



Lincoln Financial
Benefits Appeal Form

Employee Name: \_\_\_\_\_ Employee ID: \_\_\_\_\_

I wish to: \_\_\_ Enroll \_\_\_ Drop \_\_\_ Other: \_\_\_\_\_

For: \_\_\_ Employee \_\_\_ Spouse/Domestic Partner \_\_\_ Child/Domestic Child

\_\_\_ Medical Coverage Name of Medical Plan Elected: \_\_\_\_\_

\_\_\_ Dental Coverage

\_\_\_ Vision Coverage

\_\_\_ Health Care FSA \$ \_\_\_\_\_ Annual Amount Elected

\_\_\_ Dependent Care FSA \$ \_\_\_\_\_ Annual Amount Elected

\_\_\_ Other \_\_\_\_\_

If enrolling or dropping coverage for a dependent:

Dependent Name: \_\_\_\_\_ Dependent Name: \_\_\_\_\_

Dependent Name: \_\_\_\_\_ Dependent Name: \_\_\_\_\_

Instructions: Please describe all details related to your appeal for the Benefits Appeals Committee ("Committee") to review. The Committee will use this information to make their decision. Please attach this completed form including any supporting documentation and email them to: LincolnHRBenefits@lfg.com. Please note, the formal submission will be considered as the date your email is received. You will receive a written decision from the Committee within 60 days.

Should you have any questions, please call the Lincoln Benefits Service Center at 833-418-1944.

Large empty rectangular box for providing details or supporting documentation.

Print Name \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_