Lincoln Financial Group®

Electronic Funds Transfer (EFT) Authorization

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

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

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

Step 1 - Insured Information

Indicate for first policy:

Policy Number:

First Name:

Last Name:

Indicate policy information for second policy, if applicable:

Policy Number:

First Name:

Last Name:

Step 2 - Payment Information

Indicate for first policy:

Premium Amount: $

Loan Payment Amount: $

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

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

Existing Policies:

Draft Day* (01-28):

Draft Start Date: / /

Indicate for second policy:

Premium Amount: $

Loan Payment Amount: $

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

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

Existing Policies:

Draft Day* (01-28):

Draft Start Date: / /

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

Bank or Credit Union Name:

Routing Number:

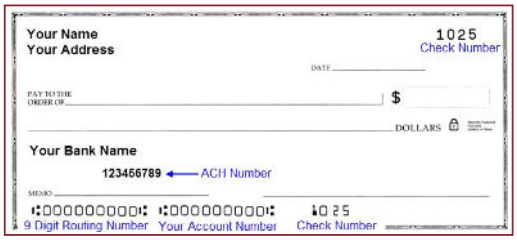
Account Number:

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

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

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

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



Step 3 - Payor Information

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

Corporation/Entity or Trust Name:

If the payor is an individual:

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

Payor Contact Information:

Address:

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

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

Step 4 - Authorizations and Signatures

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

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

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

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

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

Print Name: **Title:**

Payor Signature Requirements:

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

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

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

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

Existing Policies:

Email completed form to: CustServSupportTeam@LFG.com

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

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

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

Lincoln may require a voided check or other banking document to establish or maintain this Electronic Funds Transfer Authorization. You will be notified if this additional documentation is necessary.

Visit us on the web: LincolnFinancial.com

Lincoln Financial Group®

Application for Individual Life Insurance – General Instructions

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

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

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

Authority

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

Temporary Life Insurance Agreement (TIA)

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

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

Special Instructions

- **All applicants must complete the Application for Individual Life Insurance – Part I and if applicable, Medical Supplement (Part II).**
- If there is more than one Proposed Insured, complete and submit the following: Application for Individual Life Insurance-Part I, the Proposed Insured B Supplement, and if applicable, the Medical Supplement (Part II) for each Proposed Insured.
- The Defined Age Supplement must be completed if either Proposed Insured is age 70 or older.
- Question 25: If there are multiple Owners, provide the details on the Continuation of Details Supplement. 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.
- Questions 27 through 30: Use the Additional Beneficiary Designation Supplement for additional beneficiaries that do not fit on the application.
- If additional space is needed for any questions requiring details, complete the Continuation of Details Supplement.

Lincoln Financial Group®

Please check appropriate underwriting company:

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

☐ **Lincoln Life & Annuity Company of New York:** PO Box 21008, Greensboro, NC 27420-1008

☐ **First Penn-Pacific Life Insurance Company:** 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 professionals 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. 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®

Application for Individual Life Insurance – Part I

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

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

Proposed Insured

1. _____ /_____ /_____ /_____
   Legal Name: *(First)* *(Middle)* *(Last)* *(Suffix)*
2. Sex: ☐ Male ☐ Female
3. Date of Birth *(mm/dd/yyyy):* _____ /_____ /_____ *(If age 70 or over, complete the Defined Age Supplement.)*
4. Social Security Number (SSN): _____
5. Place of Birth *(State/Country)*: _____ /_____
6. Citizenship *(check one)*: ☐ I am a citizen of the United States.
   ☐ I am a valid green card holder and my country of citizenship is _____
   (Attach a copy of your valid green card.)
   ☐ Neither, and my country of citizenship is _____
   (Attach a copy of your passport.)
7. Driver's License Number *(provide even if suspended/revoked)*: _____ State: _____
   If no current license, check here ☐ and advise reason: _____
8. Physical Home Address *(Street)*: _____ Apt. or Suite: _____
   (City/State/ZIP): _____ /_____ /_____
   Check here ☐ if Mailing Address is same as Physical Home Address.
9. Mailing Address *(If different)*: _____ Apt. or Suite: _____
   (City/State/ZIP): _____ /_____ /_____
10. Primary Phone: _____ - _____ - _____ *(Check one)* ☐ Cell ☐ Landline
11. Secondary Phone *(If applicable)*: _____ - _____ - _____ *(Check one)* ☐ Cell ☐ Landline
12. Email: _____
13. Employer: _____ 14. Occupation: _____
15. Business Address *(Street)*:_____ Suite: _____
    (City/State/ZIP): _____ /_____ /_____
16. Individual Annual Earned Income: $ _____
17. a. Total Assets *(Retirement Accounts, Properties, etc.)*: $ _____
    b. Total Liabilities *(Mortgages, Loans/Debts, etc.)*: $ _____
18. Do you have any other sources of recurring income? ☐ Y ☐ N
    If "Yes," a. Source(s) of Income: _____ *(If the source is "disability," provide details in Number 53.)*
    b. Annual amount(s) received: $_____

Policy Information

19. Product Applied For *(if Term, include duration)*: _____

20. Amount of Insurance/Specified Amount: $ _____

21. 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

22. Guaranteed Death Benefit Duration Options: *(Select only one option where applicable, options vary by product)*
☐ Lifetime (Applicable to Lincoln SVUL/VULONE)

