



APPLICATION
FOR
LIFE INSURANCE

THE LINCOLN NATIONAL
LIFE INSURANCE COMPANY

**LFF06321-11
(PENNSYLVANIA)**

APPLICATION FOR LIFE INSURANCE

GENERAL INSTRUCTIONS FOR COMPLETING THE APPLICATION

Please follow these instructions carefully. If you have any questions, please contact your Marketing Department for assistance before completing this application. Thank you for the opportunity to underwrite your business.

Please complete #1 of the Agreement and Acknowledgement Section to indicate which Sections of the Application you are submitting.

COMPLETING THE 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, sign and date the application.
- The **LICENSED AGENT OR BROKER** must complete and date the **AGENT'S REPORT**.
- Include the completed Health Summary Sections (applicable to each Proposed Insured) when submitting an application if a completed Medical Supplement (Part II) will not be submitted or to initiate the underwriting process while an exam and Medical Supplement (Part II) are awaiting completion.
- While completion of the applicable Health Summary Sections 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 Health Summary Section must be completed.
- If applying for Variable Life Insurance please complete the Suitability Section on Page 4 of 5, the completed VUL/SVUL Allocations form must accompany the application.
- If applying for a term product, the billing options are: EFT; List Bill - 5 or more insureds; or Direct - Annual only.
- Please refer to product specifications for complete details and billing options.

AUTHORITY

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

TEMPORARY 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 noted at the top of the page 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 is 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 noted at the top of the page.
 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

- **This application is broken out in Sections (A-D) and you can either "tear-out" or not print those sections that you do not use. Please indicate in #1 of the Agreement and Acknowledgement Section (via check boxes) which Sections of the Application you are submitting.**
- If there is only 1 proposed insured, then you do not need to send in Sections B and C for Proposed Insured B. These are not needed and the application will be in good order without them. Please indicate on Page 4 of 5 in the Agreement and Acknowledgement Section #1 which Sections you are including.
- Section D, Defined Age Questionnaire, needs to be completed if either Proposed Insured is age 70 or older.
- Question 31 and 37; enter Owner(s) information here, including the name of the trust and trustees.
- Questions 62 – 64; please complete these questions if you will not be completing a Medical Supplement. Please include the full name, address and phone number for each physician consulted, as this will assist with the underwriting process.

IMPORTANT NOTICE

Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of these notices to each Proposed Insured.)

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 his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

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 are conducted with neighbors, friends, business associates, and acquaintances. 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.

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 nonprofit 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 at: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)

IMPORTANT NOTICE

Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of these notices to each Proposed Insured.)

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 his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

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 are conducted with neighbors, friends, business associates, and acquaintances. 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.

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 nonprofit 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 at: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)

APPLICATION FOR LIFE INSURANCE - PART I

APPLICANT INFORMATION - PROPOSED INSURED A (Required Section)

1. Proposed Insured A <i>(First, Middle, Last)</i>		2. <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Date of Birth (If over age 70, please complete Section D.) <i>(mm/dd/yy)</i>	4. Soc. Sec. No.	5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," what country?	
6. Place of Birth <i>(State, Country)</i>	7. Driver's License # & State		
8. Home Address <i>(Street, City, State, ZIP)</i>			
9. Occupation/Duties	10. Employer		
11. Business Address <i>(Street, City, State, ZIP)</i>			
12. Annual Earned Income \$	13. Annual Unearned Income \$	14. Net Worth \$	
15. In the last 5 years have you filed for bankruptcy? <input type="checkbox"/> Y <input type="checkbox"/> N <i>(If "Yes," please complete the Financial Supplement.)</i>	16. Primary Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	17. Work Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	

COVERAGE INFORMATION (As available per product)

18. Plan of Insurance _____ 19. Amount of Insurance \$ _____
(Specified Amount, if UL or VUL)

20. (i) Death Benefit Option *(Complete for Universal Life and Variable Universal Life Product only - not required for Term or Whole Life.)*
 Level Increase by Cash Value Increase by Premium Increase by Premium Less Policy Factor

(ii) 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.

