Lincoln Financial Group®

Please check appropriate underwriting company:
☐ **The Lincoln National Life Insurance Company**
☐ **Lincoln Life & Annuity Company of New York**
☐ **Group Protection Service Center**
(hereinafter referred to as "the Company")

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

Complete policy information for all policies to which this authorization will apply:

Policy Number	Insured's Name	Premium Amount	Loan Repayment Amount	Draft Date (01 thru 28 only) *for existing/inforce cases only*

☐ **Check box if address should be changed.**

Accountholder Information (please print):

Accountholder Name		
Address		
City	State	Zip
Phone		
Account Type	☐ Checking Account (ATTACH VOID CHECK) *No starter checks or other cash equivalents can be used* ☐ Saving Account (ATTACH DEPOSIT SLIP)	

Bank or Credit Union Information:

Bank or Credit Union Name		
Address		
City	State	Zip
Account Number		
Bank Routing Number: _____ (the 9-digit number at the bottom of your check)		

Payment Mode: *Please note that all premium payments modes are not available for certain policy types.

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

For New Business Cases:

If you choose a draft date after the policy date or elect to have a backdated policy there may be additional premium requirements. The Draft Date may be dependent on the Policy Issue Date.

For Existing/Inforce Cases:

Withdraw bank draft on the day of applicable month (01 thru 28 only) as noted above beginning with premium for month of _____. This does not apply to policies that include a Lapse Protection Guarantee (see details on back of form). **If the day selected is more than 15 days after the monthly policy date (day of month the policy was issued), the premium will be required to be paid in advance prior to the monthly policy date.**

Authorization:

I authorize the Company to collect premiums via electronic funds transfer, or to effect a charge by any other commercially accepted practice in connection with the policy(ies)/certificate(s) described above. The attached voided check/withdrawal slip shows the account number from which deductions should be made. This Authorization will apply to any renewal or change later made in the policy/certificate and in no way affects the terms of the policy(ies)/certificate(s) described above.

I authorize the Company to vary 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. **[*See information on reverse side for premium increases of more than $50.00 for Term policies]**

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 the Company. Notice to the financial institution without notice to the Company is not sufficient. The Company may terminate this agreement if any debit is not paid upon presentation, or upon 30 days written notice. The Company assumes no responsibility for bank charges, or, in the case of registered security products, for investment losses on these debits.

_____ _____
Accountholder/Authorized Signature Date

_____ _____
Accountholder/Authorized Signature Date

OVER

Frequently Asked Questions Regarding Electronic Funds Transfers

What is an Electronic Funds Transfer (EFT)?
An Electronic Funds Transfer allows us to automatically deduct your payment from your checking or savings account on a designated date each month. This transaction follows regular bank channels, and is charged to your account just as if you had written a check.

What are the advantages of this payment method?
It's convenient. We prepare the transaction for your premiums as they become due - you do nothing. You also save postage costs because you don't have to mail in your payments.

Can I use the same authorization to pay the premiums on multiple policies?
Yes. Please list all policies on the front of this form.

Can I pay optional premiums via Electronic Funds Transfer?
Yes. You may make deposits to your Universal Life and Variable Universal Life policies, as well as make Dynamic Life pour-ins and optional annuity payments. Just specify the amount that you would like to deposit with each payment.

Can I repay a policy loan via Electronic Funds Transfer?
Yes. We will draft any amount you choose on the mode you select to repay on a policy loan, subject to a $10 minimum.

How do I make changes in the amount of my transaction?
We will automatically adjust the amount of your transaction due to changes in premiums, up to a maximum of $50.00. **Term policies may have contractual premium increases that exceed $50.00 that may be changed automatically.** You will be provided advance notice of premium changes for term policies. You may also instruct us in writing to make changes to your transaction amount. Changes to deposit amounts for Universal Life and Variable Universal Life may require you to provide us with written instructions.

I have a term policy in which my premiums will automatically increase at predetermined times. Do I need to contact you to change my draft amount at these times?
No. If your term policy premiums are structured to increase in certain years, your draft amount will automatically increase to the amount specified in your policy contract **that may exceed a $50.00 increase.** You will be provided advance notice of premium changes for term policies and it will not be necessary for you to contact us.

What if I wish to use my credit union or savings account?
We can draft from statement savings accounts and credit unions, however an additional 11 business days are needed from our processing date for electronic verification through your banking institution. It is important that you speak with your financial institution first, and provide us with the ACH account and routing numbers for your account, in order to avoid delays.

What if I change financial institutions?
Notify us in writing, or call our Customer Contact Center, and we will provide you with a new EFT Authorization Form to complete and sign. Return it to us, along with a voided check or withdrawal slip. Please allow at least 30 days for the change to become effective.

Can this transaction affect the guarantees on my policy?
Yes. To ensure guarantees occur as illustrated, it is imperative for draft dates to occur prior to the policy's monthly anniversary. If a specific draft date is requested for UL policies, we will honor your request; however, please be aware that the drafts will take place on the requested date ***prior*** to the monthly anniversary date for your policy. If no preferred draft date is requested, we will set the draft date for up to 3 days prior to the policy date. The draft date will be selected at placement based on the policy date.

How do I start the plan?
Complete the reverse side of this form and forward it to us immediately. We appreciate the opportunity to serve you and hope that you will be pleased with this convenient method of payment.

Concord Mailing Address:
PO Box 515
Concord, NH 03302-0515
Phone: 800-487-1485
Fax: 800-819-1987

Greensboro Mailing Address:
PO Box 21008
Greensboro, NC 27420-1008
Phone: 800-487-1485
Fax: 800-819-1987

Group Protection Mailing Address:
PO Box 2616
Omaha, NE 68103-2616
Phone: 800-423-2765
Fax: 877-573-6177

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

Application for Life Insurance

General Instructions For Completing The Application

Please follow these instructions carefully. Thank you for the opportunity to underwrite your business.