23. 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.**

24. Additional Benefits and Riders: *(If applicable, options vary by product)*
☐ Accelerated Benefits Rider without Chronic Illness (ABR)
☐ Accelerated Benefits Rider with Chronic Illness _____ *(Complete applicable supplement)*
☐ Accelerated Death Benefit for Long-Term Care Services Rider _____ *(Complete applicable supplement)*
☐ Children's Term Rider (*Complete Children's Term Rider Supplement)*
☐ Other Insured Term Rider $ _____ *(Complete Proposed Insured B Supplement)*
☐ Lincoln Enhanced Allocation Rider
☐ Disability Waiver Rider
☐ Enhanced Surrender Value Rider _____
☐ Other Benefits and Riders not listed above *(Provide details: coverage amount, percentages, etc.; and if applicable complete supplement):*

_____

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

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

☐ Trust/Entity *(legal name)*: _____

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

Check here ☐ if address is same as Proposed Insured's, otherwise complete 25b.

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

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

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

e. Primary Phone: _____ - _____ - _____ *(Check one)* ☐ Cell ☐ Landline

f. Secondary Phone *(If applicable)*: _____ - _____ - _____ *(Check one)* ☐ Cell ☐ Landline

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

i. Owner's Email: _____

26. 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 Information *(Unless otherwise stated in Number 30 "Special Instructions," if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, in the class, if any.)*

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

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

☐ Trust/Entity *(legal name)*: _____

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

Check here ☐ if address is same as Proposed Insured's, otherwise complete 27b.

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

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

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

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

g. Beneficiary's Email: _____

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

☐ Trust/Entity *(legal name)*: _____

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

Check here ☐ if address is same as Proposed Insured's, otherwise complete 28b.

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

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

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

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

g. Beneficiary's Email: _____

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

☐ Trust/Entity *(legal name)*: _____

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

Check here ☐ if address is same as Proposed Insured's, otherwise complete 29b.

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

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

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

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

g. Beneficiary's Email: _____

30. Special Instructions *(Indicate here if proceeds are not to be paid equally. Dollar amounts are not accepted; percentages must be whole numbers and total 100%)*:

_____

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

31. Modal Planned Premium: $_____

32. a. Payment Method: ☐ Electronic Funds Transfer (EFT) ☐ Direct Bill *(Quarterly and Monthly restrictions apply)*

☐ Other *(Include List Bill Number if applicable.)*: _____

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

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

34. Will the premiums for this Policy be paid, advanced, financed or otherwise funded by any person or entity other than you (Proposed Insured), the Owner, your spouse, domestic partner or your employer? *(If "Yes," complete the Premium Financing requirements.)* ☐ Y ☐ N

35. a. Select Premium Payor: *(Check one only. If "Other" is checked, complete Questions 35b through 35e.)*

☐ Proposed Insured(s) at mailing address ☐ Owner ☐ Beneficiary in Question: ☐ 27 ☐ 28 ☐ 29 ☐ Other

b. Payor Name *(Select One)*:

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

☐ Entity *(legal name)*: _____

Check here ☐ if address is same as Proposed Insured's, otherwise complete 35c.

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

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

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

Protection Against Unintended Lapse *(For additional protection against unintended lapse, you have the right to designate one person who will receive lapse and non-payment of premium notices. The designated person should be an individual other than your Agent/Financial Professional who will receive these notices automatically.)*

36. 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 non-payment of premium. I also understand that I will be given the opportunity to change this written designation at any time.

Complete name/address below if you choose to designate an additional person to receive lapse and non-payment of premium notices.

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

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

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

Phone Number: _____ - _____ - _____

Existing and Pending Insurance Information

37. Do you have any existing annuity contracts with this Company or any other company? ☐ Y ☐ N

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

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

40. If "Yes" to Question 38 and/or 39 with regard to an annuity contract, provide company, contract number and issue date:

_____

41. Do you have any existing life insurance on your life, including any policies that have been sold? ☐ Y ☐ N *(If "Yes," provide details in box below.)*

Indicate the Type of coverage: Personal **(P)**; Business: Buy-Sell (**B**), Keyperson (**K**) or Loan (**L**); or Group **(G)**.

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

42. Regardless of the status of the application, do you have any applications currently pending, do you plan to apply for, or did you apply for additional life insurance coverage with this or any other company within the past 12 months? *(If "Yes," provide details in box below. Do not include existing coverage listed in Question 41.)* ☐ Y ☐ N

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

43. What is the total amount of **new** life insurance coverage that will be placed in force with **all companies including this application**? *(Do not include existing coverage listed in Question 41.)* $ _____

44. Have you ever applied for life, long-term care, health or disability insurance and been rated, declined or postponed? *(If "Yes," provide the reason(s) for the outcome and details in the box below.)* ☐ Y ☐ N

Details

General Information—Proposed Insured

45. Other than as a remote pilot, or as a flight attendant on a regularly scheduled airline, within the past two years have you flown as a pilot, student pilot or crew member or do you plan to do so within the next two years? *(If "Yes," complete the Aviation Supplement.)* ☐ Y ☐ N

46. Within the past 12 months have you participated in underwater diving; mountain climbing; aerial sports that do not require a pilot's certificate; or auto, motorcycle, or boat racing, or do you plan to do so within the next 12 months? *(If "Yes," complete the applicable Avocation Supplement.)* ☐ Y ☐ N