21. Save Age? Y N *(If not saving age, policy will be current dated.)*

22. Additional Benefits and Riders: <i>(If applicable)</i>	<input type="checkbox"/> Waiver of Premium
<input type="checkbox"/> Supplemental Coverage \$ _____	<input type="checkbox"/> Waiver of Monthly Deductions
<input type="checkbox"/> Term on Spouse/Other Insured Rider \$ _____ <i>(Please complete Section B - Applicant Information - Proposed Insured B)</i>	<input type="checkbox"/> Waiver of Specified Premium \$ _____
<input type="checkbox"/> Accelerated Benefit Rider	<input type="checkbox"/> Children's Term Insurance Rider <i>(Complete Child's Supplement)</i>

Other Benefits and Riders *(not listed above)*. (Please provide full details: e.g. coverage amounts/percentages/etc.):

BILLING INSTRUCTIONS (As available per product)

23. Premium Mode: Annual Semi-Annual Quarterly Monthly (EFT) Other _____

24. Modal Planned Premium: \$ _____ 25. Lump Sum: \$ _____ 1035 Exchange

26. Special Billing: *(check one, if applicable)* New List Bill Existing List Bill Number: _____

27. Source of Premium: _____ 28. Automatic Premium Loan: Y N
(inheritance, loan, business activity) (Complete for Whole Life only.)

29. Premium Notices To: *(check one only.) (Please note we cannot bill to your agent.)*
 Owner in Question 31 Owner in Question 37 Insured at Business Insured at Residence Other *(indicate below)*

30. Special Instructions:

OWNER INFORMATION (If left blank, Proposed Insured(s) will be owner)

31. Owner Name	
32. Owner Address	
33. Relationship to Proposed Insured(s)	34. Owner Soc. Sec. No. / TIN
35. Date of Birth/Trust Date	36. Citizen of (Country)
37. Owner Name	
38. Owner Address	
39. Relationship to Proposed Insured(s)	40. Owner Soc. Sec. No. / TIN
41. Date of Birth/Trust Date	42. Citizen of (Country)

43. 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? Y N

BENEFICIARY DESIGNATION (Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.)

Select Primary (P) or Contingent (C) Beneficiary for each line completed. If Trust, check here .

44. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
45. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
46. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
47. <input type="checkbox"/> P <input type="checkbox"/> C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
48.	Special Instructions	

APPLICANT INFORMATION - PROPOSED INSURED A

49. Are you, or are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Y N
(If "Yes", please complete and sign all required replacement forms.)

50. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. (Please list in the box below.)

If none, check this box:

Please indicate the Type of coverage: Business (B); Key Person (K); or Personal (P).

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	1035 Exchange	Type
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

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

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	\$		
	\$		

52. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? \$ _____

53. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? (If "Yes", please complete the Premium Financing Supplement.) Y N

54. 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 "Details" space provided.) Y N

GENERAL RISK INFORMATION - PROPOSED INSURED A

55. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? (If "Yes", an Aviation Supplement is required; this includes balloon pilots.) Y N

56. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? (If "Yes", an Avocation Supplement is required.) Y N

57. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? (If "Yes", a Foreign Travel or Residence Supplement is required.) Y N

58. 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, restricted or revoked? (If "Yes," please indicate what type and dates in the "Details" space provided.) Y N

59. Have you ever been convicted of or are you awaiting trial for a felony? (If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in the "Details" space provided.) Y N

60. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, 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 the "Details" space provided.) Y N

61. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? (If "Yes", list below.) Y N

Type:	Date First Used: (month/year)	Date Last Used: (month/year)	Amount and Frequency:

MEDICAL INFORMATION - PROPOSED INSURED A (Answer this section only when required.)

62. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

63. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? Y N
 Weight _____ lbs. b. If "Yes," by how many pounds? _____ Gain Loss

64.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? (include age of onset)	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

65. **Details:** (List details from questions answered "Yes" and please specify to which question numbers details pertain.)

