The Lincoln National Life Insurance Company
PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as the "Company")

Application for Individual Life Insurance – General Instructions

Thank you for the opportunity to provide your insurance. Please follow the instructions carefully and accurately.

- Answer all questions on each page and record each answer in complete detail using black or blue ink.
- **DO NOT USE correction fluid/tape or any similar item. If you need to change answers draw a line through the mistake and have the change initialed and dated by the Owner(s), unless it is a health question, in which case the change should be initialed and dated by the Proposed Insured.**
- Have the Proposed Insured(s) and Owner(s) read the application to confirm that all questions are answered accurately, then sign and date the application.
- The **LICENSED AGENT OR BROKER** must complete, sign and date the **AGENT'S REPORT**.
- While completion of the applicable Medical Supplement (Part II of Application) is not required if a full paramedical or medical examination is necessary, answering all medical questions will enable the underwriter to promptly begin the underwriting process. (See Underwriting Guidelines for further details.)
- If a full paramedical or medical exam is over 90 days old the applicable Medical Supplement (Part II of Application) must be completed.
- If applying for Variable Life Insurance please complete the Suitability Section on Page 5. The completed VUL/SVUL Allocation form must accompany the application.
- Some products have limited billing options. Refer to product specifications for complete details and billing options.

Authority

No agent, broker, registered representative or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.

Temporary Life Insurance Agreement (TIA)

If payment is made with the application, you must give a copy of the TIA to the Owner(s). Do not accept money orders or cash. If you are submitting applications for alternate or multiple applications, only one TIA per Proposed Insured may be in effect at a time. Please refer to the TIA for details.

- **Payment with Application May Not Be Submitted if:**
  1. The life insurance applied for exceeds $3,000,000 on any one life including optional benefit riders.
  2. Any Proposed Insured's age is less than 15 days or in excess of 70 years.
  3. Any of the questions at the beginning of the TIA are answered YES or LEFT BLANK.
- **If the Payment with Application Rules allow payment to be submitted, please follow these guidelines:**
  1. Submit acceptable form of payment with application. (See TIA for available methods of payment or special limitations.) Checks must be current dated and made payable to The Lincoln National Life Insurance Company.
  2. The TIA must be signed and dated by the Proposed Insured(s) and Owner(s). The Licensed Agent, Broker or Registered Representative must also sign as Witness.
  3. Provide a copy of the TIA to the Owner(s) and submit with the application.

Special Instructions

- **All applicants must complete the Application for Individual Life Insurance – Part I and if applicable, Medical Supplement (Part II).**
- If there is more than one Proposed Insured complete and submit the following: Application for Individual Life Insurance-Part I, the Proposed Insured B Supplement and if applicable, the Medical Supplement (Part II) for each Proposed Insured.
- The Defined Age Supplement must be completed if either Proposed Insured is age 70 or older.
- Question 23; enter Owner information here. If the Owner is a trust, include the name of the trust and all trustees. A Certification of Trustee Powers form should also be completed and submitted.
- If additional space is needed for any questions, complete the Continuation of Details Supplement.

The Lincoln National Life Insurance Company
Service Office: PO Box 21008, Greensboro, NC 27420-1008
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(Please give a copy of this notice to the Proposed Insured.)

Important Notice

Since you are applying for insurance, we would like you to know more about our underwriting process.

The Underwriting Process

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes their fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history, financial status and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information. In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on information contained in your report. This information is obtained from various sources such as, collection agencies, lenders, creditors, courts and utilities. We may use this information to decide whether to insure you or how much to charge. We may use a third party in connection with the development of your insurance score. You may request a copy of this report by writing to: The Lincoln National Life Insurance Company, PO Box 21008, Greensboro, NC 27420-1008.

Investigative Consumer Report

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews may be conducted with a business, banks, accountants, or other financial advisors or other references as designated by the applicant. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

Contestability

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

Pharmacy Benefit Manager (Rx Database Search)

We may request information on the medications you are taking provided by a Pharmacy Benefit Manager. If any adverse action is taken based on the information provided, we will notify you in writing and also provide you with the name, address and telephone number of the provider if you wish to obtain a copy of the pharmaceutical report.

MIB, Inc.

Information you provide regarding your insurability or claims will be treated as confidential except that the Company or its reinsurers may make a brief report of it to MIB, Inc. This is a not-for-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. at: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. You can reach MIB, Inc. by phone toll free at (866) 692-6901.

Lincoln Financial Group®

The Lincoln National Life Insurance Company
Service Office: PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as the "Company")

Application for Individual Life Insurance — Part I

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Proposed Insured

1. _____ /_____ /_____ /_____
   Legal Name: *(First)* *(Middle)* *(Last)* *(Suffix)*
2. Sex: ☐ Male ☐ Female
3. Date of Birth *(mm/dd/yyyy):* _____ /_____ /_____
   (If age 70 or over, complete the Defined Age Supplement.)
4. SSN: _____
5. Place of Birth *(State/Country)*: _____ /_____
6. Are you *(check one)*: ☐ a Citizen of the U.S. or ☐ Permanent Resident of the U.S. (Green Card Holder) or ☐ Neither?

   If "Neither," a. What is your country of citizenship? _____

   b. What is your National Identification Number (in country of citizenship)? _____
7. Driver's License Number *(provide even if suspended/revoked)*: _____ State: _____

   If no current license, check here ☐ and advise reason: _____
8. Home Address *(Street)*: _____ Apt. or Suite: _____

   (City/State/ZIP): _____ /_____ /_____
9. Home Phone Number: _____ - _____ - _____
10. Cell Number: _____ - _____ - _____
11. Email: _____
12. Employer: _____
13. Occupation: _____
14. Business Address *(Street)*: _____ Suite: _____

    (City/State/ZIP): _____ /_____ /_____
15. Individual Annual Earned Income: $_____
16. Net Worth *(Assets minus Liabilities)*: $_____
17. Do you have any other sources of recurring income? ☐ Yes ☐ No

    If "Yes," a. Source(s) of Income: _____ b. Annual amount(s) received: $_____

Policy Information

18. Plan of Insurance *(if Term, include duration)*: _____
19. Amount of Insurance/Specified Amount: $_____
20. Death Benefit Option: *(Complete for Universal Life and Variable Universal Life Product only–not required for Term)*
    ☐ Level ☐ Increase by Cash Value ☐ Increase by Premium ☐ Increase by Premium Less Policy Factor
21. Death Benefit Qualification Test (DBQT) – For IRS purposes, premiums will be tested using the Guideline Premium Test unless
    ☐ Cash Value Accumulation Test is checked (not available on all products or with all riders). **The DBQT cannot be changed after issue unless the terms of the policy require a change.**
22. Additional Benefits and Riders: *(If applicable)*
    ☐ Accelerated Benefits Rider with Chronic Illness _____ *(Complete applicable supplement)*
    ☐ Accelerated Benefits Rider without Chronic Illness
    ☐ Children's Term Rider Units _____ *(Complete Children's Term Rider Supplement)*
    ☐ Other Insured Term Rider $_____ *(Complete Proposed Insured B Supplement)*
    ☐ Disability Waiver Rider (*If applicable,* Specified Premium $_____)
    ☐ Enhanced Surrender Value Rider _____
    ☐ Other Benefits and Riders not listed above *(Provide details: coverage amount, percentages, etc.; and if applicable complete supplement):*

    _____

Owner Information *(If left blank, Proposed Insured(s) will be the Owner.)* Select Owner Type:

23. a. ☐ Individual Owner: _____ /_____ /_____ /_____
(First) (M.I.) (Last) (Suffix)

☐ Trust/Entity Owner: _____

Trustee/Officer: _____ /_____ /_____ /_____
(First) (M.I.) (Last) (Suffix)

b. Address *(Street)*: _____ Apt. or Suite: _____

(City/State/ZIP): _____ /_____ /_____

c. Date of Birth/Trust Date *(mm/*dd*/yyyy)*: _____ /_____ /_____ d. SSN/TIN: _____

e. Home Phone Number: _____ - _____ - _____ f. Cell Number: _____ - _____ - _____

g. Country of citizenship: _____ h. Relationship to Proposed Insured(s): _____

i. Owner's Email: _____

24. Is this policy being purchased as part of an employer-owned life insurance program where the employer is the direct or indirect beneficiary of the policy? ☐ Yes ☐ No