Application

- 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 by the Owner(s).** If a health question is changed, draw a line through the mistake and have the change initialed 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 but less than 180 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 4 of 5. The completed VUL/SVUL Allocation form must accompany the application.
- Please refer to product specifications for complete details and billing options. Some products have limited 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. Only checks payable to The Lincoln National Life Insurance Company are acceptable. If you are submitting applications for alternate or multiple applications, only one TIA per Proposed Insured may be in effect at one 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 payment with application only in the form of a currently dated check 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. Give a copy of the TIA to the Owner(s) and submit the original with the application
  4. Submit the payment with the application and write the amount of the payment in #2 of the Agreement and Acknowledgement Section.

Special Instructions

- **All applicants must complete the Application for Individual Life Insurance and Medical Supplement (Part II).**
- If there is more than one Proposed Insured complete and submit the following: Application for Individual Life Insurance, the Proposed Insured B Supplement and 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 21; 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
(hereinafter referred to as the "Company")

(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

Proposed Insured

1. Name *(First, Middle, Last)*:_____ 2. ☐ Male ☐ Female
3. Date of Birth *(mm/dd/yy)*:_____ 4. Social Security Number:_____
   (If age 70 or over, please complete Defined Age Supplement)
5. Are you a citizen of the United States? ☐ Yes ☐ No If "No," of what country?_____
   If "No," indicate Visa type and status:_____
6. Place of Birth *(State/Country)*:_____
7. Driver's License # & State:_____
8. Home Address *(Street, City, State, ZIP)*:_____
9. Employer:_____ 10. Occupation:_____
11. Business Address *(Street, City, State, ZIP)*:_____
12. Annual Earned Income $_____ 13. Annual Unearned Income $_____ 14. Net Worth $_____
15. Primary Phone #: _____

Policy Information

16. Plan of Insurance *(if Term include duration)*: _____
17. Amount of Insurance/Specified Amount: $ _____
18. 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
19. 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.**
20. Additional Benefits and Riders: *(If applicable)*
    ☐ Accelerated Benefits Rider for Chronic Illness *(Complete applicable supplement)*
    ☐ Accelerated Benefit Rider
    ☐ Children's Term Insurance Rider *(Complete Child's Supplement)*
    ☐ Other Insured Rider $ _____ *(Please complete Proposed Insured B Supplement)*
    ☐ Supplemental Coverage $ _____
    ☐ Waiver of Premium ☐ Waiver of Monthly Deductions ☐ Waiver of Specified Premium $ _____
    ☐ Other Benefits and Riders not listed above *(Please provide full details: e.g. coverage amounts/percentages/etc.):*
    _____

Owner Information ***(If left blank, Proposed Insured will be Owner)***

21. a. Name/Trust & Trustees:_____
    _____
    b. Address *(Street, City, State, ZIP)*:_____
    c. Relationship to Proposed Insured(s):_____ d. SSN/TIN:_____
    e. Date of Birth/Trust Date:_____ f. Country of Citizenship:_____
22. 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 Special Instructions below, if multiple beneficiaries are named in a class, Primary and/or Contingent, the proceeds are to be paid equally to the survivor or survivors, if any, in the class.)

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

23. a. ☐ P ☐ C Name/Trust & Trustees:_____

    _____

    b. Address *(Street, City, State, ZIP)*:_____

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

    e. Date of Birth/Trust Date:_____ f. Phone Number:_____

24. a. ☐ P ☐ C Name/Trust & Trustees:_____

    _____

    b. Address *(Street, City, State, ZIP)*:_____

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

    e. Date of Birth/Trust Date:_____ f. Phone Number:_____

25. a. ☐ P ☐ C Name/Trust & Trustees:_____

    _____

    b. Address *(Street, City, State, ZIP)*:_____

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

    e. Date of Birth/Trust Date:_____ f. Phone Number:_____

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

Billing Information

27. Modal Planned Premium: $ _____

28. Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT ☐ Lump Sum
    ☐ Other *(include List Bill Number if applicable)*: _____

29. Source of Premium (Income, loan, business activity, etc.): _____

30. Premium Notices To: *(Check one only.) (Please note we cannot bill to your agent.)*
    ☐ Owner in Question 21 ☐ Insured at Residence
    ☐ Other:_____

Third Party Designee/Secondary Addressee

31. 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.

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

    Name:_____

    Address:_____

Existing and Pending Insurance Information

32. 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," please complete all required replacement forms)* ☐ Y ☐ N

33. 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," please complete all required replacement forms)* ☐ Y ☐ N

34. If you answered "Yes" to 32 and/or 33 with regards to an annuity contract, please provide company, contract number and issue date:

    _____

35. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(List in the box below.)*
If none, check this box: ☐
Please indicate the Type of coverage: Business (**B**); 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	

36. Do you have any applications currently pending or do you plan to apply for new life insurance coverage with any other company? *(If "Yes," please provide details in the space provided.)* ☐ Y ☐ N

Company	Amount	Reason Policy Applied For

37. What is the total amount of **new** life insurance coverage that will be placed inforce with **all companies including this application**? *(Do not include inforce policies listed in Question 35.)* $_____

38. Will the premiums for this policy be loaned or otherwise financed by an individual(s) or entity other than the Proposed Insured or immediate family members of the Proposed Insured? *(If "Yes," please complete the Premium Financing requirements.)* ☐ Y ☐ N

39. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes," provide further information in the space provided.)* ☐ Y ☐ N

