



Lincoln Mutual Life and Casualty
 4510 13th Avenue South • P.O. Box 1918 • Fargo, North Dakota 58107-1918
 Toll-free 1-800-233-6050 • Fax 701-282-1840 • www.lml.com

Request for Service

Employer/Group _____

(Type or Print)

Employer's Name _____ State _____ Group _____ Division _____
 Group Name _____

Employer's Address _____
 Street _____ City _____ State _____ Zip Code _____

Telephone Number _____ Area Code _____ Number _____ Contact Person: _____
 Phone Number: _____

Please check boxes below for desired action.

Change/Correct

Employer Name

Name _____

Employer Address

Number _____ Street _____ Suite _____

City _____ State _____ Zip Code _____

Change the waiting period for new full-time Employees from _____ month(s) to _____ month(s) of continuous active full time service. Is this waiting period to apply to present full-time employees who have not become eligible prior to the effective date of this change? Yes No

Effective Date _____

Change

Reduction and Termination Provision:

LIFE

AD&D

STD

Reduces _____% at age _____

Reduces _____% at age _____

Reduces _____% at age _____

Reduces _____% at age _____

Term at age _____

Term at age _____

Term at age _____

Effective Date _____

Change the plan to a: Contributory Non-Contributory basis

If Contributory _____% of employee contribution: Life _____ Dependent Life _____ Disability _____ Effective Date _____

Change

Benefits

Classification

	CLASSIFICATION i.e. Managers, Supervisors	LIFE	AD&D	STD*	DEPENDENT LIFE
1					
2					
3					
4					

*Benefits may not exceed 66-2/3% of basic weekly earnings

Effective Date _____

Other Changes _____

Effective Date _____

It is requested that these changes be effective at 12:01 A.M. on the effective date(s) shown above. I understand and agree that any increase in benefits with respect to any insured Employee shall become effective only if such Employee is in active full-time work on the effective date of the increase in benefits; otherwise, such increase in benefits shall become effective on the date of such Employee's return to active full-time work. If a dependent is confined in a hospital on the date an Employee would otherwise become insured with respect to such dependent, the insurance with respect to such dependent shall be deferred until the final discharge from the hospital.

Date _____ Signature _____

(Authorized Company Representative)

Witness _____ Title _____

Do not write below this line

Date _____

(Lincoln Mutual Life Authorized Company Representative)