Beneficiary Information *(Unless otherwise stated in Number 28 "Special Instructions," if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.)*

Select Primary (P) or Contingent (C) and Type for each line completed. **Check here ☐ if Primary Beneficiary same as Owner.**

25. a. ☐ **P** ☐ **C** ☐ Individual: _____ /_____ /_____ /_____
(First) (M.I.) (Last) (Suffix)

☐ Trust/Entity: _____

Trustee/Officer: _____ /_____ /_____ /_____
(First) (M.I.) (Last) (Suffix)

b. Address *(Street)*: _____ Apt. or Suite: _____

(City/State/ZIP): _____ /_____ /_____

c. Relationship to Proposed Insured(s): _____ d. Date of Birth/Trust Date *(mm/dd/yyyy)*: _____ /_____ /_____

e. Beneficiary's Email: _____

f. SSN/TIN: _____ g. Phone Number: _____ - _____ - _____

26. a. ☐ **P** ☐ **C** ☐ Individual: _____ /_____ /_____ /_____
(First) (M.I.) (Last) (Suffix)

☐ Trust/Entity: _____

Trustee/Officer: _____ /_____ /_____ /_____
(First) (M.I.) (Last) (Suffix)

b. Address *(Street)*: _____ Apt. or Suite: _____

(City/State/ZIP): _____ /_____ /_____

c. Relationship to Proposed Insured(s): _____ d. Date of Birth/Trust Date *(mm/dd/yyyy)*: _____ /_____ /_____

e. Beneficiary's Email: _____

f. SSN/TIN: _____ g. Phone Number: _____ - _____ - _____

27. a. ☐ **P** ☐ **C** ☐ Individual: _____ /_____ /_____ /_____
(First) (M.I.) (Last) (Suffix)

☐ Trust/Entity: _____

Trustee/Officer: _____ /_____ /_____ /_____
(First) (M.I.) (Last) (Suffix)

b. Address *(Street)*: _____ Apt. or Suite: _____

(City/State/ZIP): _____ /_____ /_____

c. Relationship to Proposed Insured(s): _____ d. Date of Birth/Trust Date *(mm/dd/yyyy)*: ____ /____ /_____

e. Beneficiary's Email: _____

f. SSN/TIN: _____ g. Phone Number: _____ - _____ - _____

28. Special Instructions *(If proceeds are not to be paid equally indicate here. Dollar amounts are not accepted; percentages must total 100%.)*: _____

Premium and Payor Information *(We cannot bill to your agent, and not all payment methods/modes are available with all products.)*

29. Modal Planned Premium: $_____

30. a. Payment Method: ☐ Electronic Funds Transfer (EFT) ☐ Direct Bill *(Quarterly and Monthly restrictions apply)*
☐ Other *(Include List Bill Number if applicable.)*: _____

b. Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly (Term–EFT only)
☐ Monthly (All products–EFT only) ☐ Lump Sum

31. Source of Premium *(Income, savings, replacement, inheritance, etc.)*: _____

32. a. Select Premium Payor: *(Check one only.) (If Other is checked, complete Questions 32b through 32e.)*
☐ Proposed Insured(s) at residence ☐ Owner ☐ Beneficiary in Question: ☐ 25 ☐ 26 ☐ 27 ☐ Other

b. Payor Name *(Select One)*:

☐ Individual: _____ /_____ / _____ /_____
(First) *(M.I.)* *(Last)* *(Suffix)*

☐ Entity: _____

c. Payor Address *(Street)*: _____ Apt. or Suite: _____

(City/State/ZIP): _____ /_____ /_____

d. SSN/TIN: _____ e. Relationship to Proposed Insured(s): _____

Third Party Designee/Secondary Addressee *(For additional protection against unintended lapse, you may designate a Third Party below other than your agent. The agent will automatically receive any such notices.)*

33. I, the Applicant/Owner, understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I also understand that I will be given the opportunity to change this written designation at any time.

Complete name/address below if you choose to designate a Third Party Designee or Secondary Addressee:

Name: _____ /_____ /_____ /_____
(First) *(M.I.)* *(Last)* *(Suffix)*

Home Address *(Street)*: _____ Apt. or Suite: _____

(City/State/ZIP): _____ /_____ /_____

Phone Number: _____ - _____ - _____

Existing and Pending Insurance Information

34. Are you considering replacing, lapsing, stopping premium payments, surrendering, assigning to the insurer or reducing your benefits under an existing policy or annuity? *(If "Yes," complete all required replacement forms.)* ☐ Y ☐ N

35. Are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? *(If "Yes," complete all required replacement forms.)* ☐ Y ☐ N

36. If "Yes" to Question 34 and/or 35 with regard to an annuity contract, provide company, contract number and issue date:

_____

37. List amounts of all in force life insurance on your life, including any policies that have been sold. *(List in the box below.)*
If none, check here: ☐
Indicate the Type of coverage: Business: Buy-Sell (**B**), Key-Man (**K**) or Loan (**L**); Group (**G**); or Personal (**P**).

Company	Face Amount	Policy Number	Issue Date *(mm/dd/yy)*	Replacement or Change of Policy?	1035 Exchange	Type
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	

38. Regardless of the status of the application, do you have any applications currently pending, do you plan to apply for, or did you apply for additional life insurance coverage with this or any other company within the past 12 months? *(If "Yes," provide details in box below. Do not include existing coverage listed in Question 37.)* ☐Y ☐N

Company	Face Amount	Status *(Pending, Withdrawn, etc.)*	Type *(B,K,L,P)*
	$		
	$		
	$		

39. What is the total amount of **new** life insurance coverage that will be placed in force with **all companies including this application**? *(Do not include existing coverage listed in Question 37.)* $ _____
40. Will the premiums for this policy be paid, advanced, financed or otherwise funded by another person or entity who is not the Proposed Insured, the Owner, or the Proposed Insured's employer? *(If "Yes," complete the Premium Financing requirements.)* ☐Y ☐N
41. Have you ever applied for life, long-term care, health or disability insurance and been rated, declined or postponed? *(If "Yes," provide the reason(s) for the outcome and details in the space provided.)* ☐Y ☐N

General Information—Proposed Insured

42. Do you fly, do you plan to fly within the next 2 years, or have you flown during the last 2 years as a pilot, student pilot or crew member? *(If "Yes," an Aviation Supplement is required.)* ☐Y ☐N
43. Do you plan to participate within the next 2 years, or have you participated within the last 2 years in; underwater diving; mountain climbing; aerial sports; auto, motorcycle, or boat racing; heli skiing; rodeo sports; boxing; equine sports; or extreme sports? *(If "Yes," an Avocation Supplement is required.)* ☐Y ☐N
44. Do you now, or do you plan to within the next year, reside or travel outside of the United States or Canada? *(If "Yes," provide the purpose, total number of days, cities and countries where travel is planned in Number 49 below.)* ☐Y ☐N
45. Are you a member of the Military Armed Forces, Military Reserves or National Guard? *(If "Yes," indicate if retired or active; list branch of service, rank, duties, Special Forces status, mobilization category, and current duty station; and if a notice of deployment has been received, to where and when in Number 49 below.)* ☐Y ☐N
46. In the past 5 years, have you been convicted of three or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted, or revoked? *(If "Yes," provide dates and details in Number 49 below.)* ☐Y ☐N
47. Have you ever been convicted of a felony? *(If "Yes," provide details in Number 49 below including date of conviction and date of release of probation or parole.)* ☐Y ☐N
48. a. In the last 5 years have you filed for bankruptcy? ☐Y ☐N
    b. If "Yes," has it been discharged? *(For any bankruptcy, provide reason, type, and if applicable, when discharged in Number 49.)* ☐Y ☐N
49. Details to General Risk Questions: *(If more space is needed, use the Continuation of Details Supplement.)*
Ques. # Date Details/Reasons

Service Office Endorsements *(For Company Use Only. We will attach additional documentation as needed.)*

Suitability

Complete only if applying for Variable Life Insurance and submit allocation form(s) with this Application:

1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	☐ Y ☐ N
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	☐ Y ☐ N
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	☐ Y ☐ N
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	☐ Y ☐ N

CASH VALUES ARE NOT GUARANTEED AND MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS. Refer to the contract for information on any no-lapse guarantee that may be provided.