47. Within the past 12 months have you participated in: heli-skiing; rodeo sports; equine sports; BASE jumping or wingsuit flying; canyoning; highlining/tricklining; Parkour or Rooftopping; Speedflying; boxing, kickboxing, Muay Thai or MMA/Cage Fighting; or do you plan to do so within the next 12 months? *(If "Yes," provide details in Number 53 below.)* ☐ Y ☐ N

48. Do you now, or do you plan to within the next year, reside or travel outside of the United States or Canada? *(If "Yes," provide the purpose, total number of days, cities and countries where travel or residence is planned in Number 53 below.)* ☐ Y ☐ N

49. Are you a member of, have you entered into a written agreement to become a member of, or have you received a notice of required service in the armed forces, reserves or National Guard? *(If "Yes," provide details in Number 53 below. Indicate if retired or active; list branch of service, pay grade, duties, Special Forces status, mobilization category, and current duty station; and if a notice of deployment has been received, to where and when.)* ☐ Y ☐ N

50. In the past five years, have you been convicted of three or more moving violations, driving under the influence of alcohol or other drugs, distracted driving, or had your driver's license suspended, restricted, or revoked? *(If "Yes," provide dates and details in Number 53 below.)* ☐ Y ☐ N

51. Have you ever been convicted of, or are you awaiting trial for, a felony? *(If "Yes," provide details in Number 53 below including offense and date of conviction and date of release of probation or parole.)* ☐ Y ☐ N

52. a. In the last five years have you filed for bankruptcy? ☐ Y ☐ N

    b. If "Yes," have all bankruptcies been discharged? *(If all have not been discharged, for each bankruptcy provide chapter, type (personal/business), reason, and if applicable, what is your payment plan and date of expected discharge in Number 53 below.)* ☐ Y ☐ N

53. Details to Questions: *(If more space is needed, use the Continuation of Details Supplement.)*

Question #	Details

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

Agreement and Acknowledgement

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

Each of the Undersigned declares that:

1. This Application consists of: a) Application for Individual Life Insurance — Part I; b) Medical Supplement — Part II; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. The Application, as defined above, and the recorded answers contained therein, will be bound with the Policy at issue. I/We understand that if this Policy is owned by someone other than the Proposed Insured, the Owner/Applicant will have access to those recorded answers.
2. I/We further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me/us; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured(s); and 3) the Proposed Insured(s) remain in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.

   I/We have paid premium to the agent/representative in exchange for the Temporary Life Insurance Agreement, and I/we acknowledge that I/we fully understand and accept its terms. *(Complete Temporary Life Insurance Agreement and submit with application.)*
3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. For employer-owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
5. For policies held in trust by one or more trustees, the undersigned certify and acknowledge the following. The trust arrangement is identified by name and date, the trust is in effect, and the trustees named in this application are the trustees for the named trust. The trustees signing this application have the power and authority to act and exercise all ownership rights under the Policy, and the Company may rely solely upon the signatures of the trustees regarding any Policy options, privileges or benefits. Any amounts paid to the trustees by the Company according to the Policy shall fully discharge the Company with respect to those amounts. The Company shall have no obligation to inquire into the terms of the trust or to see to the use or application of any amounts paid to the trustees. The Company shall not be held liable for any party's non-compliance with the terms of the trust.
6. Corrections, additions or changes to this Application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a Policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.
7. I have been advised to consult with my own tax advisors regarding the tax effects inherent in the plan of insurance for which I am applying.
8. I/WE HAVE READ, or have had read to me/us, the completed Application for Individual Life Insurance – Part I before signing below. All statements and answers in this Application for Individual Life Insurance – Part I are correctly recorded, and are full, complete and true to the best of my/our knowledge and belief. I/We confirm that upon receipt of the Policy, I/we will review the answers recorded on the Application, as defined in number 1 above. I/We will notify the Company immediately if any information in the Application is incorrect. Caution: I/We understand that if any 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.

Fraud Notice

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 medical professional, hospital or other medical institution, Pharmacy Benefit Manager, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me or my 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 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.

Once this authorization is signed it shall be valid for 24 months or the time limit, if any, as permitted by applicable law in the state where the Policy is delivered or issued for delivery. 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.

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 Practices Notice, the Important Notice containing the Investigative Consumer Report and MIB, Inc. information and, if applicable, the Life Insurance Buyer's Guide.

Signatory Section

Signed in: _____ _____ /_____ /_____
(State) Date (mm/dd/yyyy)

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

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

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

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

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

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

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

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice, Privacy Practices Notice and, if applicable, the Life Insurance Buyer's Guide.

Signature of Licensed Agent, Broker or Registered Representative

Printed Name of Licensed Agent, Broker or Registered Representative

Lincoln Financial Group®

Agent's Report

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

Completed Form Must Accompany Ticket or Application for Life Insurance

General Information

(Always complete Questions 1-6 and the Agent Information Section. Complete Questions 7-13 if applicable to the sale.)

