Lincoln Financial Group®

The Lincoln National Life Insurance Company
(hereinafter referred to as the "Company")

Application for Individual Life Insurance

Proposed Insured

Name *(First, Middle, Last)*:_____ ☐ Male ☐ Female

Date of Birth *(mm/dd/yy)*:_____ Social Security Number:_____
(If age 70 or over, please complete Defined Age Supplement)

Are you a citizen of the United States? ☐ Yes ☐ No If "No," of what country?_____

If "No," indicate Visa type and status:_____

Place of Birth *(State/Country)*:_____

Driver's License # & State:_____

Home Address *(Street, City, State, ZIP, Country)*: _____

Employer:_____ Occupation:_____

Business Address *(Street, City, State, ZIP, Country)*: _____

U.S. Mailing Address (*Street, City, State, ZIP*): _____

Annual Earned Income $_____ Annual Unearned Income $_____ Net Worth $_____

Do you have current business interests or own property in the U.S.? ☐ Yes ☐ No Please provide details, if any:

_____

Do you have a current bank account in the U.S.? ☐ Yes ☐ No Please provide details, if any:

_____

Primary Phone #: _____ Best Times to Call: _____

*Policy Information

Term of Insurance : ☐ 10 Years ☐ 20 Years ☐ 30 Years

Amount of Insurance/Specified Amount: $ _____

Additional Benefits and Riders: *(If applicable) Contact us for more Details*

☐ Critical Illness Income Protection *(Complete applicable supplement)*
☐ Global Health Insurannce (*Complete applicable supplement*)
☐ Travel Accident Cover (*Complete applicable supplement*)
☐ Long Term Care - Nursing Cover (Complete applicable supplement)
☐ Medicare Advantage or Supplement (Complete applicable supplement)

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

a. Name/Trust & Trustees: _____

_____

Address *(Street, City, State, ZIP, Country)*: _____

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

Date of Birth/Trust Date:_____ Country of Citizenship:_____

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

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

Beneficiary Information

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

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

a. ☐ P ☐ C Name/Trust & Trustees:____________________

Address *(Street, City, State, ZIP, Country)*: ____________________

Relationship to Proposed Insured(s): ____________ SSN/TIN:____________

Date of Birth/Trust Date:________ Phone Number:____________

a. ☐ P ☐ C Name/Trust & Trustees:____________________

Address *(Street, City, State, ZIP, Country)*: ____________________

Relationship to Proposed Insured(s): ____________ SSN/TIN:____________

Date of Birth/Trust Date:________ Phone Number:____________

a. ☐ P ☐ C Name/Trust & Trustees:____________________

Address *(Street, City, State, ZIP, Country)*: ____________________

Relationship to Proposed Insured(s): ____________ SSN/TIN:____________

Date of Birth/Trust Date:________ Phone Number:____________

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

Billing Information

Annual Premium: $ ____________

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

Premium Notices To: *(Check one only.)* *(Please note we cannot bill to your agent.)*

☐ Owner in Question Above ☐ Insured at Residence

☐ Other:____________________

Third Party Designee/Secondary Addressee

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

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

Name:____________________

Address:____________________

Existing and Pending Insurance Information

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

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

If you answered "Yes" to the above with regards to an annuity contract, please provide company, contract number and issue date:

____

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

Please indicate the Type of coverage: Business (**B**); Group (**G**); or Personal (**P**).

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

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

Company	Amount	Reason Policy Applied For

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

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

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

General Risk Information—Proposed Insured

1. Do you now, or do you plan to fly within the next 2 years, or have you flown during the past 2 years as pilot, student pilot or crew member? *(If "Yes," an Aviation Supplement is required.)* ☐ Y ☐ N
2. Do you plan to participate within the next 2 years, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, skydiving or SCUBA diving, or mountain, rock or technical climbing? *(If "Yes," an Avocation Supplement is required.)* ☐ Y ☐ N
3. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? *(If "Yes," please provide the total number of days and locations where travel is planned in number 47 below.)* ☐ Y ☐ N
4. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence o alcohol or other drugs, or had your driver's license suspended or revoked? *(If "Yes," please provide dates and other details in number 47 below.)* ☐ Y ☐ N
5. Have you ever been convicted of or are you awaiting trial for a felony? *(If "Yes," please provide details in number 47 below including date of conviction and date of release of probation or parole.)* ☐ Y ☐ N
6. In the last 5 years have you filed for bankruptcy ☐ Y ☐ N

   If "Yes," what type of bankruptcy: _____ When was the bankruptcy discharged: _____
7. Are you a member of, or applied to be a member of, or have you received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes," please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in number 8 below.)* ☐ Y ☐ N
8. Details to General Risk Questions: *(If more room is needed, use the Continuation of Details Supplement.)*

Question #	Date	Details/Reasons

Agreement and Acknowledgement

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

Each of the Undersigned declares that:

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

State Disclosure

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

Authorization

I, the Proposed Insured, authorize any 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 as permitted by applicable law in the state where the policy is issued but not to exceed a time period of 24 months. 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 Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

Signatory Section

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

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

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

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