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: Western Kentucky University **Group Policy Number**: 000010179082-00000 **Group ID:** WESTKENTUC

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.