SECTION A - HEALTH SUMMARY

APPLICANT INFORMATION - PROPOSED INSURED A

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

1. Proposed Insured A <i>(First, Middle, Last)</i>	2. Date of Birth <i>(mm/dd/yy)</i>
► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.	
	Yes No
3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	<input type="checkbox"/> <input type="checkbox"/>
4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	<input type="checkbox"/> <input type="checkbox"/>
5. Have you ever had, been diagnosed with, and/or treated by a licensed medical professional for:	
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	<input type="checkbox"/> <input type="checkbox"/>
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	<input type="checkbox"/> <input type="checkbox"/>
c. Anemia, leukemia, clotting disorder or any other blood disorder?	<input type="checkbox"/> <input type="checkbox"/>
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	<input type="checkbox"/> <input type="checkbox"/>
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	<input type="checkbox"/> <input type="checkbox"/>
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	<input type="checkbox"/> <input type="checkbox"/>
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	<input type="checkbox"/> <input type="checkbox"/>
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	<input type="checkbox"/> <input type="checkbox"/>
i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	<input type="checkbox"/> <input type="checkbox"/>
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	<input type="checkbox"/> <input type="checkbox"/>
k. Any disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> <input type="checkbox"/>
l. Any mental or physical disorder or medically or surgically treated condition not listed above?	<input type="checkbox"/> <input type="checkbox"/>
6. Have you ever been diagnosed with, and/or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome (AIDS), or any condition which you were medically advised is related to AIDS?	<input type="checkbox"/> <input type="checkbox"/>
7. Do you use alcoholic beverages? <i>(If "Yes", provide Type, Frequency & Amount.)</i>	<input type="checkbox"/> <input type="checkbox"/>
Type _____ Frequency _____ Amount _____	
8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	<input type="checkbox"/> <input type="checkbox"/>
9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	<input type="checkbox"/> <input type="checkbox"/>
10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.	
11. Details: <i>(List details from questions answered "Yes" and please specify to which question numbers details pertain.)</i>	

SECTION B - ADDITIONAL INSURED

APPLICANT INFORMATION - PROPOSED INSURED B

1. Proposed Insured B <i>(First, Middle, Last)</i>		2. <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Date of Birth (If over age 70 please complete Section D.) <i>(mm/dd/yy)</i>	4. Soc. Sec. No.	5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," what country?	
6. Place of Birth <i>(State, Country)</i>	7. Driver's License # & State		
8. Home Address <i>(Street, City, State, ZIP)</i>			
9. Occupation/Duties		10. Employer	
11. Business Address <i>(Street, City, State, ZIP)</i>			
12. Annual Earned Income \$	13. Annual Unearned Income \$	14. Net Worth \$	
15. In the last 5 years have you filed for bankruptcy? <input type="checkbox"/> Y <input type="checkbox"/> N <i>(If "Yes," please complete the Financial Supplement.)</i>	16. Primary Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	17. Work Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	

18. Beneficiary for applicable Rider: a. Name		
b. Soc Sec. No./TIN	c. Relationship to Proposed Insured B	

19. Are you, or are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Y N
(If "Yes", please complete and sign all required replacement forms.)

20. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*
If none, check this box:
 Please indicate the Type of coverage: Business **(B)**; Key Person **(K)**; or Personal **(P)**.

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	1035 Exchange	Type
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

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

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	\$		
	\$		

22. What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? \$ _____

23. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes", please complete the Premium Financing Supplement.)* Y N

24. 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 "Details" space provided.)* Y N

GENERAL RISK INFORMATION - PROPOSED INSURED B

25. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? (If "Yes", an Aviation Supplement is required; this includes balloon pilots.) Y N

26. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? (If "Yes", an Avocation Supplement is required.) Y N

27. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? (If "Yes", a Foreign Travel or Residence Supplement is required.) Y N

28. 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, restricted or revoked? (If "Yes," please indicate what type and dates in space provided below.) Y N

29. Have you ever been convicted of or are you awaiting trial for a felony? (If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in space provided below.) Y N

30. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, 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; on the space provided below.) Y N

31. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? (If "Yes", list below.) Y N

Type	Date First Used: (month/year)	Date Last Used: (month/year)	Amount and Frequency:

MEDICAL INFORMATION - PROPOSED INSURED B (Answer this section only when required.)

32. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

33. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? Y N
 Weight _____ lbs. b. If "Yes," by how many pounds? _____ Gain Loss

34.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? (include age of onset)	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

35. **Details:** (List details from questions answered "Yes" and please specify to which question numbers details pertain.)

SECTION C - HEALTH SUMMARY

APPLICANT INFORMATION PROPOSED INSURED B

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

1. Proposed Insured B <i>(First, Middle, Last):</i>	2. Date of Birth <i>(mm/dd/yy):</i>
► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.	
	Yes No
3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	<input type="checkbox"/> <input type="checkbox"/>
4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	<input type="checkbox"/> <input type="checkbox"/>
5. Have you ever had, been diagnosed with, and/or treated by a licensed medical professional for:	
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	<input type="checkbox"/> <input type="checkbox"/>
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	<input type="checkbox"/> <input type="checkbox"/>
c. Anemia, leukemia, clotting disorder or any other blood disorder?	<input type="checkbox"/> <input type="checkbox"/>
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	<input type="checkbox"/> <input type="checkbox"/>
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	<input type="checkbox"/> <input type="checkbox"/>
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	<input type="checkbox"/> <input type="checkbox"/>
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	<input type="checkbox"/> <input type="checkbox"/>
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	<input type="checkbox"/> <input type="checkbox"/>
i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	<input type="checkbox"/> <input type="checkbox"/>
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	<input type="checkbox"/> <input type="checkbox"/>
k. Any disorder of the eyes, ears, nose or throat?	<input type="checkbox"/> <input type="checkbox"/>
l. Any mental or physical disorder or medically or surgically treated condition not listed above?	<input type="checkbox"/> <input type="checkbox"/>
6. Have you ever been diagnosed with, and/or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome (AIDS), or any condition which you were medically advised is related to AIDS?	<input type="checkbox"/> <input type="checkbox"/>
7. Do you use alcoholic beverages? <i>(If "Yes", provide Type, Frequency & Amount.)</i>	<input type="checkbox"/> <input type="checkbox"/>
Type _____ Frequency _____ Amount _____	
8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	<input type="checkbox"/> <input type="checkbox"/>
9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	<input type="checkbox"/> <input type="checkbox"/>
10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.	
11. Details: <i>(List details from questions answered "Yes" and please specify to which question numbers details pertain.)</i>	

SECTION D - DEFINED AGE QUESTIONNAIRE
(Complete if either Proposed Insured is age 70 or over.)

1. Proposed Insured A (First, Middle, Last) _____

2. Proposed Insured B (First, Middle, Last) _____

	Proposed Insured A	Proposed Insured B
3. Will you, the proposed insured and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
4. Have you, the proposed insured, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf which will have an ownership or beneficial interest in this policy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Have you, the proposed insured, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the proposed insured, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
6. Have you, the proposed insured, ever sold a policy to a life settlement, viatical or other secondary market provider, or are you in the process of selling a policy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
7. Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.)		

OWNER INFORMATION

	Owner
8. Owner Name _____	
9. Will you, the proposed owner and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Have you, the proposed owner, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf?	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Have you, the owner, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the owner, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? (If "Yes", please complete the Premium Financing Application Supplement.)	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.)	

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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

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 (including Sections A-D if needed); b) Part II Medical Application, if required; 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. This Application for Life Insurance - Part I shall be complete when it includes Applicant Information - Proposed Insured A, and any or none of the following (please check, as applicable, included Sections A-D):

- Section A- Health Summary -Proposed Insured A, Section B- Applicant Information -Proposed Insured B,
 Section C -Health Summary -Proposed Insured B, and Section D - Defined Age Questionnaire.