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

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

2. (a) How long have you known the Proposed Insured(s)?_____
   (b) Are you related to the Proposed Insured(s)? ☐ Y ☐ N If "Yes," Give details:_____

3. Do the Proposed Insured(s) and Owner(s) read and understand the English Language? ☐ Y ☐ N If "No," how was the application completed?_____

4. **Purpose Of Insurance:**
   (Select One; if Business selected, complete Business Finances section):

Personal	**Business**
☐ Charitable Gift	☐ Business loan collateral
☐ Estate planning/Wealth Transfer	☐ Buy-sell/Stock redemption
☐ Family or Mortgage Protection/ Income Replacement	☐ Keyperson
☐ Other: _____	☐ Other: _____

5. (a) Is this policy being paid for with a premium financing loan? ☐ Y ☐ N If "Yes," provide complete details including the name of the financing plan, name and address of institution providing loan, and 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? ☐ Y ☐ N If "Yes," provide details below:

   _____

6. Is the Proposed Insured using income from their spouse/domestic partner to financially justify the coverage applied?
   ☐ Y ☐ N If "Yes," provide the following information for the spouse/domestic partner:
   (a) Income: $_____ (b) Life Insurance (Inforce plus any additional to be placed): $_____

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

	Amount Inforce	Amount Applied For
(a) Father's Life Insurance:	$_____	$_____
(b) Mother's Life Insurance:	$_____	$_____
(c) Are siblings also being insured? ☐ Y ☐ N	$_____	$_____

   If "No," explain:_____

8. I have verified that this policy will not replace a policy that has already been sold to a life settlement, viatical or other secondary market provider. If otherwise, explain:

   _____

9. Answer only if the Proposed Insured(s) participate(s) in aviation activities. If underwriting results in a higher premium, indicate which of the following is preferred *(check one)*:
   ☐ Pay the extra premium for coverage if death results from a covered aviation activity
   ☐ Aviation Exclusion Rider (not available in all states, and subject to underwriter discretion)

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

10. Type of business: ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other: _____

11. Proposed Insured is: ☐ Employee ☐ Owner of _____ % of business

Required if purpose of insurance is Keyperson

12. (a) Do all Keypersons have similar coverage in force or currently applied for? ☐ Y ☐ N If "No," explain:

_____

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

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

Required if purpose of insurance is Buy-Sell

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

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

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

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

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

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

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

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

Broker/Dealer Client/Owner Account #: _____

15. Have you recently submitted paperwork for a change in reporting hierarchy or commission set-up? ☐ Y ☐ N

If "Yes" describe the change requested: _____

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

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

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

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

19. **Compensation and Commission Schedule** *(contact your upline/hierarchy for details)*

☐ For VUL policies: Select one appropriate commission schedule, as applicable ***(election is irrevocable)***:

☐ A – Heaped (default) ☐ B – Modified-Heaped ☐ C – Trails

☐ As applicable to selected Rider ***(election is irrevocable)***:

☐ D – Level ☐ E – Semi-Heaped

☐ Other special compensation instructions or commission schedule:

_____

☐ No special commission program

Agent Certification

- ► I have reviewed with the Proposed Insured(s) each question on the application. For those questions asked by me, the answers have been recorded exactly as stated. For any answers provided by the Proposed Insured(s) during a telephone or online interview and recorded by a third party, I have confirmed that those answers as contained in the application were accurately recorded. I know of nothing affecting the insurability of the Proposed Insured(s) which is not fully recorded in this application.
- ► If I become aware of a change in the health or habits of the Proposed Insured(s) occurring after the date of the application but before policy delivery, I will inform The Lincoln National Life Insurance Company (Lincoln) of the change and agree to withhold policy delivery until instructed by Lincoln.
- ► For application states other than MA, I have provided the Applicant and the Proposed Insured(s) with a current copy of Lincoln's Important Notice as well as Lincoln's Privacy Practices Notice. If the application state is MA, I have provided the Important Notice of Insurance Information Practices as well as Lincoln's Privacy Practices Notice.
- ► I have verified all life insurance coverage in force, or in the process of being applied for, on the Proposed Insured(s), 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 have not been involved in any recommendation regarding the possible sale or assignment of this policy to a life settlement, viatical or other secondary market provider. **If otherwise, explain:** _____
- ► To the best of my knowledge, the source of funding for this policy does not include: (1) a non-recourse premium financing loan; or (2) any arrangement, other than a premium financing loan, which involves any person or entity with an interest in the potential for earnings based on the provision of funding for the policy. **If otherwise, explain:** _____
- ► 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 I 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 solicitation/application.
- ► I have obtained sufficient information about the Applicant and the Proposed Insured(s) to mitigate risks associated with money laundering, terrorist activity/funding, and to avoid doing business with a sanctioned individual or resident of a sanctioned country.
- ► I have reviewed and I understand Lincoln Financial Group's Position Regarding Marijuana-Related Businesses as published in form GB10877.
- ► The undersigned confirms that the policy or contract was solicited, issued and delivered in the state where the application was signed. Communications between the Producer and the Owner(s) pertaining to the sale and solicitation of the policy or contract, including the signing of the application, the collection of initial premium and the issuance for delivery of the policy/ contract to the Owner(s) have taken, or will take place, outside of New York.
- ► All of the above statements and answers provided to questions in the Agent's Report, in connection with this application, are true and accurate.

_____ _____ /_____ /_____

Signature of Licensed Agent, Broker or Registered Representative **Date (mm/dd/yyyy)**

Lincoln Financial Group®

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

DISCLOSURE STATEMENT FOR TERMINAL ILLNESS ACCELERATED BENEFITS 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 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 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, 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 the Proposed Insured Date

Signature of Owner Date
(If other than Proposed Insured)

What Does Lincoln Financial Group Do with Your Personal Information?