Agreement and Acknowledgement

I, the Owner, certify that the tax identification or social security number as provided by me is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Application for Individual Life Insurance — Part I; b) Medical Supplement — Part II; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. I/We further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me/us; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured(s); and 3) the Proposed Insured(s) remain in the same state of health and insurability to the best of the Proposed Insured's knowledge or belief as described in each part of the application at the time conditions 1) and 2) are met.

   I/We have paid premium to the agent/representative in exchange for the Temporary Life Insurance Agreement, and I/we acknowledge that I/we fully understand and accept its terms. *(Complete Temporary Life Insurance Agreement and submit with application.)*
3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
5. For policies held in trust by one or more trustees, the undersigned certify and acknowledge the following. The trust arrangement is identified by name and date, the trust is in effect, and the trustees named in this application are the trustees for the named trust. The trustees signing this application have the power and authority to act and exercise all ownership rights under the policy, and the Company may rely solely upon the signatures of the trustees regarding any policy options, privileges or benefits. Any amounts paid to the trustees by the Company according to the policy shall fully discharge the Company with respect to those amounts. The Company shall have no obligation to inquire into the terms of the trust or to see to the use or application of any amounts paid to the trustees. The Company shall not be held liable for any party's non-compliance with the terms of the trust.
6. Corrections, additions or changes to this Application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.
7. I have been advised to consult with my own tax advisors regarding the tax effects inherent in the plan of insurance for which I am applying.
8. I HAVE READ, or have had read to me, the completed Application before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true to the best of my knowledge and belief. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. **Caution: If your answers on this application are misstated or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.**

State Disclosure

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Authorization

I, the Proposed Insured authorize any licensed physician, medical professional, hospital, clinic or any other medical institution, Pharmacy Benefit Manager, insurance support organizations, insurance company, Medical Information Bureau (MIB, Inc.), state motor vehicle division, consumer reporting agency, Social Security Administration, or employer that has any records or knowledge of my physical or mental health history, diagnosis, treatment, and prognosis, information regarding alcohol or drug abuse and including but not limited to transaction records,employment records, financial records, and complete medical records (including information regarding insurance, demographics, referral documents and records from other facilities), or motor vehicle information to give all such information to The Lincoln National Life Insurance Company, their licensed representatives and/or their reinsurers, MediConnect.net Inc., GiS, or any other party acting on the Company's behalf. I authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I authorize the Company to disclose information related to my insurability to other insurers to whom I may apply for coverage. I acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected I or my authorized representative may have a copy of this authorization upon request.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

☐ I elect to be interviewed if an Investigative Consumer Report is prepared.

Each of the undersigned declares that:

I/We acknowledge receipt of the Buyer's Guide, Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

Signatory Section

Signed in: _____ _____ /_____ /_____
(State) Date (MM/DD/YYYY)

Signature of Proposed Insured
(Parent or Guardian if under 16 years of age)

Signature of Applicant/Owner/Trustee
(If other than Proposed Insured)
Provide Title if owned by a Trust or a Corporation

Signature of Applicant/Owner/Trustee
(If other than Proposed Insured)
Provide Title if owned by a Trust or a Corporation

To Be Completed By Agent Only *(All questions are required to be answered.)*

(i) Does the applicant have any existing life insurance policies or annuities? ☐ Y ☐ N

(ii) Do you know or have you any reason to believe that replacement of insurance is involved? ☐ Y ☐ N
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Buyer's Guide and Important Notice, as well as a copy of the Privacy Practices Notice.

Signature of Licensed Agent, Broker or Registered Representative

Printed Name of Licensed Agent, Broker or Registered Representative

Applicable to Variable Life Only

I have reviewed the Application, Supplements, New Account Form and allocation forms and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

Printed Name of Registered Principal of Broker/Dealer

Lincoln Financial Group®

The Lincoln National Life Insurance Company
PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as the "Company")

Completed Form Must Accompany Application for Life Insurance

Agent's Report

General Information

1. (a) _____ /_____ /_____ /_____
   Proposed Insured A Name: *(First)* *(Middle)* *(Last)* *(Suffix)*

   _____ /_____ /_____ /_____
   Proposed Insured B Name: *(First)* *(Middle)* *(Last)* *(Suffix)*

   (b) How long have you known the Proposed Insured(s)? _____
2. Are you related to the Proposed Insured(s)? ☐ Yes ☐ No If "Yes," Give details: _____
3. Do the Proposed Insured(s) and Owner(s) read and understand the English Language? ☐ Yes ☐ No If "No," how was the application completed? _____
4. Purpose of Insurance: ☐ Estate Planning/Wealth Transfer ☐ Family Protection ☐ Charitable Gift ☐ Outright Gift ☐ Key Person *(Complete Business Finance Section)* ☐ Buy/Sell *(Complete Business Finance Section)* ☐ Deferred Compensation ☐ Pension/Profit Sharing ☐ Supplemental Retirement Protection ☐ Other: _____
5. (a) Is this policy being paid for with a premium financing loan? ☐ Yes ☐ No If "Yes," provide complete details to include the name of the financing plan being used, name and address of institution providing loan, name and phone number of the lending officer:

   _____

   (b) Is this policy being paid for with funds from any person or entity whose only interest in the policy is the potential for earnings based on the provision of funding for the policy? ☐ Yes ☐ No If "Yes," provide details below:

   _____
6. If LifeComp® program was used, have you completed the required paperwork? ☐ Yes ☐ No
7. Is the Proposed Insured using income from their spouse/domestic partner to financially justify the coverage applied? ☐ Yes ☐ No If "Yes," provide the following information for the spouse/domestic partner:

   (a) Income: $_____ (b) Life Insurance (In-force and additional applied for that will be placed): $_____
8. Answer only if Proposed Insured is under age 18.

	Amount Inforce	Amount Applied For
(a) Father's Life Insurance:	$ _____	$ _____
(b) Mother's Life Insurance:	$ _____	$ _____
(c) Are siblings also being insured? ☐ Yes ☐ No	$ _____	$ _____

   If "No," explain: _____
9. I have verified that this policy will not replace a policy that has already been sold to a life settlement, viatical or other secondary market provider. If otherwise, explain:

   _____

Business Finances *(Complete only if this is business insurance)*

10. Type of business: ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other: _____
11. Proposed Insured is: ☐ Employee ☐ Owner of _____ % of business

Required if purpose of insurance is Key Person

12. (a) Do all Key Persons have similar coverage in force or currently applied for? ☐ Yes ☐ No

    (b) What is the Fair Market Value of the business? $_____

    (c) How was the Fair Market Value determined? _____

Required if purpose of insurance is Buy/Sell

13. (a) What insurance does the business maintain on the lives of each corporate officer/key person/partner and the amount of business insurance on each?