General Risk Information—Proposed Insured

40. Do you now, or do you plan to fly within the next 2 years, or have you flown during the past 2 years as a pilot, student pilot or crew member? *(If "Yes," an Aviation Supplement is required.)* ☐ Y ☐ N

41. Do you plan to participate within the next 2 years, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, skydiving or SCUBA diving, or mountain, rock or technical climbing? *(If "Yes," an Avocation Supplement is required.)* ☐ Y ☐ N

42. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? *(If "Yes," please provide the total number of days and locations where travel is planned in number 47 below.)* ☐ Y ☐ N

43. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended or revoked? *(If "Yes," please provide dates and other details in number 47 below.)* ☐ Y ☐ N

44. Have you ever been convicted of a felony? *(If "Yes," please provide details in number 47 below including date of conviction and date of release of probation or parole.)* ☐ Y ☐ N

45. In the last 5 years have you filed for bankruptcy? ☐ Y ☐ N

If "Yes," what type of bankruptcy: _____ When was the bankruptcy discharged: _____

46. Are you a member of the Military Armed Forces, Military Reserves or National Guard? *(If "Yes," please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in number 47 below.)* ☐ Y ☐ N

47. Details to General Risk Questions: *(If more room is needed, use the Continuation of Details Supplement.)*

Question #	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) Part I; b) Part II Medical Application; 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) to the best of the Proposed Insured's knowledge and belief, the Proposed Insured(s) remain in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.
   I/We have paid $ _____ 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. (Please 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 for Life Insurance 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 incorrect 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 Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

Signatory Section

Signed in_____, this _____ day of _____ _____
(city, state) (month) (year)

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

Signature of Applicant/Owner/Trustee with Title
(If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

Signature of Applicant/Owner/Trustee with Title
(If other than Proposed Insured)
(Provide Officer's Title if policy is owned by 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 Important Notice as well as a copy of the Privacy Practices Notice.

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)

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

Name of Registered Principal of Broker/Dealer
(Please Print)

Lincoln Financial Group®

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

Agent's Report

(Completed Form Must Accompany Application for Life Insurance)

General Information

1. (a) Name of Proposed Insured(s) _____

   (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. Purpose of Insurance: (check one) ☐ Buy/Sell ☐ Key Person ☐ Charitable Gift ☐ Deferred Compensation ☐ Estate Planning ☐ Family Income ☐ Outright Gift ☐ Pension/Profit Sharing ☐ Other: _____
4. (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:

   _____
5. Do the Proposed Insured(s) and Owner(s) read and understand the English Language? ☐ Yes ☐ No If "No," how was the application completed? _____
6. If LifeComp® program was used, have you completed the required paperwork? ☐ Yes ☐ No
7. Answer only if Proposed Insured is a Homemaker.

	Amount Inforce	Amount Applied For
(a) Spouse's Life Insurance:	$ _____	$ _____

8. Answer only if Proposed Insured is under age 18.

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

   If "No," please 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, please 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
12. Total Business Assets: $_____ Total Business Liabilities: $_____ Total Business Net Worth: $_____
13. Net Income (Profit) for the past 2 years: Last year $_____ Previous year $ _____
14. 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
_____	_____	_____	$ _____	$ _____
_____	_____	_____	$ _____	$ _____
_____	_____	_____	$ _____	$ _____

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

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

    Broker/Dealer Client/Owner Account #: _____

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

    If "Yes" please describe the change requested: _____

17. Agents who participated in this application: *(please print)*

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

18. Primary Agent's: (a) Email Address: _____ (b) Phone Number: _____

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 asked and/or reviewed all the questions on this application with the Proposed Insured(s) and certify that all answers have been recorded accurately. I know nothing affecting the insurability of the Proposed Insured(s) that is not fully recorded in this application and I recommend this risk to the Company without reservation.
- ► 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, please 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, please 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**

Lincoln Financial Group®

The Lincoln National Life Insurance Company, Life Service Office: 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 testing, diagnosis, and/or treatment of communicable diseases.
- 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

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

FINANCIAL DISCLOSURE FOR CALIFORNIA RESIDENTS AGE 65 AND OVER

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 advisor 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 _____

LF02085 2/10

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 _____

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

OUT-OF-STATE SALE VERIFICATION FORM

This form must be completed if the owner is a resident of New York or Montana and the application is taken outside the state of residence. Complete and return with the application.

State of Residence of Owner _____
(or Insured in the case of a Trust)

State in Which Application Was Signed _____

The undersigned, by signing below, confirm that the policy or contract was principally negotiated, issued and delivered in the state where the application was signed. Communications between the agent and the owner pertaining to the sale, solicitation and negotiation of the policy or contract, including the signing of the application, the collection of initial premium and the issuance and delivery of the policy/ contract to the proposed owner have taken or will take place principally outside of New York or Montana, as appropriate.

_____ _____
Date Owner's Signature *(or Insured in the case of a Trust)*

_____
Insured/Annuitant Printed Name

_____ _____
Date Agent's Signature

_____
Agent Number

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.

Information We May Collect And Use

We collect personal information about you to help us identify you as 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; or 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 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.
- **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; and your payment and claims history.
- **Information from outside our family of companies**: If you are 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 from other individuals or businesses.
- **Information from your employer**: If your employer purchases group products from us, we may obtain information about you from your employer 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 have requested; provide customer service; to analyze in order to enhance our products and services; and 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.

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, 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 share your information with outside marketers who may want to offer you their own products and services; nor do we share 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 provide you with products, services, or to maintain your accounts. 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

Access: We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you request a copy of the information, we may charge you a fee for copying and mailing costs. In very limited circumstances, your request may be denied. You may then request that the denial be reviewed.