2. **The company will have no liability (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), under this application unless and until: a) it has been received and approved by the Company at its Service Office: b) the policy has been issued and delivered to the policyowner; c) the first premium has been paid to and accepted by the Company; and d) at the time of delivery and payment, the facts concerning the insurability of each person proposed for insurance are as stated in this application.**

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. 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. 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.
5. 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.
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 of insurance, amount of insurance, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURES

AR, KY, ME, NM, OH and PA Only. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TRUST VERIFICATION

I/WE hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me/us or my/our physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I/We authorize the Company to disclose information related to my insurability to MIB, Inc., and to other insurers to whom I/we may apply for coverage.

I/We 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/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

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.

SIGNATORY SECTION

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

Signature of Proposed Insured A
(Parent or Guardian if under 18 years of age)

Signature of Proposed Insured B (If coverage applied for)
(Parent or Guardian if under 18 years of age)

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

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

TO BE COMPLETED BY AGENT ONLY

(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)

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:
Details: _____

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Managing General Agency (MGA), Brokerage General Agency (BGA), or Independent Marketing Organization (IMO):

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 (xxx-xx-xxxx)	Agent Number or Sa/Pc Code Share	% Comm.
Writing			%
Second			%
Third			%

18. Primary Agent's: (a) E-mail Address: _____ (b) Phone Number: _____

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

Please 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

Complete this section if you are affiliated with a MGA, RLS or RD:

20. MGA/RD/RLS Name: _____

21. Broker Dealer Client/Owner Account #: _____

Broker Dealer Affiliation: _____

AGENT CERTIFICATION

- ▶ I have reviewed all the questions on this application with the Proposed Insured and confirmed with the Proposed Insured that the answers have been recorded accurately. I know of nothing affecting the insurability of the Proposed Insured(s) which is not fully recorded in this application.
- ▶ I declare that I have provided each Proposed Insured and Owner with the Important Notice as well as a copy of the Privacy Practices Notice.
- ▶ 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 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 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

PENNSYLVANIA 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 AIDS-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.

The Pennsylvania Health Department can provide information regarding alternative HIV-related testing sites and counseling services. More information may be obtained on such testing and counseling by calling (717) 783-0479.

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 you wish to be informed of a negative test result, initial here: _____. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated. 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: _____

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 the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by one of the following organizations. Please designate your choice by checking the appropriate box:

The Pennsylvania Health Department Bureau of HIV/AIDS, PO Box 90, Harrisburg, PA 17108

The local Health Department _____

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.

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

DISCLOSURE STATEMENT FOR TERMINAL CONDITION ACCELERATED BENEFIT RIDER

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 Condition 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 Condition. 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 Condition – a noncorrectable medical condition, which will result in the death of the Insured within 6 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.

Below is an example of how the payment of the maximum accelerated benefit would affect a level premium policy with cash values, a policy loan and \$100,000 face amount.

	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 no later than the time the benefit is made, for attachment to your policy, a new policy data page showing the decrease in policy values and loan balance resulting from the payment.

I ACKNOWLEDGE RECEIPT OF THIS DISCLOSURE.

Signature of Agent Date

Signature of the Proposed Insured Date

Signature of Owner (If other than Proposed Insured) Date



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

CERTIFICATION FOR DISCLOSURE STATEMENT

Name of Proposed Owner/Applicant: _____

I hereby certify that I have delivered a Disclosure Statement to the proposed owner/applicant prior to the signing of the application for coverage.

Date

Signature of Agent



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

CERTIFICATION FOR SURRENDER COMPARISON INDEX DISCLOSURE

Name of Proposed Owner/Applicant: _____

I hereby certify that the Surrender Comparison Index Disclosure Statement was delivered to the owner/applicant upon delivery of the policy or earlier at the request of the owner/applicant.

Date

Signature of Agent



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

DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE.

THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

Name of Proposed Insured(s): _____ Age(s): _____ Sex(es): _____

* Name of Agent preparing disclosure: _____

* Agent home or agency address: _____

* Telephone number of Agent: _____

Name of Insurer: The Lincoln National Life Insurance Company

Home Office Address
 (City and State): Ft. Wayne, IN

Direct all
 Correspondence to: The Lincoln National Life Insurance Company
 PO Box 21008
 Greensboro, NC 27420

	Descriptive Title of Coverage	Face Amount of Coverage (1) If not applicable, Description of Coverage	Annual Premium If not known, Premium for Mode Quoted
*Policy			
*Rider(s)			

*(1) The face amount of coverage of the _____ (indicate if policy or rider) changes as follows

Total _____ (indicate if initial, annual, monthly, etc.) premium for the policy and rider(s) will be \$_____.

*Retirement Income. Your policy is designed to pay a guaranteed retirement income of \$_____ starting at _____ (indicate age, year) for _____ (indicate duration or life), but no less than 10 years.

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

*Guaranteed Cash Value. If you continuously pay your premiums on this policy as they come due, you will have the following guaranteed value for each \$1,000 (or face amount). *You may borrow against this cash value at an annual _____% loan interest rate.

Number of Years Policy Has Been in Force	5	10	20	AGE 65
Total Accumulated Cash Value Per \$1,000 (or Total Face Amount)				

*Dividends. The following is a dividend illustration for your policy based on the current interest, mortality and expense experience of the company as reflected in the dividends currently paid. However, the illustrations are not a guarantee of what future dividends will be.

*Payment of the first year's policy dividend is contingent upon the payment of the premiums for the full second policy year.

Number of Years Policy Has Been in Force	10	20
Illustrated Dividend for that Individual Year per \$1000 (or Face Amount)		

*A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

*The prospective insured has has not requested an earlier delivery of the Index.

Upon request either the Company or agent will furnish you with additional information about the insurance described.

*If inapplicable to insurance being offered, section may be clearly marked "Not Applicable."



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

**SURRENDER COMPARISON INDEX DISCLOSURE
PER \$1,000 OF FACE AMOUNT OF BASIC INSURANCE**

Name of Insured(s): _____ Age(s): _____ Sex(es): _____

Face Amount of Policy: _____

Descriptive Title of Policy
(Flexible Premium Adjustable Life, Whole Life, etc.): _____

Policy Number: _____

10 Year Surrender Index: _____ *(reflects equivalent level annual dividend and a termination dividend in the total amount of _____)

20 Year Surrender Index: _____ *(reflects equivalent level annual dividend and a termination dividend in the total amount of _____)

*Based on 20___ Dividend Scale. Dividends are not guaranteed and are subject to change.

The Surrender Comparison Index was designed to measure the relative cost of life insurance protection and may be useful for comparison of similar policies offered by other companies. Technically, the Index shows the relationship between the amounts paid by the owner/applicant (the average annual premiums minus any average annual dividend) and the amounts paid by the insurer (the cash value of the policy in the event of surrender over periods of 10 and 20 years all adjusted for compound interest at the rate of five percent per annum to reflect the timing of the payments).

*The Index reflects illustrative dividends based upon the current year's dividend scale. In the case of participating life insurance policies, the Index may change since future dividends are subject to change depending on the Company's experience. If future dividends increase within the 10 or 20 year period, the Index will be lower; if dividends decrease, the Index will be higher.

When comparing similar policies, if all things are equal, the policy with the lower Index is generally the lower cost policy and the better buy in the event that the policy was surrendered at the end of the designated period. If death would occur during the designated period, the policy with the lower Index would not necessarily be the lower cost policy. The Index does not take into account, among other things: (1) the value of the services of an agent or Company; (2) the relative strength and reputation of the Company; and (3) small differences in policy provisions. The Index does assume that annual premiums are paid, *that dividends are taken in cash or applied to premiums, and that no additional benefit provisions are included.

*If inapplicable, section may be clearly marked "Not Applicable".