Name	Title	% of Ownership	Amount Inforce	Amount Applied For
_____	_____	_____	$ _____	$ _____
_____	_____	_____	$ _____	$ _____
_____	_____	_____	$ _____	$ _____

(b) Total Business Assets: $ _____ Total Business Liabilities: $_____ Total Business Net Worth: $_____

(c) Net Income (Profit) for the past 2 years: Last year $ _____ Previous year $ _____

(d) What is the Fair Market Value of the company? $_____

(e) How was the Fair Market Value determined? _____

Agent Information *(To ensure proper payment of commissions, fully complete the following sections. Incomplete or incorrect information may delay compensation payment.)*

14. Name of Affiliated Agency and/or Broker/Dealer: _____

    Broker/Dealer Client/Owner Account #: _____

15. Have you recently submitted paperwork for a change in reporting hierarchy or commission set-up? ☐ Yes ☐ No

    If "Yes" describe the change requested: _____

16. Agents who participated in this application: *(print or type)*

Full Name of Agent(s) entitled to commission:	SSN/TIN:	Agent Number or Sa/Pc Code Share:	Split %:
Writing _____	_____	_____	_____%
Second _____	_____	_____	_____%
Third _____	_____	_____	_____%

17. Primary Agent's: (a) Email Address: _____

    (b) Phone Number: _____ -_____ -_____

18. Case Contact Email Address *(if other than Agent)*: _____

19. Identify any special compensation instructions or commission schedule or ☐ check here if there is no special commission program:

_____

For VUL policies: Check appropriate commission schedule as applicable—select one:
(Election is irrevocable; contact upline/hierarchy for details.)
☐ A—Heaped ☐ B—Mod-Heaped ☐ C—Trails

As applicable to selected Rider:
(Election is irrevocable.)
☐ D—Level ☐ E—Semi-Heaped

Agent Certification

- ► I declare that I have reviewed with the Proposed Insured(s) each question on the application. For those questions asked by me, the answers have been recorded exactly as stated. For any answers provided by the Proposed Insured(s) during a telephone interview and recorded by a third party, I have confirmed that those answers as contained in the application were accurately recorded. I know of nothing affecting the insurability of the Proposed Insured(s) which is not fully recorded in this application.
- ► I have asked my client if there is any intention to replace, surrender, borrow against, sell or use any portion of any existing life insurance policy or annuity to finance any portion of the policy being applied for and know of no other replacement than that indicated within the application. If a replacement is intended, I have given the appropriate replacement forms to the client at the time of application.
- ► I declare that if replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.
- ► I declare I have not been involved in any recommendation regarding the possible sale or assignment of this policy to a life settlement, viatical or other secondary market provider. If otherwise, explain:

_____

- ► I declare that I have verified that all life insurance coverage in force, or in the process of being applied for, on the Proposed Insured(s) has been disclosed on this application, including any coverage that has been sold or is in the process of being sold to a life settlement, viatical or other secondary market provider.
- ► I declare, to the best of my knowledge, that this policy is not being funded via non-recourse premium financing and is not being paid for with funds from any person or entity whose only interest in the policy is the potential for earnings based on the provision of funding for the policy. If otherwise, explain:

_____

- ► I have reviewed and I understand Lincoln Financial Group's Position Regarding Marijuana-Related Businesses as published in form GB10877.
- ► I declare that I have accurately answered all questions contained in the Agent's Report in connection with this application.

_____ _____/_____/_____

Signature of Licensed Agent, Broker or Registered Representative **Date (MM/DD/YYYY)**

Lincoln Financial Group®

Electronic Funds Transfer (EFT) Authorization

The Lincoln National Life Insurance Company ("Lincoln")
Lincoln Life & Annuity Company of New York ("Lincoln")
First Penn-Pacific Life Insurance Company ("Lincoln")

This form allows Lincoln to collect payments from your checking or savings account for Life Insurance premium payment(s).

☐ By checking this box, I elect to Opt Out of using an electronic funds transfer for my Policy.

Step 1 - Insured Information

Indicate for first policy:

Policy Number:

First Name:

Last Name:

Indicate policy information for second policy, if applicable:

Policy Number:

First Name:

Last Name:

Step 2 - Payment Information

Indicate for first policy:

Premium Amount: $

Loan Payment Amount: $

☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annually**

☐ **Annually** ☐ **One Time - Initial Premium Only**

Existing Policies:

Draft Day* (01-28):

Draft Start Date: / /

Indicate for second policy:

Premium Amount: $

Loan Payment Amount: $

☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annually**

☐ **Annually** ☐ **One Time - Initial Premium Only**

Existing Policies:

Draft Day* (01-28):

Draft Start Date: / /

Checking Account: ☐ **Savings Account:** ☐

Bank or Credit Union Name:

Routing Number:

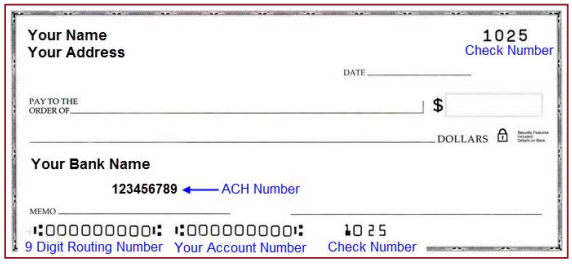
Account Number:

***New Policies. Please do not select a draft date. This date will be determined when the case is complete.**

If the draft day selected is more than 15 days after the day of the month that the policy was issued, the premium will be required to be paid in advance of the monthly policy date. This does not apply to policies with a Lapse Protection Provision.

Refer to the policy product information to determine which premium payment frequencies are available.

Use the diagram to the right to locate the routing and account numbers on your check. The check number may precede the account number and be in-between the routing and account numbers. Include any leading zeros in the account and/or routing number.



Step 3 - Payor Information

If the payor is a Corporation/ Entity or Trust, indicate the full legal name and the trustee or officer first and last name.

Corporation/Entity or Trust Name:

If the payor is an individual:

First Name: **MI:** **Last Name:** **Suffix:**

Payor Contact Information:

Address:

City: **State:** **Zip Code:**

Mobile Number: - - **Email Address:**

Step 4 - Authorizations and Signatures

As ***Payor,*** I authorize Lincoln to collect premiums via electronic funds transfer, or to affect a charge by other commercially accepted practices for the policy(ies) described above. I understand that this Authorization applies to any renewals and future changes later made in the policy and in no way affects the terms of the policy(ies) listed above.

I authorize Lincoln to change the transfer amount **without notice**, in order to maintain the policy in force in accordance with its terms up to a maximum of $50.00 per plan, and additionally authorize the Company to increase the amount of the scheduled transfer if over $50.00 upon my written request. ***Term policies may have automatic contractual premium increases that exceed $50.00 and you will be notified in advance of the change.***

If I change my financial institution or my account number, or wish to discontinue this agreement, I agree to give 30 days written notice to Lincoln. Notice to the financial institution without notice to Lincoln is not sufficient. Lincoln may terminate this agreement if any debit is not paid upon presentation, or upon 30 days written notice. Lincoln assumes no responsibility for bank charges, or, in the case of registered security products, for investment losses on these debits.

I certify that the information provided on this form is complete and correct:

Payor's Signature: _____ **Date:** / /

Print Name: **Title:**

Payor Signature Requirements:

Individual Payor - Sign, print name, and date. The title is not required.

Corporation, Bank or Financial Institution Payor - One officer signature, print name, title, and date.

Trust Payor - Trustee sign, print name, title, and date.

Partnership or LLC Payor - One general/managing partner signature, print name, title, and date.

Existing Policies:

Email completed form to: CustServSupportTeam@LFG.com

Mail completed form to: Lincoln Financial
P.O. Box 21008
Greensboro, NC 27420-1008

Contact us for further assistance: 1-800-487-1485

New or Pending Policies, please return the form and direct any questions to your New Business team.

Visit us on the web: LincolnFinancial.com

Lincoln Financial Group®

Lincoln Financial Group® Privacy Practices Notice

The Lincoln Financial Group companies* are committed to protecting your privacy. To provide the products and services you expect from a financial services leader, we must collect personal information about you. We do not sell your personal information to third parties. This Notice describes our current privacy practices. While your relationship with us continues, we will update and send our Privacy Practices Notice as required by law. Even after that relationship ends, we will continue to protect your personal information. You do not need to take any action because of this Notice, but you do have certain rights as described below.

We are committed to the responsible use of information and protecting individual privacy rights. As such, we look to leading data protection standards to guide our privacy program. These standards include collecting data through fair and lawful means, such as obtaining your consent when appropriate.

