

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
 Group Insurance Service Office: P.O. Box 2616, Omaha, NE 68103-2616
 Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE Please Use Ink or Type

GROUP ID: COOPPHYS	GROUP POLICY #: LTD 125649 / Life 11370	CONTRACT HOLDER NAME: Cooperative of American Physicians, Inc.
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A. Member Information (Complete for ALL Enrollments)				
Member Last Name	First Name	Middle Initial	Member Number	Date of Birth
Billing Address			City	State Zip
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		Home Phone ()	Specialty

B. Product Selection (Complete for ALL Enrollments)

NOTE: Please mark Yes or No for each coverage.
 All coverage amounts are subject to the limitations and exclusions as stated in the policy.

TYPE OF COVERAGE	AMOUNT OF COVERAGE
Disability Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	Income: \$120,000 or more <input type="checkbox"/> Yes <input type="checkbox"/> No* *If "No" please indicate amount \$ _____
Life Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$100,000 or <input type="checkbox"/> \$200,000

C. Beneficiary Information (Complete ONLY for Voluntary Life Enrollments)

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary
Street Address			City State Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary
Street Address			City State Zip

NOTICE: CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

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, 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 a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Member Full Name: _____ Member Signature:  _____ Date: _____

Please fax Confidentially to 213-477-2125