Accuracy of Information: If you feel the personal information we have about you is inaccurate or incomplete, you may ask us to amend 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. 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 the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years. If your requested change is denied, we will provide you with reasons for the denial. You may write to request the denial be reviewed. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request.

Accounting of Disclosures: If applicable, you may request an accounting of disclosures made of your medical information, except for disclosures:

- For purposes of payment activities or company operations;
- To the individual who is the subject of the personal information or to that individual's personal representative;
- To persons involved in your health care;
- For notification for disaster relief purposes;
- For national security or intelligence purposes;
- To law enforcement officials or correctional institutions;
- Included in a limited data set; or
- For which an authorization is required.

You may request an accounting of disclosures for a time period of less than six years from the date of your request.

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.

Questions about your personal information should be directed to:

Lincoln Financial Group
Attn: Enterprise Compliance and Ethics
Corporate Privacy Office, 7C-01
1300 S. Clinton St.
Fort Wayne, IN 46802

Please include all policy/contract/account numbers with your correspondence.

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

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

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

California AIDS Counseling Facilities

California Insurance Code paragraph 799.03(a) states that an Insurer must obtain written informed consent from an applicant for Life Insurance before testing and analysis of the applicants blood can be performed to determine the presence of human immunodeficiency virus (HIV) antibodies.

The California Code also requires that a list of counseling resources be made available, where the applicant can obtain assistance in understanding the meaning of the test and its results.

The following are California AIDS Counseling Facilities:

- AIDS Project—East Bay
  1320 Webster Street
  Oakland, CA 94612
  (510) 663-7979

- AIDS Project—Los Angeles
  611 S. Kingsley Dr.
  Los Angeles, CA 90005
  (213) 201-1600

- AIDS Services Foundation of Orange County
  17982 Sky Park Circle
  Suite J
  Irvine, CA 92614
  (949) 809-5700

- Central Valley AIDS Team
  PO Box 4640
  Fresno, CA 93744
  (559) 264-2437

- The CARES Foundation
  1500 21st Street
  Sacramento, CA 95811
  (916) 914-6390

- San Diego AIDS Project
  (619) 543-0300 San Diego

- San Francisco AIDS Foundation
  1035 Market Street
  Suite 400
  San Francisco, CA 94102
  (415) 581-7077

- AIDS Hotline
  U.S. Public Health Service
  (800) 342-AIDS

- Spanish AIDS Hotline
  (800) 344-7423

- AIDS Hotline—Toll free for California and
  inside San Francisco
  (800) 367-AIDS
  outside California (415) 863-AIDS

- California Dept. of Health Services
  Statewide Services—Office of AIDS
  (916) 323-7415
  Sacramento

- AIDS Health Education and Information Project/
  C.A.R.E. Program
  (562) 624-4999
  Long Beach

- National AIDS Research and Education
  (415) 626-8784
  San Francisco

- Inland Empire AIDS Coordination and
  Education Project
  (951) 683-2360
  Riverside

- AIDS Project, Hemophilia Council
  (714) 834-2604
  Santa Ana

- San Joaquin AIDS Foundation
  (209) 476-8533
  Stockton

- AIDS Education Program
  (530) 229-8400
  Redding

- Los Angeles County AIDS Education Program
  (213) 201-1547
  Los Angeles

Lincoln Financial Group®

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

HIV INFECTION AND AIDS: AN OVERVIEW

AIDS - acquired immunodeficiency syndrome - was first reported in the United States in 1981 and has since become a major worldwide epidemic. AIDS is caused by the human immunodeficiency virus (HIV). By killing or damaging cells of the body's immune system, HIV progressively destroys the body's ability to fight infections and certain cancers. People diagnosed with AIDS may get life-threatening diseases called opportunistic infections, which are caused by microbes such as viruses or bacteria that usually do not make healthy people sick.

More than 790,000 cases of AIDS have been reported in the United States since 1981, and as many as 900,000 Americans may be infected with HIV. The epidemic is growing most rapidly among minority populations and is a leading killer of African-American males ages 25 to 44. According to the U.S. Centers for Disease Control and Prevention (CDC), AIDS affects nearly seven times more African Americans and three times more Hispanics than whites.

How is HIV transmitted?

HIV is spread most commonly by having unprotected sex with an infected partner. The virus can enter the body through the lining of the vagina, vulva, penis, rectum, or mouth during sex.

HIV also is spread through contact with infected blood. Before donated blood was screened for evidence of HIV infection and before heat-treating techniques to destroy HIV in blood products were introduced, HIV was transmitted through transfusions of contaminated blood or blood components. Today, because of blood screening and heat treatment, the risk of getting HIV from such transfusions is extremely small.

HIV frequently is spread among injection drug users by the sharing of needles or syringes contaminated with very small quantities of blood from someone infected with the virus. It is rare, however, for a patient to give HIV to a health care worker or vice-versa by accidental sticks with contaminated needles or other medical instruments.

Women can transmit HIV to their babies during pregnancy or birth. Approximately one-quarter to one-third of all untreated pregnant women infected with HIV will pass the infection to their babies. HIV also can be spread to babies through the breast milk of mothers infected with the virus. If the mother takes the drug AZT during pregnancy, she can reduce significantly the chances that her baby will be infected with HIV. If health care providers treat mothers with AZT and deliver their babies by cesarean section, the chances of the baby being infected can be reduced to a rate of 1 percent.

A study sponsored by the National Institute of Allergy and Infectious Diseases (NIAID) in Uganda found a highly effective and safe drug regimen for preventing transmission of HIV from an infected mother to her newborn that is more affordable and practical than any other examined to date. Results from the study show that a single oral dose of the antiretroviral drug nevirapine (NVP) given to an HIV-infected woman in labor and another to her baby within three days of birth reduces the transmission rate by half compared with a similar short course of AZT.