Information we may collect and use

We collect personal information about you to help us identify you as a consumer, our customer, or our former customer; to process your requests and transactions; to offer investment or insurance services to you; to pay your claim; to analyze in order to enhance our products and services; to tell you about our products or services we believe you may want and use; and as otherwise permitted by law. The type of personal information we collect depends on your relationship and on the products or services you request and may include the following:

- **Information from you:** When you submit your application or other forms, you give us information such as your name, address, Social Security number; and your financial, health, and employment history. We may also collect voice recordings or biometric data for use in accordance with applicable law.
- **Information about your transactions:** We maintain information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; payment details; and your payment and claims history.
- **Information from outside our family of companies**: If you are applying for or purchasing insurance products, we may collect information from consumer reporting agencies, such as your credit history; credit scores; and driving and employment records. With your authorization, we may also collect information (such as medical information, retirement information, and information related to Social Security benefits), from other individuals or businesses.
- **Information from your employer**: If your employer applies for or purchases group products from us, we may obtain information about you from your employer or group representative in order to enroll you in the plan.

How we use your personal information

We may share your personal information within our companies and with certain service providers. They use this information to process transactions you, your employer, or your group representative have requested; to provide customer service; to analyze in order to evaluate or enhance our products and services; to gain customer insight; to provide education and training to our workforce and customers; and to inform you of products or services we offer that you may find useful. Our service providers may or may not be affiliated with us. They include financial service providers (for example, third party administrators; broker-dealers; insurance agents and brokers, registered representatives; reinsurers and other financial services companies with whom we have joint marketing agreements). Our service providers also include non-financial companies and individuals (for example, consultants; vendors; and companies that perform marketing services on our behalf). Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law. We may execute agreements with our service providers that permit the service provider to process your personal information outside of the United States, when not prohibited by our contracts and permitted by applicable law.

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners or their designees (for example, to your employer for employer-sponsored plans and their authorized service providers), regulatory authorities and law enforcement officials, and to other non-affiliated or affiliated parties as permitted by law. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or release your information to outside marketers who may want to offer you their own products and services; nor do we release information we receive about you from a consumer reporting agency. You do not need to take any action for this benefit.**

Security of information

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. Our employees are authorized to access your information only when they need it to perform their job responsibilities. Employees who have access to your personal information are required to keep it confidential. Employees are required to complete privacy training annually.

Your rights regarding your personal information

This Privacy Notice describes how you can exercise your rights regarding your personal information. Lincoln complies with all applicable laws and regulations regarding the provision of personal information. The rights provided to you in this Privacy Notice will be administered in accordance with your state's specific laws and regulations.

Access to personal information: You must submit a written request to receive a copy of your personal information. You may see your personal information in person, or you may ask us to send you a copy of your personal information by mail or electronically, whichever you prefer. We will need to verify your identity before we process the request. Within 30 business days of receiving your request, we will, depending on the specific request you make, (1) inform you of the nature and substance of the recorded personal information we have about you; (2) permit you to obtain a copy of your personal information; and (3) provide the identity (if recorded) of persons to whom we disclosed your personal information within two years prior to the request (if this information is not recorded, we will provide you with the names of those insurance institutions, agents, insurance support organizations or other persons to whom such information is normally disclosed). If you request a copy of your information by mail, we may charge you a fee for copying and mailing costs.

Changes to personal information: If you believe that your personal information is inaccurate or incomplete, you may ask us to correct, amend, or delete the information. Your request must be in writing and must include the reason you are requesting the change. We will respond within 30 business days from the date we receive your request.

If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received your personal information within the past two years. We will also send the updated information to any insurance support organization that gave us the information and any insurance support organization that systematically received personal information from us within the prior 7 years unless that support organization no longer maintains your personal information.

If we deny your request to correct, amend or delete your information, we will provide you with the reasons for the denial. You may write to us and concisely describe what you believe our records should say and why you disagree with our denial of your request to correct, amend, or delete that information. We will file this communication from you with the disputed information, identify the disputed information if it is disclosed, and provide notice of the disagreement to the persons and in the manner described in the paragraph above.

Basis for adverse underwriting decision: You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate, or terminate your coverage.

Your state may provide for additional privacy protections under applicable laws. We will protect your information in accordance with these additional protections.

If you would like to act upon your rights regarding your personal information, please provide your full name, address and telephone number and either email your inquiry to our Data Subject Access Request Team at DSAR@lfg.com or mail to: Lincoln Financial Group, Attn: Corporate Privacy Office, 1301 South Harrison St., Fort Wayne, IN 46802. The DSAR@lfg.com email address should only be used for inquiries related to this Privacy Notice. For general account service requests or inquiries, please call 1-877-ASK-LINC.

*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Financial Distributors, Inc.
Lincoln Financial Group Trust Company
Lincoln Investment Advisors Corporation
Lincoln Life & Annuity Company of New York
Lincoln Life Assurance Company of Boston
Lincoln Retirement Services Company, LLC
Lincoln Variable Insurance Products Trust
The Lincoln National Life Insurance Company

**This Notice is effective 14 calendar days after it is made available on Lincoln's website, www.LFG.com/privacy.

The Lincoln National Life Insurance Company
PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as the "Company")

Authorization for Release of Information

Proposed Insured/Patient:

_____ /_____ /_____ /_____
(First) *(Middle)* *(Last)* *(Suffix)*

Date of Birth (MM/DD/YYYY): ____ /____ /_____

I (the undersigned) authorize any licensed physician, medical practitioner, nurse, records custodians, hospital, clinic, Pharmacy Benefit Manager or any other medically related facility, insurance support organizations, insurance company, Medical Information Bureau (MIB), or other organization, institution or person that has any records or knowledge about me or my health, including but not limited to complete medical records in paper or electronic format, (including information regarding insurance, referral documents and records from other facilities) to give all such information to the Company, their licensed representatives, their reinsurers, and/or approved vendors.

I understand that:

- information released may include information obtained through my telephonic or Personal Health Interview(s) and include information regarding my physical and mental health and my insurance policies and claims, including, but not limited to, those containing diagnosis, treatments, prognosis, prescription drug information, alcohol or drug abuse or information regarding testing, diagnosis, presence and/or treatment of communicable diseases to include, Human Immunodeficiency Virus (HIV) also known as Acquired Immune Deficiency Syndrome (AIDS).
- an Authorization for Release or disclosure of psychotherapy notes may not be combined with an Authorization for Release or disclosure of any other information (a separate Authorization must be completed for release or disclosure of psychotherapy notes).
- I am authorizing the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc.
- the information obtained may be used by the Company to determine eligibility for insurance, for analysis to enhance our products and services or to administer my coverage. The Company may not give the information to any person or entity except: 1) a reinsurer, or other insurers to whom I have applied or may apply; 2) MIB; 3) any other person or entity who performs business or legal services in connection with the application for or administration of my insurance coverage; 4) the agent and/or agency; or 5) any person or entity who conducts other legally permissible activities that relate to any coverage I have, or have applied for with the Company. I understand that some of these people or entities may not be covered by federal or state privacy regulations and that the information they receive may be redisclosed, however the Company contractually requires them to protect the information we disclose to them. Information may be disclosed as allowed by law or regulation.

- this consent may be revoked in writing to the address above, at any time, except to the extent: 1) the Company has previously taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim regarding my policy. If written revocation is not received, this Authorization will be considered valid for 24 months from the date of signing and I agree that a copy of this Authorization shall be as valid as the original and that I may have a copy upon request.
- there is a possibility of re-disclosure of any information disclosed pursuant to this Authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.
- the entries made in the Vendor Use box below do not alter this Authorization.
- I do not have to sign this Authorization in order to obtain health care benefits (treatment, payment or enrollment).
- if I refuse to sign this Authorization to release my complete medical records in paper or electronic format, that medical treatment cannot be withheld. If I refuse to sign this Authorization, the Company may not be able to process my application for insurance.