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. This Notice describes our current privacy practices. While your relationship with us continues, we will update and send our Privacy Practices Notice as required by law. Even after that relationship ends, we will continue to protect your personal information. You do not need to take any action because of this Notice, but you do have certain rights as described below.

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

Financial companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this carefully to understand what we do.

Information We May Collect and Use

We collect personal information about you:

- to help us identify you as a consumer, our customer or our former customer;
- to process your requests and transactions;
- to offer investment, insurance, retirement and other financial services to you;
- to pay your claim;
- to analyze in order to enhance our products and services;
- to tell you about our products or services we believe you may want and use; and
- as otherwise permitted by law.

The types of personal information we collect depend on your relationship and on the products or services you request and may include the following:

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

When you are no longer our customer, we continue to share your information as described in this notice.

How We Share and Use Your Personal Information

We may share your personal information within our companies and with certain service providers. They may use this information:

- to process transactions you, your employer, or your group representative have requested;
- to provide customer service;
- to analyze in order to evaluate or enhance our products and services;
- to gain customer insight; to provide education and training to our workforce and customers; and/or
- to inform you of products or services we offer that you may find useful.

Our service providers may or may not be affiliated with us. Affiliates are companies related by common ownership or control. Nonaffiliates are companies not related by common ownership or control. They include:

- Financial service providers: third party administrators; broker-dealers; insurance agents and brokers; registered representatives; reinsurers and other financial services companies with which we have joint marketing agreements. A joint marketing agreement is a formal agreement between nonaffiliated financial companies that together market financial products or services to you. Our joint marketing partners include, but are not limited to, insurance providers and financial technology solutions.
- Non-financial companies and individuals: consultants; vendors; and companies that perform marketing services on our behalf.

Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law. We may execute agreements with our service providers that permit the service provider to process your personal information outside of the United States, when not prohibited by our contracts and permitted by applicable law.

When you apply for one of our products:

- We may share information about your application with credit bureaus.
- We may provide information to group policy owners or their designees (for example, to your employer for employer-sponsored plans and their authorized service providers).
- We may provide information to regulatory authorities, law enforcement officials, and to other nonaffiliated 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 with the acquiror as part of the sale.
- **We do not sell or release your information to outside marketers who may want to offer you their own products and services unless we receive your express consent; nor do we release information we receive about you from a consumer reporting agency.**

All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Lincoln chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	**Does Lincoln share?**	**Can you limit this sharing?**
For our everyday business purposes—such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes—to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes—information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes—information about your creditworthiness	No	We Don't Share
For our affiliates to market to you	No	We Don't Share
For nonaffiliates to market to you	Yes	Yes (We don't share unless we receive your express consent)

Federal law gives you the right to limit only:

- sharing for our affiliates' everyday business purposes – information about your creditworthiness;
- sharing for our affiliates to market to you; and
- sharing for nonaffiliates to market to you.

State laws and individual companies may give you additional rights to limit sharing. California residents can review our California Privacy Notice located at https://www.lincolnfinancial.com/public/general/privacy/californiaprivacynotice.

Security of Information

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. Our employees are authorized to access your information only when they need it to perform their job responsibilities. Employees who have access to your personal information are required to keep it confidential. Employees are required to complete privacy training annually.

Your Rights Regarding Your Personal Information

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

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

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

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

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

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

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

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

For general account service requests or inquiries unrelated to this Privacy Notice, please call 1-877-ASK-LINC.

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

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

Lincoln Financial Group®

Authorization for Release of Information

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

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

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

I (the undersigned) authorize any physician, health plan, health care professional, medical practitioner, records custodians, medical facility, hospital, clinic, laboratory, Pharmacy Benefit Manager, insurance support organizations, insurance company, Medical Information Bureau (MIB, LLC), or any other health care provider that has provided payment, treatment or services to me or on my behalf that has any records or knowledge about me or my health, including, information regarding insurance, payments, referral documents, and records from other facilities (whether in paper or electronic format), to give copies of all such records and information concerning me to the Company, their licensed representatives, their reinsurers, and/or approved vendors.

I understand that:

- Medical information released may include, without limitation, information obtained through my telephonic or Personal Health Interview(s), information about my physical and mental health, protected health information, insurance policies, and claims, information relating to any medical consultations, diagnoses and test results, treatments, or surgeries; hospital confinements for physical and mental conditions; prescription medications; use of drugs or alcohol; communicable diseases; disorder of the immune system, including, but not limited, to HIV and AIDS; and mental and physical history, condition, advice or treatment (collectively "Medical Information"), excluding genetic information and psychotherapy notes.
- 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).
- the Medical Information obtained may be used by the Company to determine eligibility for insurance, for analysis to enhance their products and services, or to administer my coverage. The Company may not give the Medical Information to any person or entity except:1) a reinsurer; 2) other insurers to whom I have applied or may apply; 3) MIB, LLC; 4) any other person or entity who performs business or legal services in connection with the application for or administration of my insurance coverage; 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 the Company will not share HIV and AIDS test results except for underwriting purposes in connection with my application for insurance, or as required by law. I understand that some of these people or entities may not be covered by federal or state privacy regulations and that Medical Information they receive may be redisclosed, however the Company contractually requires them to protect the Medical Information we disclose to them. Medical Information may be disclosed as allowed by law.
- the Medical Information used by the Company to determine eligibility for insurance may be communicated to my agent, agency, and/or representative to facilitate underwriting, communicate underwriting decisions, or to administer my coverage. The Company will not disclose Medical Information to my agent, agency, and/or representative about non-admission to the use of drugs or alcohol; communicable diseases; disorder of the immune system, including, but not limited, to HIV and AIDS; psychotherapy notes; and genetic information.
- I may revoke this consent at any time by sending a written request to the address above, 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 the Company does not receive written revocation, this Authorization will be valid for twenty-four (24) months from the date of my signature below, or the duration of any claim for insurance benefits, whichever is later. I agree that a copy of this Authorization, and that a photographic or electronic copy of this Authorization is as valid as the original and that I may have a copy upon request.
- there is a possibility of re-disclosure of any Medical Information disclosed pursuant to this Authorization and that Medical 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.
- the Company may not be able to process my application for insurance if I refuse to sign this Authorization.
- if I refuse to sign this Authorization the Company cannot withhold my health care benefits (treatment, payment or eligibility).