Although researchers have found HIV in the saliva of infected people, there is no evidence that the virus is spread by contact with saliva. Laboratory studies reveal that saliva has natural properties that limit the power of HIV to infect. Research studies of people infected with HIV have found no evidence that the virus is spread to others through saliva by kissing. No one knows, however, whether so-called "deep" kissing, involving the exchange of large amounts of saliva, or oral intercourse increase the risk of infection. Scientists also have found no evidence that HIV is spread through sweat, tears, urine, or feces.

Studies of families of HIV-infected people have shown clearly that HIV is not spread through casual contact such as the sharing of food utensils, towels and bedding, swimming pools, telephones, or toilet seats. HIV is not spread by biting insects such as mosquitoes or bedbugs. HIV can infect anyone who practices risky behaviors such as

- Sharing drug needles or syringes
- Having sexual contact with an infected person without using a condom
- Having sexual contact with someone whose HIV status is unknown

Having a sexually transmitted disease such as syphilis, genital herpes, chlamydial infection, gonorrhea, or bacterial vaginosis appears to make people more susceptible to getting HIV infection during sex with infected partners.

What are the early symptoms of HIV infection?

Many people do not have any symptoms when they first become infected with HIV. Some people, however, have a flu-like illness within a month or two after exposure to the virus. This illness may include

- Fever
- Headache
- Tiredness
- Enlarged lymph nodes (glands of the immune system easily felt in the neck and groin)

These symptoms usually disappear within a week to a month and are often mistaken for those of another viral infection. During this period, people are very infectious, and HIV is present in large quantities in genital fluids.

More persistent or severe symptoms may not appear for 10 years or more after HIV first enters the body in adults, or within two years in children born with HIV infection. This period of "asymptomatic" infection is highly individual. Some people may begin to have symptoms within a few months, while others may be symptom-free for more than 10 years.

Even during the asymptomatic period, the virus is actively multiplying, infecting, and killing cells of the immune system. HIV's effect is seen most obviously in a decline in the blood levels of CD4 positive T cells (also called T4 cells) — the immune system's key infection fighters. At the beginning of its life in the human body, the virus disables or destroys these cells without causing symptoms.

As the immune system worsens, a variety of complications start to take over. For many people, their first sign of infection is large lymph nodes or "swollen glands" that may be enlarged for more than three months. Other symptoms often experienced months to years before the onset of AIDS include

- Lack of energy
- Weight loss
- Frequent fevers and sweats
- Persistent or frequent yeast infections (oral or vaginal)
- Persistent skin rashes or flaky skin
- Pelvic inflammatory disease in women that does not respond to treatment
- Short-term memory loss

Some people develop frequent and severe herpes infections that cause mouth, genital, or anal sores, or a painful nerve disease called shingles. Children may grow slowly or be sick a lot.

What is AIDS?

The term AIDS applies to the most advanced stages of HIV infection. CDC developed official criteria for the definition of AIDS and is responsible for tracking the spread of AIDS in the United States.

CDC's definition of AIDS includes all HIV-infected people who have fewer than 200 CD4 positive T cells per cubic millimeter of blood. (Healthy adults usually have CD4 positive T-cell counts of 1,000 or more.) In addition, the definition includes 26 clinical conditions that affect people with advanced HIV disease. Most of these conditions are opportunistic infections that generally do not affect healthy people. In people with AIDS, these infections are often severe and sometimes fatal because the immune system is so ravaged by HIV that the body cannot fight off certain bacteria, viruses, fungi, parasites, and other microbes.

Symptoms of opportunistic infections common in people with AIDS include

- Coughing and shortness of breath
- Seizures and lack of coordination
- Difficult or painful swallowing
- Mental symptoms such as confusion and forgetfulness
- Severe and persistent diarrhea
- Fever
- Vision loss
- Nausea, abdominal cramps, and vomiting
- Weight loss and extreme fatigue
- Severe headaches
- Coma

Children with AIDS may get the same opportunistic infections as do adults with the disease. In addition, they also have severe forms of the bacterial infections all children may get, such as conjunctivitis (pink eye), ear infections, and tonsillitis.

People with AIDS are particularly prone to developing various cancers, especially those caused by viruses such as Kaposi's sarcoma and cervical cancer, or cancers of the immune system known as lymphomas. These cancers are usually more aggressive and difficult to treat in people with AIDS. Signs of Kaposi's sarcoma in light-skinned people are round brown, reddish, or purple spots that develop in the skin or in the mouth. In dark-skinned people, the spots are more pigmented.

During the course of HIV infection, most people experience a gradual decline in the number of CD4 positive T cells, although some may have abrupt and dramatic drops in their CD4 positive T-cell counts. A person with CD4 positive T cells above 200 may experience some of the early symptoms of HIV disease. Others may have no symptoms even though their CD4 positive T-cell count is below 200.

Many people are so debilitated by the symptoms of AIDS that they cannot hold steady employment or do household chores. Other people with AIDS may experience phases of intense life-threatening illness followed by phases in which they function normally.

A small number of people first infected with HIV 10 or more years ago have not developed symptoms of AIDS. Scientists are trying to determine what factors may account for their lack of progression to AIDS, such as particular characteristics of their immune systems or whether they were infected with a less aggressive strain of the virus, or if their genes may protect them from the effects of HIV. Scientists hope that understanding the body's natural method of control may lead to ideas for protective HIV vaccines and use of vaccines to prevent the disease from progressing.

How is HIV infection diagnosed?

