Fairfield Board of Education Enrollment Form

Group Life and Disability Insurance

Please return completed form to your benefits department

Employer Name	Group Policy Number
Fairfield Board of Education	01-531705
Employer Address (City, State, ZIP Code)	Coverage Effective Date: For office use only
501 Kings Highway East Fairfield, CT 06825	

Employee Name (Last, First, Middle)			
Address (City, State, ZIP Code)			
Social Security Number	Date of Birth (MM/DD/YY)	Gender	Marital Status
		☐ Male ☐ Female	☐ Single ☐ Divorced ☐ Married ☐ Widowed
Hire Date (MM/DD/YY)	Annual Salary	Type of Enrollment	
	$	☐ New Employee ☐ Qualified Life Event	☐ Annual/Open Enrollment ☐ Rehire Rehire Date:

Coverage Elections

Please indicate your coverage elections below. Please see your plan booklet for additional information.

Type of Coverage	Selection
Employee Basic Life (Employer Paid)	☐ Yes ☐ No
Employee Optional Long-Term Disability	☐ Yes ☐ No

Employee Signature and Authorization	
☐	ACCEPT: I declare that all information given in this enrollment form is true and complete to the best of my knowledge and belief. I request coverage under my employer's plan of benefits as indicated above. I authorize my employer to deduct from my earnings my contributions for the coverage(s) selected. I understand that with respect to coverages I have declined, Lincoln Financial Group has the right to require Evidence of Insurability in order to consider any later request to change this decision and that my request may be denied. I am an employee in active employment working at the employer's regular place of business.
☐	DECLINE: I hereby decline all optional coverage as offered by my employer. I certify that I have been given the opportunity by my employer to enroll for coverage. I understand that Lincoln Financial Group has the right to require Evidence of Insurability in order to consider any later request to change this decision and that my request may be denied. I am an employee in active employment working at the employer's regular place of business.
Employee Signature:	Date:

Completion of this enrollment form does not guarantee coverage. Evidence of Insurability may be required. Please see your plan booklet for additional information.

Submit completed form to your employer and retain a copy for your records.