Medical Information Bureau (MIB, LLC)

I am authorizing the Company or its reinsurer to make a brief report of my protected health information to MIB, LLC.

Optional Authorization to Disclose Medical Information to Agent, Agency or Representative

In regards to my request for life insurance, should the Company decline this request or provide an offer other than what was applied for, upon the Company's receipt of notice from my agent, agency or representative that I will be applying to another insurer for life insurance coverage, I hereby authorize the Company to disclose all Medical Information, collected by the Company in connection with my request for life insurance to the agent, agency or representative that submitted my life insurance application.

I understand the Company assumes no liability or responsibility for the accuracy or completeness of the Medical Information, and it is my responsibility to provide accurate medical and other pertinent information requested by any insurer(s) to which I apply for insurance. I further understand that, upon release of the Medical Information, such information may be released to an individual and/or entity to evaluate me for insurance, and it will be subject to the policies and procedures governing confidentiality and privacy of such individual and/or entity.

I may revoke my consent to this Optional Authorization to Disclose Medical Information ("Optional Authorization") at any time by sending a written request to the address above. If the Company does not receive written revocation, this Optional Authorization will be valid for twenty-four (24) months from the date of my signature below. I agree that a copy of this Optional Authorization, and that a photographic or electronic copy of this Optional Authorization, is as valid as the original and that I may have a copy upon request.

I have read this Optional Authorization and I authorize the Company to disclose the Medical Information as described in this section to the agent, agency or representative that submitted my life insurance application.

If you DO NOT want to authorize the Company to disclose the Medical Information as described in this section to the agent, agency or representative check this box. ☐

Signature Section

I have read and understand all sections of this Authorization for Release of Information.

_____ _____ /_____ /_____

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
Lincoln Life & Annuity Company of New York
PO Box 21008, Greensboro, NC 27420-1008

Out-of-State Sale Verification Form

This form must be completed and returned with the application if the Owner and/or Proposed Insured is a resident of New York or Montana (or in the case of a Business-Owned policy, the entity has a bona fide location in NY or MT) and the application is taken outside the state of residence.

State of Residence of Owner (or Trustee, if Trust-Owned): _____
(If Business-Owned, does the entity have a bona fide location in NY or MT?) ☐ Yes ☐ No

State of Residence of Proposed Insured _____
(In the case of a Trust or Business-Owned policy the residence of the Proposed Insured must be considered.)

State in Which Application Was Signed _____

The undersigned confirms that the policy or contract was solicited, issued and delivered in the state where the application was signed. Communications between the Producer and the Owner pertaining to the sale and solicitation 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 Owner have taken, or will take place, outside of New York or Montana, as appropriate.

_____ /_____ /_____
Date (MM/DD/YYYY)

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

_____
Printed Name of Applicant/Owner/Trustee

_____ /_____ /_____
Date (MM/DD/YYYY)

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

_____
Printed Name of Proposed Insured

_____ /_____ /_____
Date (MM/DD/YYYY)

_____
Signature of Licensed Producer, Broker or Registered Representative

_____
Printed Name of Licensed Producer, Broker or Registered Representative

Lincoln Financial Group®

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

TEXAS 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, oral fluid extracted from cheek and gum tissue, or urine 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 that has been approved by the FDA and complies with applicable Texas and federal laws.

Pre-Testing Considerations
Many public health organizations have recommended that before taking an HlV-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 indentity of any particular person.

Notification of Test Result
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 will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver the information so that you can understand clearly what the test result means, please 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 positive test result: _____

Address: _____

_____

In the event the test is positive and you are denied coverage because of the 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 a representative of the Texas Department of Health.

Consent
I have read and I understand this Notice and Consent for HlV-Related Testing. I voluntarily consent to the withdrawal of blood , oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, 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.

