Lincoln Enrollment Form 2026/2027

Lake County Board of DD

EMPLOYEE INSTRUCTIONS: Complete Sections A, B, C, D, F and G.					
SECTION A. EMPLOYEE INFORMATION					
FIRST NAME		M.I.	LAST NAME		
STREET ADDRESS			CITY	STATE	ZIP
HOME PHONE		EFFECTIVE DATE	DOB	SSN	
DATE OF EMPLOYMENT		HOURS/WEEK	GENDER (M/F) _____		
EMAIL ADDRESS			SALARY	WORK LOCATION	
ENROLLMENT TYPE: ☐ New Hire ☐ Open Enrollment ☐ Qualifying Event					

SECTION B. DEPENDENT INFORMATION				
SPOUSE NAME	SPOUSE SSN	SPOUSE DOB	GENDER (M/F)	

CHILD NAME (LAST, FIRST)	CHILD SSN	BIRTHDATE	GENDER	RELATIONSHIP

SECTION C. BENEFIT ELECTIONS					
BENEFIT	WAIVE	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	FAMILY
Dental	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐
Accident	☐	☐	☐	☐	☐
Critical Illness	☐	☐	☐	☐	☐
Hospital Indemnity	☐	☐	☐	☐	☐

SECTION D. VOLUNTARY LIFE INSURANCE			
COVERAGE	ELECTION	AMOUNT REQUESTED	LIMITS
Employee	☐ Elect ☐ Waive	$_____	GI $200,000
Spouse	☐ Elect ☐ Waive	$_____	GI $30,000 / Max $50,000
Child(ren)	☐ Elect ☐ Waive	$10,000	$10,000 Coverage

SECTION E. BENEFICIARY DESIGNATION		
BENEFICIARY NAME	RELATIONSHIP	PERCENTAGE

SECTION F. PAYROLL DEDUCTION AUTHORIZATION	
BENEFIT	MONTHLY PAYROLL DEDUCTION
Dental	$_____
Vision	$_____

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Voluntary Life	$_____
Accident	$_____
Critical Illness	$_____
Hospital Indemnity	$_____
Total Monthly Deduction	$_____
SECTION G. EMPLOYEE CERTIFICATION	

I certify the information provided is complete and accurate and authorize payroll deductions for elected benefits.

Employee Signature _____ Date _____

SECTION H. EMPLOYER USE ONLY	
Effective Date	Processed Date
EOI Required ☐ Yes ☐ No	EOI Approved ☐ Yes ☐ No
Processed By	Comments
Lake County Board of DD	Lincoln Financial