Because early HIV infection often causes no symptoms, a doctor or other health care provider usually can diagnose it by testing a person's blood for the presence of antibodies (disease-fighting proteins) to HIV. HIV antibodies generally do not reach detectable levels in the blood for one to three months following infection. It may take the antibodies as long as six months to be produced in quantities large enough to show up in standard blood tests.

People exposed to the virus should get an HIV test as soon as they are likely to develop antibodies to the virus - within 6 weeks to 12 months after possible exposure to the virus. By getting tested early, people with HIV infection can discuss with a health care provider when they should start treatment to help their immune systems combat HIV and help prevent the emergence of certain opportunistic infections (see section on treatment below). Early testing also alerts HIV-infected people to avoid high-risk behaviors that could spread the virus to others.

Most health care providers can do HIV testing and will usually offer counseling to the patient at the same time. Of course, individuals can be tested anonymously at many sites if they are concerned about confidentiality.

Health care providers diagnose HIV infection by using two different types of antibody tests, ELISA and Western Blot. If a person is highly likely to be infected with HIV and yet both tests are negative, the health care provider may request additional tests. The person also may be told to repeat antibody testing at a later date, when antibodies to HIV are more likely to have developed.

Babies born to mothers infected with HIV may or may not be infected with the virus, but all carry their mothers' antibodies to HIV for several months. If these babies lack symptoms, a doctor cannot make a definitive diagnosis of HIV infection using standard antibody tests until after 15 months of age. By then, babies are unlikely to still carry their mothers' antibodies and will have produced their own, if they are infected. Health care experts are using new technologies to detect HIV itself to more accurately determine HIV infection in infants between ages 3 months and 15 months. They are evaluating a number of blood tests to determine if they can diagnose HIV infection in babies younger than 3 months.

How is HIV infection treated?

When AIDS first surfaced in the United States, there were no medicines to combat the underlying immune deficiency and few treatments existed for the opportunistic diseases that resulted. During the past 10 years, however, researchers have developed drugs to fight both HIV infection and its associated infections and cancers.

The U.S. Food and Drug Administration (FDA) has approved a number of drugs for treating HIV infection. The first group of drugs used to treat HIV infection, called nucleoside reverse transcriptase (RT) inhibitors, interrupts an early stage of the virus making copies of itself. Included in this class of drugs (called nucleoside analogs) are AZT, ddC (zalcitabine), ddI (dideoxyinosine), d4T (stavudine), 3TC (lamivudine), abacavir (ziagen), and tenofovir (viread). These drugs may slow the spread of HIV in the body and delay the start of opportunistic infections.

Health care providers can prescribe non-nucleoside reverse transcriptase inhibitors (NNRTIs), such as delvaridine (Rescriptor), nevirapine (Viramune), and efravirenz (Sustiva), in combination with other antiretroviral drugs.

More recently, FDA has approved a second class of drugs for treating HIV infection. These drugs, called protease inhibitors, interrupt virus replication at a later step in its life cycle. They include

- Ritonavir (Norvir)
- Saquinivir (Invirase)
- Indinavir (Crixivan)
- Amprenivir (Agenerase)
- Nelfinavir (Viracept)
- Lopinavir (Kaletra)

Because HIV can become resistant to any of these drugs, health care providers must use a combination treatment to effectively suppress the virus. When RT inhibitors and protease inhibitors are used in combination, it is referred to as highly active antiretroviral therapy, or HAART, and can be used by people who are newly infected with HIV as well as people with AIDS.

Researchers have credited HAART as being a major factor in significantly reducing the number of deaths from AIDS in this country. While HAART is not a cure for AIDS, it has greatly improved the health of many people with AIDS and it reduces the amount of virus circulating in the blood to nearly undetectable levels. Researchers, however, have shown that HIV remains present in hiding places, such as the lymph nodes, brain, testes, and retina of the eye, even in patients who have been treated.

Despite the beneficial effects of HAART, there are side effects associated with the use of antiviral drugs that can be severe. Some of the nucleoside RT inhibitors may cause a decrease of red or white blood cells, especially when taken in the later stages of the disease. Some may also cause inflammation of the pancreas and painful nerve damage. There have been reports of complications and other severe reactions, including death, to some of the antiretroviral nucleoside analogs when used alone or in combination. Therefore, health care experts recommend that people on antiretroviral therapy be routinely seen and followed by their health care providers. The most common side effects associated with protease inhibitors include nausea, diarrhea, and other gastrointestinal symptoms. In addition, protease inhibitors can interact with other drugs resulting in serious side effects.

A number of drugs are available to help treat opportunistic infections to which people with HIV are especially prone. These drugs include

- Foscarnet and ganciclovir to treat cytomegalovirus (CMV)eye infections
- Fluconazole to treat yeast and other fungal infections
- Trimethoprim/sulfamethoxazole (TMP/SMX) or pentamidine to treat *Pneumocystis carinii* pneumonia (PCP)

In addition to antiretroviral therapy, health care providers treat adults with HIV, whose CD4+ T-cell counts drop below 200, to prevent the occurrence of PCP, which is one of the most common and deadly opportunistic infections associated with HIV. They give children PCP preventive therapy when their CD4+ T-cell counts drop to levels considered below normal for their age group. Regardless of their CD4+ T-cell counts, HIV-infected children and adults who have survived an episode of PCP take drugs for the rest of their lives to prevent a recurrence of the pneumonia.

HIV-infected individuals who develop Kaposi's sarcoma or other cancers are treated with radiation, chemotherapy, or injections of alpha interferon, a genetically engineered naturally occurring protein.

How can HIV infection be prevented?

