



Lincoln Mutual
 Life & Casualty Insurance Company
 4510 13th Ave South • P.O. Box 1918
 Fargo, ND 58107-1918
 1-800-233-6050

**GROUP APPLICATION FOR
 VOLUNTARY BENEFITS**

PARTICIPANT INFORMATION

Name of Applicant (Participating Employer)			Contact (Name/Title)		
Mailing Address (Do not use P.O. Box)	Street	City	State	Zip	
Telephone Number	Nature of Business		SIC Code		
Effective Date	First Anniversary	Number of Eligible Employees		Number Enrolled	

Waiting Period:

None Days First of the month following _____ days

Applicable to: Present & Future employees
 Future employees only

SCHEDULE OF BENEFITS (Plan or Plans selected shall be available to all eligible employees)

_____ Term Life Insurance	Term Life Benefits	
_____ Term Life and AD&D Insurance	Employee	Minimum \$10,000; Maximum \$300,000
	Spouse*	Minimum \$5,000; Maximum 50% of employee's benefit
<i>*Contingent on approval of employee coverage</i>	Dependent Child*	10% of employee's benefit; Maximum \$10,000

GENERAL CONDITIONS

1. All active employees who work at least 20 hours a week are eligible.
2. It is understood that employee coverage is subject to the following conditions: Each employee must make written application to Lincoln Mutual; his/her application must be accepted on the basis of such evidence of insurability as We may require; and he/she must be Actively at Work on his/her effective date. If not Actively at Work on the day coverage would otherwise be effective, an employee's coverage will be effective on the date of his/her return to Active Work (as defined in the policy).
3. Premiums are due and payable monthly on the first day of each month.
4. It is further understood that I have read and understand all the sections of this application.

The above information is accurate to the best of my knowledge. I understand that the information on this application and any other information I provide shall serve as the basis for the insurance to be issued, and that I have a duty to notify the Company of any changes. I have relied upon no oral or written representations that contradict item (1) above.

_____ Authorized Signature	_____ Date	_____ Licensed Resident Agent (if required)
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Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.