



The Lincoln National Life Insurance Company  
 P.O. Box 2616, Omaha, NE 68103-2616  
 Phone: (800) 423-2765 Fax: (877) 573-6177

**ENROLLMENT FORM FOR LTD**

Please Use Ink or Type	GROUP ID: CITMILWAUK	GROUP POLICY #: 000010178968	Billing Division or Location: 1504106
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**A. Employee Information (Complete for ALL Enrollments)**

Employer Name/Company Name (Please Print) <b>City of Milwaukee</b>	Employee ID	Date of Birth (Mo/Day/Yr)
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Employee Last Name	First Name	Middle Initial
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<input type="checkbox"/> CITY	<input type="checkbox"/> HACM	<input type="checkbox"/> RACM	<input type="checkbox"/> MEDC
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Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation:	Date of Full-Time Employment (Mo/Day/Yr):	Rehire Date (Mo/Day/Yr):
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**B. Product Selection (Complete for ALL Enrollments)**

**Basic Coverage NOTE:** Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

**Type of Coverage**

Long Term Disability	Buy-Up Option A – (120 days)	<input type="checkbox"/>
	Buy-Up Option B – (90 days)	<input type="checkbox"/>
	Buy-Up Option C – (60 days)	<input type="checkbox"/>

**C. Request for Coverages**

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

**REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby enroll for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.

**I ELECT TO TERMINATE MY BUY-UP LTD COVERAGE.**

**NOTE: A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.**

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name: \_\_\_\_\_ Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**INSTRUCTIONS: If you intend to enroll in one of the LTD options, complete this enrollment form and return it to DEPARTMENT OF EMPLOYEE RELATIONS, CITY HALL, ROOM 706, 200 EAST WELLS STREET, MILWAUKEE, WI 53202-3560. IF YOU HAVE QUESTIONS, PLEASE CALL EMPLOYEE BENEFITS DIVISION AT (414) 286-3184.**