current group monthly premium.

DEPENDENT LIFE
PREMIUM CALCULATION

Dependent Life rates are $2.00 per $10,000 of coverage.