_____ ____/____/_____

Signature Date (MM/DD/YYYY)

Proposed insured/patient or legal representative (Next-of-kin or legal guardian to sign only if patient is a minor, legally incompetent, or deceased)

Relationship to proposed insured/patient of personal/legal representative signing for proposed insured/patient:

_____

For Vendor Use Only

Lincoln Financial Group®

Financial Disclosure for California Residents Age 65 and Over

The Lincoln National Life Insurance Company
PO Box 21008, Greensboro, NC 27420-1008

I acknowledge that the agent has informed me of the following details at the time I signed the application for life insurance or annuity:

- The sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this life insurance or annuity product may have tax consequences, early withdrawal penalties or other costs or penalties due to the sale or liquidation.

- I may wish to consult an independent legal or financial professional before selling or liquidating any assets and prior to the purchase of any life insurance or annuity products being solicited, offered for sale or sold.

_____ _____ /_____ /_____
Owner's Signature Date

_____
Owner's Printed Name

_____ _____ /_____ /_____
Joint Owner's Signature (if any) Date

_____
Joint Owner's Printed Name

_____ _____ /_____ /_____
Agent's Signature Date

_____
Agent's Printed Name

Lincoln Financial Group®

The Lincoln National Life Insurance Company, Service Office: PO Box 21008, Greensboro, NC 27420-1008

NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY FOR CALIFORNIA RESIDENTS AGE 65 OR OVER

IF YOU OR YOUR SPOUSE ARE CONSIDERING PURCHASING A FINANCIAL PRODUCT BASED ON ITS TREATMENT UNDER THE MEDI-CAL PROGRAM, READ THIS IMPORTANT MESSAGE!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

Unmarried Resident An unmarried resident may be eligible for Medi-Cal benefits if he/she has less than $2,000 in countable resources. The Medi-Cal recipient is allowed to keep from his/her monthly income a personal allowance of $35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share-of-cost.

Married Resident

Community spouse resource allowance: if one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $109,560.

Minimum monthly maintenance needs allowance: if a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his/her individual monthly income, or $2,739 in monthly income, whichever is greater.

Fair Hearings and Court Orders Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than $109,560 in countable resources. The order also may allow the at-home spouse to retain more than $2,739 in monthly income.

Real and Personal Property Exemptions Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

Real Property Exemptions

- *One principal residence.* One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.

  The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

  Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.
- *Real property used in a business or trade.* Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

Property and Other Exempt Assets

- *IRAs, KEOGHs, and other work-related pension plans.* These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal, and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.
- *Personal property used in a trade or business.*
- *One motor vehicle.*
- *Irrevocable burial trusts or irrevocable prepaid burial contracts.*

There may be other assets that may be exempt.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed Information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

I have read the above notice and have received a copy.

Owner's Signature _____ Date _____

Owner's Printed Name _____

Joint Owner's Signature (if any) _____ Date _____

Joint Owner's Printed Name _____

Legal Representative's Signature (if any) _____ Date _____

Legal Representative's Printed Name _____

Agent's Signature _____ Date _____

Agent's Printed Name _____

Lincoln Financial Group®

The Lincoln National Life Insurance Company
Service Office: PO Box 21008, Greensboro, NC 27420-1008

NOTICE AND CONSENT FOR HIV - RELATED TESTING

To evaluate your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an AlDS-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: _____

_____

If you do not wish to know the results of the test, initial here: _____. In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If you want to know the results of the test but do not at present have a private physician, initial here:_____. The result will be sent to you at the address provided by registered mail with delivery restricted to you only. If you desire the results to be mailed to some person other than yourself who is not a physician, print that person name and address here:

_____. The result will be sent to that person by registered mail with restricted delivery.

Consent

I have read and I understand this Notice and Consent for AIDS-related Testing. I voluntarily consent to the withdrawal of blood and/or other bodily fluid from me, the testing of that blood and/or other bodily fluid, and the disclosure of the test results as described above.

I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive. I understand that this consent can be withdrawn at any time prior to the drawing of the blood and/or other bodily fluid for testing.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____	_____
Name of Proposed Insured (Please Print)	Signature of Proposed Insured or Parent/Guardian
_____	_____
Address	Date Signed

The Lincoln National Life Insurance Company
Service Office: PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as the "Company")

Disclosure Form For ***Lincoln LifeElements®*** Level Term

Applicable to *Lincoln LifeElements®* Level Term products (2009 and later) with the following features:

TERM TO ATTAINED AGE 95 LIFE INSURANCE
FIXED LEVEL PREMIUMS DURING THE LEVEL TERM PERIOD
FIXED INCREASING PREMIUMS AFTER THE LEVEL TERM PERIOD
ONE-TIME FACE AMOUNT DECREASE AT THE END OF THE LEVEL TERM PERIOD

Name of Proposed Insured:_____ Date of Birth: _____
(First, Middle Initial, Last) *(mm/dd/yy)*

This disclosure for *Lincoln LifeElements®* Level Term Products is required due to a unique feature—a one-time, automatic and significant decrease in the face amount immediately following the level term period.

This decrease was added as a feature to assist our policyowners in avoiding the immediate and significant premium increase usually found at the end of the level premium period. In most cases, the premium will continue to be the same level premium for three years following the level term period (though the face amount will have reduced), after which premiums will increase annually to age 95. If you choose to continue coverage past the level term period, this three year period of level premiums will give you an opportunity to make a decision about your future insurance needs.

The premium and face amount will not change during the level term period. The face amount and premium amounts during and after the level term period will be reflected in the policy specifications under the Annual Premiums and Face Amounts Schedule. Per the contract provisions, there is no option to opt out of the decrease in the face amount.

Please note that there are several options available during, and at the end of the level term period:

- The right, prior to the end of the selected level term period, to convert the policy to an available permanent life conversion plan offered by the Company. The terms and conditions of conversion including age limitations, will be outlined in your policy, once issued, under Conversion Privileges.
- If there is no longer a need for insurance at the end of the level term period, simply discontinue premium payments and the coverage will lapse.
- Continue to pay the premiums that will be outlined in your policy, once issued, to maintain coverage at the reduced face amount.

I acknowledge that I understand the preliminary policy information and the options available. I also understand that there is a decrease in face amount with increasing premiums following the level term period. I understand this only occurs if coverage is continued beyond the level term period selected. I acknowledge that I have reviewed this disclosure for the applied for policy and understand how the policy will perform during and after the level term period.

Signature of Owner(s)/Applicant(s)	**Date**	**Signature of Insurance Producer**	**Date**
Name of Owner(s)/Applicants(s) (Please Print)		**Insurance Producer's Name (Please Print)**	

The Lincoln National Life Insurance Company
Service Office: P.O. Box 21008, Greensboro, NC 27420-1008

Disclosure Statement for Terminal Illness Accelerated Benefits Rider

Important Notice **To Applicant/Buyer Regarding Accelerated Death Benefits**

The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site www.insurance.ca.gov section regarding long-term care insurance.

If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death.

Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, you should seek assistance from a qualified tax adviser.

Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

DEATH BENEFITS WILL BE REDUCED IF AN ACCELERATED BENEFIT IS PAID. PAYMENT OF AN ACCELERATED BENEFIT MAY BE TAXABLE, YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR.

With the attachment of the Terminal Illness Accelerated Benefit Rider, your policy includes an accelerated benefit feature. This feature provides that a benefit payment of up to 50% of the Eligible Death Benefit of the policy, less certain deductions, will be paid to you, the policyowner, if the Insured develops a Terminal Illness. You choose the percentage of the Eligible Death Benefit to be paid. In no event will the amount payable for all policies with the rider exceed $250,000 per Insured. In addition, the accelerated benefit is payable only once. No benefits will be paid for self-inflicted injuries.

Definitions

Benefit Ratio – the result of dividing the requested portion of the Eligible Death Benefit by the Death Benefit or current Face Amount of insurance under the policy to which the rider is attached.

Eligible Death Benefit – the Death Benefit or current Face Amount of insurance on the life of the Insured provided by the policy.

Terminal Illness – a noncorrectable medical condition, which will result in the death of the Insured within 12 months or less from the date of a Physician Statement.