Because no vaccine for HIV is available, the only way to prevent infection by the virus is to avoid behaviors that put a person at risk of infection, such as sharing needles and having unprotected sex.

Many people infected with HIV have no symptoms. Therefore, there is no way of knowing with certainty whether a sexual partner is infected unless he or she has repeatedly tested negative for the virus and has not engaged in any risky behavior.

People should either abstain from having sex or use male latex condoms or female polyurethane condoms, which may offer partial protection, during oral, anal, or vaginal sex. Only water-based lubricants should be used with male latex condoms.

Although some laboratory evidence shows that spermicides can kill HIV, researchers have not found that these products can prevent a person from getting HIV.

The risk of HIV transmission from a pregnant woman to her baby is significantly reduced if she takes AZT during pregnancy, labor, and delivery, and her baby takes it for the first six weeks of life.

What research is going on?

NIAID-supported investigators are conducting an abundance of research on all areas of HIV infection, including developing and testing preventive HIV vaccines and new treatments for HIV infection and AIDS- associated opportunisitc infections. Researchers also are investigating exactly how HIV damages the immune system. This research is identifying new and more effective targets for drugs and vaccines. NIAID-supported investigators also continue to trace how the disease progresses in different people.

Scientists are investigating and testing chemical barriers, such as topical microbicides, that people can use in the vagina or in the rectum during sex to prevent HIV transmission. They also are looking at other ways to prevent transmission, such as controlling sexually transmitted diseases and modifying people's behavior, as well as ways to prevent transmission from mother to child.

MORE INFORMATION

NIAID is a component of the National Institutes of Health (NIH). NIAID supports basic and applied research to prevent, diagnose, and treat infectious and immune-mediated illnesses, including HIV/AIDS and other sexually transmitted diseases, illness from potential agents of bioterrorism, tuberculosis, malaria, autoimmune disorders, asthma and allergies.

Press releases, fact sheets and other NIAID-related materials are available on the NIAID Web site at http://www.niaid.nih.gov.

Prepared by:
Office of Communications and Public Liaison
National Institute of Allergy and Infectious Diseases
National Institutes of Health
Bethesda, MD 20892

U.S. Department of Health and Human Services

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

Lincoln Financial Group®

LIFE INSURANCE BUYER'S GUIDE

This guide can help you when you shop for life insurance. It discusses how to:

- Find a policy that meets your needs and fits your budget
- Decide how much insurance you need
- Make informed decisions when you buy a policy

Prepared by the National Association of
Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

Reprinted by
The Lincoln National Life Insurance Company

IMPORTANT THINGS TO CONSIDER

- Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
- Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you afford it?
- Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
- Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
- Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance **may be costly**.
- Read your policy carefully. Ask your agent or company about anything that is not clear to you.
- Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

BUYING LIFE INSURANCE

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need - and for how long - and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

WHAT ABOUT THE POLICY YOU HAVE NOW?

If you are thinking about dropping a life insurance policy, here are some points you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

HOW MUCH DO YOU NEED?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

WHAT IS THE RIGHT KIND OF LIFE INSURANCE?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also, ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period - even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the early years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would initially pay for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

LIFE INSURANCE ILLUSTRATIONS

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what ***could*** happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

FINDING A GOOD VALUE IN LIFE INSURANCE

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find one which is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at ***all*** ages for ***all*** kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

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.**

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®

Anti-Money Laundering Alert
Lincoln Financial Group's Position Regarding Marijuana-Related Businesses

The Lincoln National Life Insurance Company, Lincoln Life & Annuity Company of New York, and other affiliates of Lincoln Financial Group (herein referred to as "Lincoln") continue to monitor recent state legislative activity regarding the legalization of marijuana use. There are currently 20 states and the District of Columbia that have legalized certain marijuana-related activity. Although the majority of these states restrict the sale of marijuana for medicinal purposes only, Colorado and Washington also permit the sale of marijuana for recreational purposes.

Despite these state laws, the Controlled Substances Act makes it illegal under federal law for someone to manufacture, sell and/or distribute marijuana. In August 2013, U.S. Department of Justice Deputy Attorney General James M. Cole issued a memorandum to all U.S. Attorneys reiterating Congress's determination that marijuana is a dangerous drug and that the illegal distribution and sale of marijuana is a serious crime that provides a significant source of revenue to large-scale criminal organizations.

In February 2014, the Financial Crimes Enforcement Network ("FinCEN") issued guidance to clarify the expectations under the Bank Secrecy Act for financial institutions which provide services to marijuana-related businesses. The FinCEN guidance requires financial institutions, including life insurance companies, to assess the risks associated with opening accounts or issuing policies to individuals or companies associated with the manufacturing, sale or distribution of marijuana. The guidance further requires financial institutions to file Suspicious Activity Reports ("SARs") for any customer involved in a marijuana-related business because federal law prohibits the distribution and sale of marijuana and, thus, views such activity as inherently involving funds derived from illegal activity.

Because the federal laws define marijuana as an illegal drug, and because of the risks inherent in marijuana-related businesses, Lincoln will not issue any policies or contracts or open accounts for an individual or business involved in the manufacturing, sale or distribution of marijuana. We ask for your partnership in identifying any customers who have submitted an application for a policy, contract or account to Lincoln who are involved in marijuana-related businesses (whether for medicinal or recreational purposes) so that we can prevent the issuance of a policy, contract or account. If, after a policy, contract or account is issued or opened, you discover that a customer is involved in marijuana-related businesses, please contact us via our Fraud Hotline at https://www.lfg.com/LincolnPageServer?LFGPage=/lfg/lfgclient/cus/fraud/index.html.

As the federal and state legislative environment regarding marijuana continues to evolve, Lincoln will monitor the potential impacts to our business and update you regarding our position accordingly.

