Duke
Ref #80553

SUPPLEMENTAL TERM LIFE INSURANCE ENROLLMENT FORM

EMPLOYEE NAME:_____ **SS#:**____/____/____
Last First M.I.

ADDRESS:_____ **CITY:**_____ **STATE:**____ **ZIP:**_____
No. Street

SEX: ❑ M ❑ F **BIRTH DATE:**____/____/____ **TITLE:** ❑ MR. ❑ MRS. ❑ MS. **ANNUAL PAY:**_____
(MM/DD/YYYY)

DAYTIME PHONE:_____ **EMPLOYEE I.D.:**_____ **HIRE DATE:**____/____/____

REASON FOR ENROLLMENT

❑ New Enrollment ❑ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)____/____/____

EMPLOYEE COVERAGE

A. Select the annual pay multiple that you desire. Your choice is from 1 to 8 times your annual pay to a maximum of $2,500,000. Plan minimum is 1 times your annual pay.[1] (Coverage is rounded up to the next higher $10,000 increment if not an even $10,000.) A health statement is required if the amount of the increase is greater than the lesser of $500,000 or two times your base annual salary; or if you apply for coverage outside of your initial enrollment or a qualified family status event. A statement of health form will be mailed to the address listed on the Enrollment Form for your completion.
❑ 1x ❑ 2x ❑ 3x ❑ 4x ❑ 5x ❑ 6x ❑ 7x ❑ 8x Annual Pay

B. Have you smoked cigarettes, pipes or cigars or used tobacco in any form in the past 1 year?..... ❑ Yes ❑ No

SPOUSE COVERAGE

A. Select coverage in $10,000 increments between $10,000 and $100,000. A health statement is required if the amount of the increase is greater than $10,000; or if you apply for coverage outside of your initial enrollment or a qualified family status event. A statement of health form will be mailed to the address listed on the Enrollment Form for your completion.[1,2]
I elect the following total amount of coverage for my spouse: $_____

B. Has your spouse smoked cigarettes, pipes or cigars or used tobacco in any form in the past 1 year?..... ❑ Yes ❑ No

NAME:_____ **BIRTH DATE:**____/____/____ **SS#:**____/____/____
Last First M.I. (MM/DD/YYYY)

SEX: ❑ M ❑ F **TITLE:** ❑ MR. ❑ MRS. ❑ MS.

CHILD(REN) COVERAGE

A. Check box of desired coverage:[2] ❑ $10,000

NAME:_____ **BIRTH DATE:**____/____/____ **SEX:** ❑ M ❑ F
Last First M.I. (MM/DD/YYYY)

NAME:_____ **BIRTH DATE:**____/____/____ **SEX:** ❑ M ❑ F
Last First M.I. (MM/DD/YYYY)

If you have more than two children, include their information on a separate sheet.

[1]Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.
[2]Amounts will be subject to state limits, if applicable.

BENEFICIARY DESIGNATION

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the Lincoln Financial Group insurance coverage applied for in this Enrollment Form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.
I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

☐ Check if you need more space for additional beneficiaries and attach a separate page, include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)	Relationship	Date of Birth (MM/DD/YYYY)	Phone #	Address (Street, City, State, Zip)	Share
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				**TOTAL:**	**100%**

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Full Name (First, Middle, Last)	Relationship	Date of Birth (MM/DD/YYYY)	Phone #	Address (Street, City, State, Zip)	Share
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				**TOTAL:**	**100%**

Mercer Voluntary Benefits
P.O. Box 9122, Des Moines, IA 50306-9122
1-800-552-9670 • Fax: 515-365-1520

PLEASE CONTINUE ON THE REVERSE SIDE OF THIS FORM

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by Lincoln Financial Group to determine my insurability.

2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.

3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.

4. I understand that if I do not enroll for life coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that Lincoln Financial Group has approved the coverage or increase.

5. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.

6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.

SIGN & DATE X _____ _____ _____

Signature of Employee | Print Name | Date Signed (MM/DD/YYYY)

Some services in connection with your coverage may be performed by our affiliates, Lincoln Financial Group, a Lincoln Life Assurance Company of Boston company, unless prohibited by state or local law or by mutual agreement with the group customer. These service arrangements in no way alter Lincoln Financial Group's obligation to you. Your coverage will continue to be administered in accordance with Lincoln Financial Group's policies and procedures.

Mercer's Role and Compensation

In this transaction, Mercer Health & Benefits Administration LLC (Mercer Voluntary Benefits) is acting as the exclusive insurance agent and program manager for MetLife (Insurer) for this type of coverage, and not as your insurance broker. As the agent for Insurer, Mercer Voluntary Benefits may provide these services: enrollments, ongoing servicing, billing, marketing, customer administrative and claim servicing and communications. In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. We may also receive additional monetary and nonmonetary compensation from insurers or from other insurance intermediaries, which may be contingent upon such factors as volume, growth or retention of business. This compensation may include payment from insurers for marketing-related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. We will provide you additional information about our compensation upon your request. You may obtain this information by referring to https://www.personal-plans.c/disclosure and entering the security code G3802460 or call us at 1-888-206-5088 for specific details.

Program Administered by Mercer Health & Benefits Administration LLC
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