Reductions and Adjustments

The requested portion of the Eligible Death Benefit will be reduced by:

1. An actuarial discount based on an annual interest rate declared by us and the then current premium or cost of insurance rate. The maximum interest rate used will be the greater of the yield on 90 day treasury bills or the maximum statutory adjustable policy loan interest rate in effect upon the date of request;
2. The amount of any outstanding policy loan multiplied by the Benefit Ratio;
3. Any premiums due within the policy's grace period and are unpaid at the time we approve your request; and
4. An Administrative Expense Charge.

After we pay the accelerated benefit, your policy and all riders will continue in force subject to the following adjustments:

1. The policy's Death Benefit or current Face Amount, its current and Guaranteed Cash Value, if any, its Fund Account or Accumulation Value, if any, and its required Premium, if any, will be reduced by the Benefit Ratio; and,
2. Any outstanding policy loan will be reduced by the portion of the policy loan repaid when calculating the benefit.

		Premium	Cash Value	Face Amount	Outstanding Loan
Example:	Before accelerated payment	$1,200.00	$16,000.00	$100,000.00	$4,000.00
	After accelerated payment	600.00	8,000.00	50,000.00	2,000.00

If this benefit is paid, we will mail you, for attachment to your policy, a new policy data page showing the decrease in policy values resulting from the payment.

I ACKNOWLEDGE RECEIPT OF THIS DISCLOSURE.

Signature of Agent Date

Signature of Proposed Insured Date

Signature of Owner (If other than Proposed Insured) Date

Lincoln Financial Group®

The Lincoln National Life Insurance Company
Service Office: PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as the "Company")

Temporary Life Insurance Agreement

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY - DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

► **If any of the questions below are answered "Yes" or left blank with respect to a Proposed Insured(s), no representative of the Company is authorized to accept money, and NO COVERAGE will take effect under this Agreement with respect to such Proposed Insured(s).**

Questions apply to all Proposed Insured(s) shown on application.

1. Does Amount applied for exceed $3,000,000? ☐ Yes ☐ No
2. Within the past 90 days, has any Proposed Insured been admitted to a hospital or other medical facility, or by a licensed medical professional been advised to be admitted or had surgery performed or recommended? ☐ Yes ☐ No
3. Within the past 2 years has any Proposed Insured been treated by a licensed medical professional for heart trouble, stroke, or cancer, or had such treatment recommended by a licensed medical professional? ☐ Yes ☐ No
4. Is Age of any Proposed Insured under 15 days old or over age 70? ☐ Yes ☐ No

This Agreement provides a **Limited Amount** of Life Insurance protection for a **Limited Period** of time, subject to the terms of this Agreement, in consideration of advance payment in the amount of $_____ in connection with the Application or Company approved solicitation forms packet (Ticket) dated _____ made on the life of: _____ .
Name(s) of Proposed Insured(s)

Method of Payment: *(Check one only.)*

☐ Check ☐ Electronic Funds Transfer *(Attach completed EFT Authorization Form.)*

☐ Credit/Debit Card (**Check product, state and premium mode availability.** *See also Important Information Regarding Credit/Debit Card Payments.*)

Terms and Conditions

AMOUNT OF COVERAGE - $500,000 MAXIMUM FOR ALL APPLICATIONS OR AGREEMENTS

If money has been accepted by the Company as advance payment for an application for Life Insurance and death of a Proposed Insured(s) (and death of the surviving Proposed Insured under Survivorship Life Insurance) occurs while this Agreement is in effect, the Company will pay to the beneficiary designated in the Application the lesser of a) the amount of all death benefits applied for in the Application(s) with respect to said Proposed Insured(s), including any accidental or supplemental death benefits, if applicable, or b) $500,000. This total benefit limit applies to all insurance applied for under this and any current Company Tickets or Applications to the Company and any other Temporary Life Insurance Agreements. Temporary Long-Term Care coverage is not available under this Agreement.

DATE COVERAGE BEGINS

Coverage under this Agreement will begin on the date of this Agreement but only if a Company Ticket(s) or Part I of the Application(s) has been completed on the same date or not more than 7 days prior to the date of this Agreement.

DATE COVERAGE TERMINATES - 90 DAY MAXIMUM

- Coverage under this Agreement will terminate automatically on the earliest of: a) 45 days from date of this Agreement if a required Exam or Medical Supplement (Part II) is not received by the Company, or b) 90 days from the date of this Agreement, or c) the date the insurance takes effect under the policy applied for, or d) the Proposed Insured(s)'/Applicant(s)' receipt of termination of coverage also defined herein as 5 days immediately following the date the Company mails notice of termination of coverage to the premium notice address designated in the Company Ticket(s) or Part I of the Application(s). The Company may terminate coverage at any time.

SPECIAL LIMITATIONS

- This Agreement does not guarantee the Company will issue a life insurance policy or any special riders or endorsements thereto.
- Fraud or material misrepresentations in the Company Ticket(s) or Application(s) or in the answers to the Health Questions of this Agreement invalidates this Agreement and the Company's only liability is for refund of any payment made.
- If a Proposed Insured(s) (or the surviving Proposed Insured under Survivorship Life Insurance) dies by suicide, the Company's liability under this Agreement is limited to a refund of the payment made.
- There is no coverage under this Agreement if the premium check, EFT Authorization Form or Credit/Debit Card information is not submitted to the Company and/or the bank/financial institution does not honor the check, EFT request or Credit/Debit Card charge within 7 days of signing this Agreement.
- No one is authorized to waive or modify any of the provisions of this Agreement.

I (WE) HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND AND AGREE TO ALL ITS TERMS.
Agent is to leave a copy with the applicant.

Signature of Proposed Insured A (Parent or Guardian if under 18 years of age)	**Witness** (Licensed Representative/Agent)	**Date**
Signature of Proposed Insured B (Parent or Guardian if under 18 years of age)	**Witness** (Licensed Representative/Agent)	**Date**
Signature of Applicant/Owner/Trustee with Title (Provide Officer's Title if policy is owned by a Corporation)	**Witness** (Licensed Representative/Agent)	**Date**

The Lincoln National Life Insurance Company
PO Box 21008, Greensboro, NC 27420-1008

Important Information Regarding Credit and Debit Card Payments

The Lincoln National Life Insurance Company (Lincoln) is pleased to offer credit and debit cards as a convenient method of payment in connection with an application for a term life insurance policy. This method of payment is allowed for the Temporary Insurance Agreement (TIA) and the initial premium only, and is available for all premium modes.

- **Credit/Debit card payments can only be accepted with our term products.**
- **This payment method can only be used for the initial premium and/or payment made under a signed TIA. Refer to TIA for additional details and conditions. TIA is not accepted in the state of KS.**
- **If the premium mode has been requested as monthly or quarterly, you will need to submit a signed Electronic Funds Transfer (EFT) authorization for future payments.**
- **Credit/Debit card payments are not available in NY, NJ, MD and AK.**
- **Only Visa, Discover and MasterCard credit/debit cards are accepted. NO other types of credit/debit cards will be accepted (American Express, etc.)**

How to Make a Payment Under a Temporary Insurance Agreement (TIA)

In order to remit the payment, please visit: https://ww2.e-billexpress.com/ebpp/LFGTIA.

- You will need to provide your agent's name and the Proposed Insured's name in order to make a payment.
- Payment must be submitted within the guidelines on the TIA.
- If the payment is not successful, please contact your agent.

How to Pay the Initial Premium Online Using a Credit/Debit Card

Once Lincoln has issued your term policy, you have the ability to pay your initial premium online. To make a payment after the policy is issued, please visit: https://ww2.e-billexpress.com/ebpp/LFG.

- **In order to avoid duplication of payments**, you must submit the credit/debit card initial premium prior to the completed delivery requirements being returned to Lincoln.
- You will need to provide your policy number and the insured's Date of Birth in order to make a payment for the full balance due.
- If the payment is not successful and/or you need additional assistance please contact your agent.

Lincoln Financial Group®

Certification of Trustee Powers

Please check appropriate underwriting company:
☐ **The Lincoln National Life Insurance Company**
☐ **Lincoln Life & Annuity Company of New York**
Life Service Office: PO Box 21008, Greensboro, NC 27420-1008
Annuity Service Office: PO Box 2348, Fort Wayne, IN 46801-2348
www.LincolnFinancial.com

Use this form to certify the existence of the Trust, and the identity and powers of the Trustee(s). Please read this entire form and complete all fields before signing. If more space is needed for additional information, attach a separate sheet of paper.