AUTHORIZATION FOR RELEASE OF INFORMATION

I (the undersigned) authorize any licensed physician, medical practitioner, hospital, clinic 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 of:

Proposed Insured/Patient _____ Date of Birth _____

or the proposed insured's health, 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 if other, indicate here: _____
to give all such information to The Lincoln National Life Insurance Company (the Company), their licensed representatives and/or their reinsurers, MediConnect.net Inc, GiS, or if other, indicate here: _____
_____.

I understand that 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 understand that the information obtained may be used by the Company to determine eligibility for insurance, 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; or 3) any other person or entity who performs business or legal services in connection with the administration of my insurance coverage. 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.

I understand this consent may be revoked in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my policy with that Company. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months (12 months in Kansas) from the date of signing. To initiate revocation of this Authorization direct all correspondence to the address above.

I understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application.

I agree that a copy of the Authorization shall be as valid as the original. I may have a copy upon request.

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

SIGNATURE: _____ DATE: _____

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: _____



DISCLOSURE FORM FOR Lincoln LifeElementsSM LEVEL TERM (2009)

- 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(s): _____ Date of Birth: _____
(First, Middle Initial, Last) (mm/dd/yy)

This disclosure for Lincoln LifeElementsSM Level Term (2009) 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 Section 5 - 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 Agent Date

Name of Owner(s)/Applicants(s) (Please Print)

Agent's Name (Please Print)

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" 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). All questions **must** be answered.

Questions apply to **all** Proposed Insured(s) shown on application, and all questions must be answered.

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, been advised to be admitted or had surgery performed or recommended? Yes No N/A if applying for a MoneyGuard® product.
3. Within the past 2 years has any Proposed Insured been treated for heart trouble, stroke, or cancer, or had such treatment recommended by a physician or other medical practitioner? Yes No N/A if applying for a MoneyGuard® product.
4. Is Age of any Proposed Insured under 15 days old or over age 70? Yes No N/A if applying for a MoneyGuard® product.

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 dated _____ made on the life of: 1) _____

Name(s) of Proposed Insured(s)

or on the life of all individuals who _____

Name of Pension or Profit Sharing Plan of Participants to be insured (the Proposed Insureds)

are to be insured in the Pension or Profit Sharing Plan of 2) _____

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 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 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 Non medical 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 date the Company mails notice of termination of coverage to the premium notice address designated in 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 endorsement thereto.
- Fraud or material misrepresentations in the 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 check or draft submitted as payment is not honored by the bank.
- 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 (Provide
Officer's Title if policy is owned by a Corporation.)

Witness (Licensed Representative/Agent)

Date

Please check appropriate underwriting company:
 The Lincoln National Life Insurance Company
 Lincoln Life & Annuity Company of New York
 (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	Optional Premium Amount

Check box if address should be changed.

Print Accountholder Name and Address Below:

Bank or Credit Union Information:

Accountholder Name	Bank or Credit Union Name
Address	Address
City State Zip	City State Zip
Phone	Account Number

- Checking Account (ATTACH VOID CHECK)
- Savings Account (ATTACH WITHDRAWAL SLIP)

Routing Number: _____
 (This is the 9-digit number at the bottom of your check)

Withdraw monthly bank draft on _____ (day of each month - Day 01 thru 28 if available). *This does not apply to policies that include a Lapse Protection Guarantee (see details on back of form). The day selected, if more than 15 days after the premium's due date, will require the premium to be paid prior to the due 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.

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

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 each month.

Can I repay a policy loan via Electronic Funds Transfer?

Yes. We will draft any monthly amount you choose to repay on a policy loan, subject to a \$10 minimum.

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.

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.

You will be notified of any changes made by us. You may also instruct us in writing to make changes to your transaction amount.

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.

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.

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 of 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 will be selected at placement based on the policy date.

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. It will not be necessary to contact us.

Concord Mailing Address:

PO Box 515
Concord, NH 03302-0515
800-453-8588

Greensboro Mailing Address:

PO Box 21008
Greensboro, NC 27420-1008
800-487-1485



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

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misrepresentation or omission concerning the medical information requested in your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are canceling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it and have found it acceptable to you.

Applicant's Signature

Date

Agent's Signature

Date



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

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