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

Lincoln Financial Group®

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

Agent's Report

(Completed Form Must Accompany Application for Life Insurance)

General Information

1. (a) Name of Proposed Insured(s) _____

   (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. Purpose of Insurance: (check one) ☐ Buy/Sell ☐ Key Person ☐ Charitable Gift ☐ Deferred Compensation ☐ Estate Planning ☐ Family Income ☐ Outright Gift ☐ Pension/Profit Sharing ☐ Other: _____
4. (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:

   _____
5. Do the Proposed Insured(s) and Owner(s) read and understand the English Language? ☐ Yes ☐ No If "No," how was the application completed? _____
6. If LifeComp® program was used, have you completed the required paperwork? ☐ Yes ☐ No
7. Answer only if Proposed Insured is a Homemaker.

	Amount Inforce	Amount Applied For
(a) Spouse's Life Insurance:	$ _____	$ _____

8. Answer only if Proposed Insured is under age 18.

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

   If "No," please 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, please 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
12. Total Business Assets: $_____ Total Business Liabilities: $_____ Total Business Net Worth: $_____
13. Net Income (Profit) for the past 2 years: Last year $_____ Previous year $ _____
14. 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
_____	_____	_____	$ _____	$ _____
_____	_____	_____	$ _____	$ _____
_____	_____	_____	$ _____	$ _____

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

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

    Broker/Dealer Client/Owner Account #:_____

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

    If "Yes" please describe the change requested: _____

17. Agents who participated in this application: *(please print)*

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

18. Primary Agent's: (a) Email Address:_____ (b) Phone Number:_____

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 asked and/or reviewed all the questions on this application with the Proposed Insured(s) and certify that all answers have been recorded accurately. I know nothing affecting the insurability of the Proposed Insured(s) that is not fully recorded in this application and I recommend this risk to the Company without reservation.
- ► 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, please 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, please 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**

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

Employer Owned Life Insurance Consent and Notice

Employer's Name _____

Your Employer is considering the purchase of one or more life insurance policies on your life. The Pension Protection Act of 2006 requires all employers to provide information regarding the life insurance program to affected employees, and obtain the employee's consent to the purchase of the life insurance policy on his or her life.

Please read this notice and carefully consider your Employer's request to purchase life insurance on your life. Please sign this form if you are willing to consent to the purchase of life insurance on your life.

Please note, all benefits paid under any policy issued, will be paid to the employer or a designee of the employer.

The maximum face amount of life insurance for which you may be insured at the time of issue

is _____ .

Consent

I consent to the purchasing of one or more life insurance policies on my life. I understand that the maximum face amount of life insurance on my life, as of the time of issue, is the dollar amount shown above. I understand and agree that the Employer may be the sole owner and may be the sole beneficiary of the life insurance policy(ies) on my life. I further understand and agree that the Employer may continue the life insurance coverage after my employment terminates.

_____ _____

Signature of Employee **Date**

Important Note About This Sample Document: In order to comply with the requirement of the Pension Protection Act of 2006, you should provide a Notice, and obtain a signed Consent, from all affected employees if the trade or business, or a related party, is directly or indirectly a beneficiary under the policy. The employer must determine which employees are eligible to be insured within the restrictions imposed by the Pension Protection Act of 2006. The above Sample Consent should be reviewed by your attorney or legal advisor before use. Neither Lincoln Financial Group, nor any of its representatives, is authorized or permitted to provide legal or tax advice.

LF06337
2/13

The Lincoln National Life Insurance Company, Fort Wayne, IN 46801
Service Office: PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as "the Company")

CALIFORNIA DISCLOSURE NOTICE TO PERSONS AGE 65 AND OLDER

Note Instructions to Agent/Broker/Registered Representative - This notice must be delivered no less than 24 hours and no more than 14 days prior to initial meeting if meeting is to be held in Proposed Owner/Insured's home. If other than initial meeting in Proposed Owner/Insured's home and request for meeting in Proposed Owner/Insured's home was initiated same day by Proposed Owner/Insured, this notice may be delivered prior to meeting.

The following information is being presented to you in compliance with California Insurance Code Section 789.10:

(1) I am a licensed insurance agent, my purpose for coming to your home is to sell, discuss, and/or deliver one of the following:

☐ Life insurance, including annuities

☐ Other insurance products (specify): _____ .

(2) You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.

(3) You have the right to end the meeting at any time.

(4) You have the right to contact the California Department of Insurance for information, or to file a complaint. (The Consumer Toll-Free Hotline is: 800-927-4357).

(5) The following individuals will be coming to your home (list all attendees, including full names, insurance license numbers, mailing address and telephone number):

Lincoln Financial Group®

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

FOREIGN TRAVEL OR RESIDENCE SUPPLEMENT

Proposed Insured: _____ Date of Birth *(mm/dd/yy)*: _____

1. Citizen of (Country) _____
2. To what countries do you intend to travel? _____

   _____
3. Purpose of Trip _____

   _____
4. What cities will you be visiting? _____

   _____
5. How often do you travel to these locations? _____
6. Give Dates of Travel or Residence:

   From (month and year): _____ To (month and year): _____
7. Do you anticipate any flying other than as a passenger on a regularly scheduled commercial airline?

I have read or have had read to me the completed Foreign Travel or Residence Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete and true. I agree that this Foreign Travel or Residence Supplement constitutes a part of my application for insurance. I understand that any false statements or material misrepresentations may result in the loss of coverage under the policy.

Signed in _____, this _____ day of _____ _____
(state) (month) (year)

_____ _____
Signature of Proposed Insured (Parent or Guardian if under 14 years of age) **Witness**