Contract or Policy* Information

Contract or Policy Number(s) (if known):_____

Owner Name: _____ Owner Social Security Number/TIN: _____

Annuitant/Insured Name:_____ Annuitant/Insured Social Security Number: _____

Trust Information

Trust Name as it appears on the Trust ("Trust"): _____

Original Trust Date: _____ Latest Amendment Date (if any): _____

Taxpayer Identification Number (TIN):_____ State Governing Law of Trust: _____

Trust Address (for correspondence): _____

Trust Type (select one): ☐ Irrevocable ☐ Revocable ☐ Charitable Remainder Trust (CRT) ☐ Testamentary ☐ Nominee

Is this a grantor trust**? ☐ Yes ☐ No

If yes, include living grantor information below.

Name of Grantor:_____ Social Security Number:_____ Date of Birth: _____

Name of Grantor:_____ Social Security Number:_____ Date of Birth: _____

Note: If the trust listed above is a Grantor Trust under Section 671-679 of the Internal Revenue Code (IRC), the following will apply:

- If this trust has a Tax ID Number (TIN), any taxable distributions from an annuity to the trust will be reported to the trust and the Internal Revenue Service. If this trust does not have a TIN, such annuity distributions will be reported to the Grantor and the Internal Revenue Service.
- The trust will be treated as a natural person under IRC Section 72 (u) and the grantor will be treated as the holder of the contract under IRC Section 72(s).
- If the trust should cease to be a Grantor Trust, the Trustee and/or Grantor will immediately give written notification, including new TIN, to the Lincoln Financial Group.

Trustee Information

Trustee Name:_____ Social Security Number:_____

Trustee Address: _____

Additional Trustee Name (if any): _____ Social Security Number:_____

Additional Trustee Address:_____

Additional Trustee Name (if any): _____ Social Security Number:_____

Additional Trustee Address:_____

Transaction requests must be authorized by (select one): ☐ All Trustees ☐ Majority of Trustees ☐ Any One Trustee

☐ Only Specified Named Trustee(s) (provide name): _____

* Contract or Policy may be referred to as "certificate."

** A grantor trust is one in which the grantor has reserved to him/her/itself certain powers that, under current tax law, may generate a tax liability on the grantor. Generally, these would be powers that could lead to a conclusion that the assets of the trust are treated as owned by the grantor and not the trust (See, IRC Sections 671-679.) If not sure, please contact your tax/legal advisor to determine whether your trust is a grantor trust.

FOR LIFE POLICIES ONLY

Will Trust be paying the premium? ☐ Yes ☐ No

If yes, provide the following information:

Bank Name:_____

Name on Bank Account: _____

Individuals with Signature Authority: _____

Certification and Signatures

The Trustee(s) is (are) referred to as "you" in this form. By signing below, the undersigned Trustee(s) acknowledge and certify the following:

- You are the named Trustee(s) under the Trust and the information provided on this form is true and accurate;
- You have the power under the Trust and applicable law to exercise all ownership rights, privileges, options, and benefits under the contract(s) and/or policy(ies) listed above, and you understand and agree that the Company is not obligated to verify that the Trust is in effect or that you are acting within the authority granted to you under the terms of the Trust;
- You agree to indemnify and hold harmless the Company from any and all liability, including attorney's fees the Company may incur by acting upon instructions reasonably believed by the Company to be valid instructions originating from you with respect to any life insurance policy or annuity contract, and from all other acts related to such policy(ies) or contract(s);
- The Trust is currently in effect and has not been revoked, modified or amended in any manner that would cause the representations in this certification to be incorrect;
- This certification is being signed by all currently acting trustees of the Trust; and
- You agree to inform the Company in writing of any change in the Trustee(s), or any event that could alter this certification. (Provide supporting written documentation such as a letter stating that the named Trustee is no longer a Trustee, or a copy of the Trustee's certified death certificate.)
- You understand that, to the extent Lincoln is in receipt of part or all of the trust instrument, Lincoln's representatives will not undertake to read the instrument, and will rely solely on the representations made above with respect to the trust. In addition, knowledge of the terms of the trust instrument may not be inferred solely from the fact that the trust instrument is being held by Lincoln.
- You understand that Lincoln reserves the right to require the full trust document and any subsequent amendments and/or restatements.

Trustee Signature	Trustee Name (printed)	Date
Trustee Signature	Trustee Name (printed)	Date
Trustee Signature	Trustee Name (printed)	Date

If the Trust has more than three Trustees, please provide Trustee names, addresses, signatures and dates on an additional sheet of paper and attach that page to this form.

Lincoln Financial Group®

Please check appropriate underwriting company:

☐ **The Lincoln National Life Insurance Company,** Life Service Office: PO Box 21008, Greensboro, NC 27420-1008
☐ **The Lincoln National Life Insurance Company,** Annuity Service Office: PO Box 2348, Fort Wayne, IN 46801-2348
☐ **The Lincoln National Life Insurance Company,** Group Protection Service Center, PO Box 2616, Omaha, NE 68103-2616

APPROPRIATENESS VERIFICATION STATEMENT

The Lincoln National Life Insurance Company (Lincoln) Replacement Position Statement: Lincoln does not encourage the replacement of a long-term care policy, life insurance policy or annuity contract. Replacements should only occur when it is in the client's best interest. Therefore, Lincoln expects each producer selling its products to determine the appropriateness of each replacement according to Lincoln's guidelines prior to submitting an application to Lincoln. Before issuing a replacement policy, Lincoln must be reasonably satisfied that the product meets the client's needs and objectives; that the client was fully educated on the advantages and disadvantages of a policy or contract replacement to have the knowledge necessary to make an informed decision; and that the client received complete and accurate replacement forms as required by state regulations.

Guidelines: Lincoln expects that each producer will discuss at least the following replacement issues and concerns with the client prior to submitting a replacement application to Lincoln:

- Potential reduction of current cash value due to new acquisition costs - how long will it take to recover the costs associated with the proposed policy or annuity contract.
- Potential tax implications of replacing the existing policy or annuity contract.
- Potential impact on client's immediate liquidity needs.
- Potential impact of surrender charges on existing and proposed policy or annuity contract
- Potential increase in cost of insurance due to insured's increased age.
- Potential for new contestability/suicide periods.
- Potential impact of variable factors on planned premiums.
- Circumstances under which the existing and proposed policy could lapse.
- Duration of coverage under the existing and proposed policy.
- Differences in features and benefits between the existing and proposed coverage or annuity contract.
- Differences in loan features and benefits between the existing and proposed coverage or annuity contract.

Producer Verification:

- I have discussed the advantages and disadvantages of discontinuing or modifying the existing long-term care policy, life insurance policy or annuity contract with my client, including the replacement concerns and issues mentioned above.
- I have determined that the existing coverage or annuity contract no longer meets the client's insurance needs and objectives and that the proposed replacement is appropriate in accordance with the Lincoln Replacement Position Statement.
- I have used only company approved sales material in conjunction with this sale; and,
- I have left copies of all sales material with the applicant(s) at the time the application was submitted.

_____ _____

Producer's Name (please print) Signature

_____

Date

_____

Insured/Annuitant Printed Name

Lincoln Financial Group®

Please check appropriate underwriting company:

☐ **The Lincoln National Life Insurance Company,** Life Service Office: PO Box 21008, Greensboro, NC 27420-1008
☐ **The Lincoln National Life Insurance Company,** Annuity Service Office: PO Box 2348, Fort Wayne, IN 46801-2348
☐ **The Lincoln National Life Insurance Company,** Group Protection Service Center, PO Box 2616, Omaha, NE 68103-2616

NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Applicant's Name (please print)

Applicant's Signature

Date

Joint Applicant's Name (please print)

Joint Applicant's Signature

Date

Insured/Annuitant Printed Name

Agent's Signature

Date