_____ _____

Signature of Proposed Insured or Parent/Guardian Date Signed

_____

Name and address of Proposed Insured (Please Print)

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**

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

ICC16LFF11524
10/16

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

Important Information Regarding Credit and Debit Card Payments

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

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

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

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

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

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

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

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

Life Insurance Buyer's Guide

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

National Association of Insurance Commissioners
1100 Walnut Street, Suite 1500
Kansas City, MO 64106-2197
(816) 842-3600

Before You Buy Life Insurance

Understand What Life Insurance Is

Life insurance pays a death benefit if you die while the policy is in effect, in exchange for premiums you pay before your death. You can use the death benefit to protect against financial hardships such as loss of your income, funeral expenses, medical or nursing care expenses, debt repayments, and child care costs after your death. You can get information from the NAIC InsureU Life Insurance website -- *www.insureuonline.org/insureu_type_life.htm*

If You Need Life Insurance, Decide How Much Coverage to Buy

How much life insurance to buy depends on the financial needs that will continue after your death. Examples include supporting your family, paying for child(ren)'s education, and paying off a mortgage. Some questions you may want to ask about your own needs include:

- Does anyone depend on me financially?
- How much of the family income do I provide?
- How will my family pay my final expenses and repay debts after my death?
- Do I want to leave money to charity or family?
- If I have life insurance through my employer, is it enough to meet my financial obligations?

The answers to these questions can help you decide how much coverage you need. An insurance agent, financial advisor, or insurance company representative can help you evaluate your insurance needs and give you information about available policies.

If You Already Have Life Insurance, Assess Your Current Life Insurance Policy

It's important to compare your current policy with any new policy you might buy. Keep in mind that you may be able to change your current policy to get benefits you want. Also, know that any changes in your health may impact your ability to get a new policy or the premium you'll pay. Don't cancel your current policy until you get the new one.

Also, while you may have free or low-cost life insurance through your employer, the death benefit usually is less than you need. And if you leave the employer, you may not be able to take this coverage with you.

Compare the Different Types of Insurance Policies

There are many types of life insurance policies. You should choose a policy with features that fit your individual needs. Some things to consider are:

- ***Term Insurance vs. Cash Value Insurance.*** Term insurance is intended to provide lower-cost coverage for a specific period of time ("a term"). If you want coverage for a longer period of time, such as for your lifetime, cash value insurance may be more cost effective. Most term policies don't build up cash values that you can use in the future.
- ***Renewable Term vs. Non-renewable Term.*** Most term life insurance coverage can be continued ("renewed") at the end of the term, even if your health has changed. If you renew a term policy, the new premiums are higher. Ask what the premiums will be before you renew the policy. Also ask if you'll lose the right to renew the policy at a certain age. A Non-renewable term policy can't be continued. You'll have to apply for a new policy if you still want coverage.
- ***Whole Life vs. Universal Life.*** Whole life and universal life insurance are two types of cash value insurance. A key difference between the two is how you pay for the coverage. You typically pay premiums for whole life insurance according to a set schedule. In a universal life policy, you can choose a flexible premium payment pattern as long as you pay enough to keep your policy in force.

- ***Variable Life vs. Non-variable Life.*** The investments you will choose (such as stock and bond funds) in a variable life policy directly impact your cash value. These policies have the greatest potential to build cash value but also the greatest risk of losing cash value. Non-variable life policies often have guaranteed minimums for some features (interest or cash value, for example) but not all. Non-variable life policies also have less potential to build cash value than variable life policies.

Be Sure You Can Afford the Premium

Before you buy a life insurance policy, be sure you can pay the premiums. Can you afford the initial premium? If the premium increases later, will you still be able to afford it? The premiums for many life insurance policies are sensitive to changes in the company's investment earnings, claims costs, and other expenses. If those are worse than expected, you may have to pay a much higher premium. Ask what might be the highest premium you'd have to pay to keep your coverage.

Understand the Application Process

You can apply for life insurance through life insurance agents, the mail, and online. In addition to basic information, such as your name, address, employer, job title, and date of birth, you'll be asked for more personal information. Depending on the type of policy, the insurer may require you to see a doctor, answer health-related questions, or have a medical professional come to your home or office to assess your health. Usually a policy that doesn't require detailed health information will cost more and provide less coverage than one that does.

It's important to tell the truth on the application. The insurance company will check your answers so review the application before you sign. If the insurance company discovers false statements on your application after it issues your policy, it could reduce or cancel your coverage.

Choose a Beneficiary

A beneficiary is the person(s) or organization(s) you name to receive your life insurance policy's death benefit. You'll need to know the Social Security or tax identification number for all beneficiaries. Experts advise you not to name a minor child as a beneficiary. Insurance companies won't pay a minor. Instead, consider leaving the money to your estate or trust.

Evaluate the Future of Your Policy

Does your policy have a cash value? In some cash value policies, the values are low in the early years but build later on. In other policies the values build up gradually over the years. Most term policies have no cash value. Ask your insurance agent, financial advisor, or an insurance company representative for an illustration showing future values and benefits.

After You Buy Life Insurance

Read Your Policy Carefully

After you carefully read your policy, you should be able to answer the following important questions:

- Is your personal information correct?
- Do premiums or policy values vary from year to year?
- What part of the premium or policy value isn't guaranteed?
- How will the timing of money paid and received affect any interest the policy might earn?

Your insurance agent, financial advisor, or an insurance company representative can help you understand anything that isn't clear.

If you're not satisfied with your new policy, you can return it for a full refund within a certain period, usually 10 days after you receive it. The review period usually is stated on the first page of the policy.

Review Your Life Insurance Program Every Few Years

Review your policy with your insurance agent, financial advisor, or an insurance company representative every few years to keep up with changes in your policy and your needs.

- Have the premiums or benefits changed since your policy was issued?
- Do the death benefits still meet your needs?
- Do you need more or less coverage after life events, such as birth, adoption, marriage, job change, death, or divorce?

The insurance company can provide policy statements and illustrations to help with this review. As the policy owner, you can change beneficiaries at no cost. Be sure to review your beneficiaries every few years, especially after major life events that affect your life insurance needs.

Notes

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®

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®

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

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ YES ☐ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy will be replaced or used as a source of financing:

Insurer Name	Contract or Policy #	Insured or Annuitant	Replaced (R) or Financing (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because (Required. Answer N/A if you are not replacing.):

I certify that the responses herein are, to the best of my knowledge, accurate:

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

Insured/Annuitant Printed Name

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

Should you have any questions regarding this form, please contact your insurance representative or the Company at the address or telephone number shown on your application.

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

Premiums:

Are they affordable?
Could they change?
You're older – are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

Policy values:

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

Insurability:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

If You are keeping the Old Policy as well as the New Policy:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

If You are Surrendering an Annuity or Interest Sensitive Life Product:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

Other Issues to Consider for All Transactions:

What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

INSTRUCTIONS FOR REPLACEMENT REGULATIONS

New replacement regulations have been adopted in a number of states. The following steps are necessary to comply with the new regulations.

1. Existing Insurance

For each application, a producer is required to ask an applicant if he or she has any existing life insurance policies or annuity contracts. The producer and the applicant must complete and sign the statement on the application regarding existing policies or contracts.

2. Replacement Notice

If there are existing policies or contracts, the producer and the applicant must also complete and sign "Important Notice: Replacement of Life Insurance or Annuities", Form 33503. This form must accompany the application whether or not a replacement is proposed. A copy must be provided to the applicant.

If there is a replacement, all policies and contracts to be replaced must be listed on the form in detail, including the reason for replacement. The producer is required to read the form aloud to the applicant or the applicant must initial the form to indicate that the reading was waived.

3. Sales Material

We require that only approved sales material be used. The regulations define "sales material" as a sales illustration and any other written, printed or electronically presented information created, completed or provided by the producer that is used in the presentation to the applicant. (A printed hard copy of any electronically presented sales material must be given to the applicant no later than the time of contract delivery.)

If there is a replacement, a producer must complete and sign "Appropriateness Verification Statement", Form 33555, certifying that only company approved sales material was used and that copies were left with the applicant.

The producer must maintain documentation of all sales materials used.

The replacement regulations require that we contact the applicant after the contract is issued to affirm that you left copies of all sales materials used with the applicant. We make this contact via a letter. If the contract is mailed to you for delivery, it is your responsibility to provide this letter to the applicant with the contract. The regulations require this letter to be provided to the applicant within 10 days of the issue date.

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®

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.

INTERNATIONAL BROKERAGE AGENCIES, INC.

HIPAA AUTHORIZATION RELEASE
TO OBTAIN AND DISCLOSE INFORMATION

Name of Proposed Insured

Please Print

_____ _____/_____/_____

First MI Last DOB Month/Day/Year

I authorize any person licensed to provide health care services, hospital, clinic or other medical or medically related facility, insurer, reinsurer, insurance support organization, the Medical Information Bureau, Inc., consumer report agency, state motor vehicle agency, employer, or any other person or institution to release to each of the insurance companies listed below, as well as to their reinsures, any insurance support organizations, those person authorized to represent them; and International Brokerage Agencies, Inc.; any information related to my mental and physical health, lab results, other insurance coverage, hazardous activities, character, general reputations, finances, occupations, other personal traits, drug and/or alcohol use and driving record for me and my minor children who are to be insured. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases.

THIS AUTHORIZATION APPLIES TO THE FOLLOWING:

- Aetna Companies
- Allstate Health Solutions
- American National
- APPS
- Brighthouse Life
- Corebridge
- ExamOne
- Express Imaging Services
- Fidelity Life
- Gerber
- Global Atlantic
- Illinois Mutual
- IMG
- J&H
- John Hancock
- Kemper
- Legal & General
- Lincoln Financial Group
- MassMutual
- Mutual of Omaha
- Nationwide
- North American
- OneAmerica
- Pacific Life
- Principal Life
- Protective
- Prudential
- SBLI
- Securian Financial
- Symetra
- Transamerica
- World Trips

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPPA protected health information do not apply for purposes of this authorization and I instruct my physician, health care professional, hospital, clinic, medical facility or any other health care provider to release and disclose my entire medical record without restriction to International Brokerage Agencies, Inc. I understand that any information that it is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, disability income, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt, or evaluation of insurance applications or prospective applications of the insurance companies listed above and their re-insurers as well as International Brokerage Agencies, Inc. and its staff, employees and affiliated companies.

I understand and agree that this form is not an application for life insurance and that no life insurance coverage is provided in connection with this form.

This authorization shall be valid for twenty-four (24) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization. I understand I may revoke this authorization in writing at any time by providing that written notification to International Brokerage Agencies, Inc. at the service address below. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the lifetime of the undersigned, absent any provision of any applicable state statute regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under. I understand that if I refuse to sign this authorization, International Brokerage Agencies, Inc. may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health services if I refuse to sign this authorization.

_____ _____

Signature of Proposed Insured Name of Proposed Insured

_____ _____ _____

City State Month/Day/Year

International Brokerage Agencies, Inc.
P.O. Box 1345, Joshua, TX 76058
Phone: (817) 752-4980; Fax: (817) 752-4982