Lincoln Financial Group®
You're In Charge®

Lincoln Unified Application

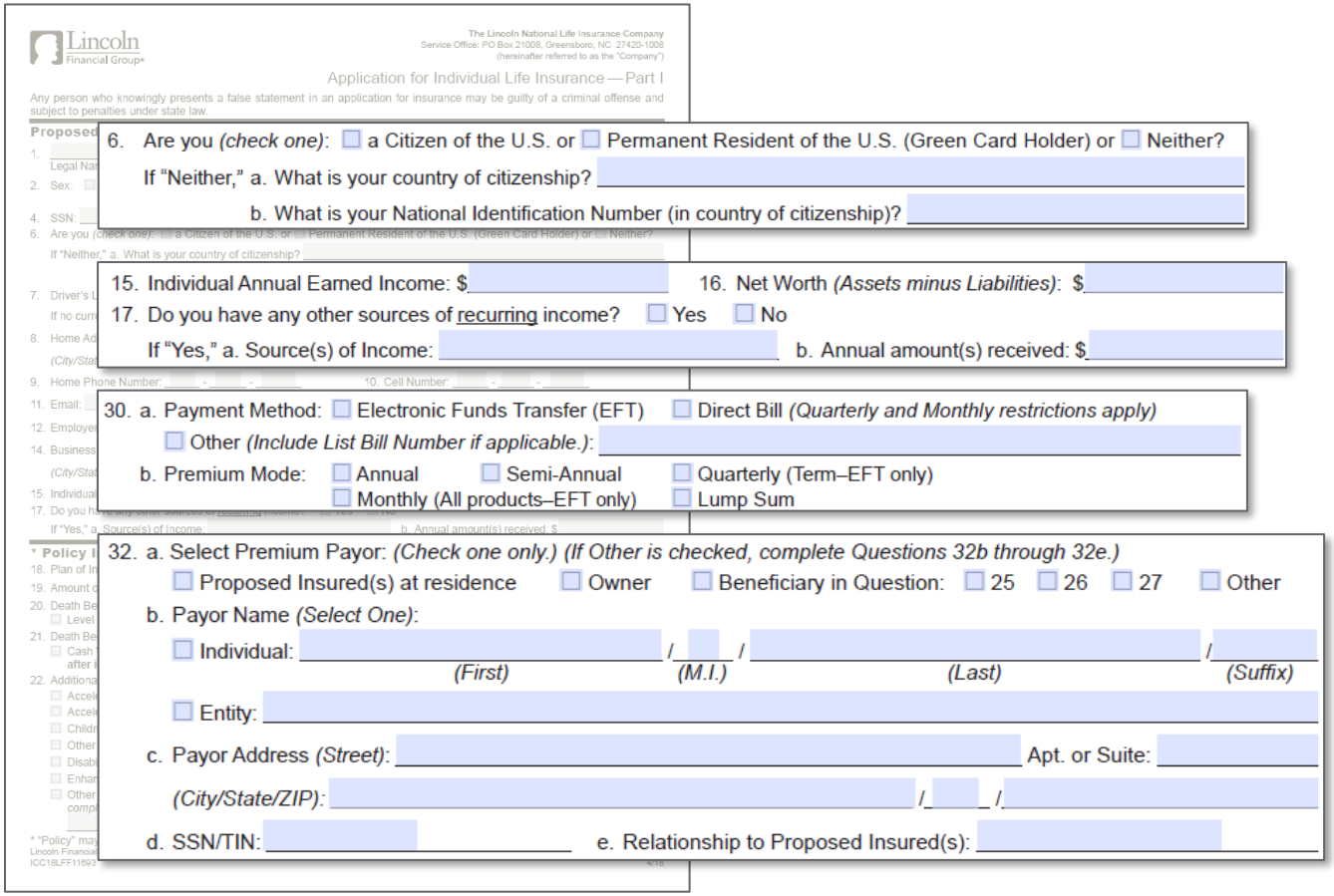
One life insurance application to drive efficiency & consistency in the submission process

OVERVIEW OF KEY CHANGES

As a leader in the market, Lincoln Underwriting & New Business is committed to providing an excellent experience for our agents and customers. **Effective February 11, 2019**, Lincoln will launch a new life insurance application and ticket that will improve efficiency and enhance the agent and client experience by integrating all life insurance product processes into one streamlined approach. Key changes to the individual life insurance application are highlighted in this document. Please reference the Unified Application Overview Flier for more information or contact your dedicated Underwriting and New Business team.

Application for Individual Life Insurance – PART I

Form ICC18LFF11693; state variations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The Lincoln National Life Insurance Company
Service Office: PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as the "Company")

Application for Individual Life Insurance — Part I

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

6. Are you *(check one)*: ☐ a Citizen of the U.S. or ☐ Permanent Resident of the U.S. (Green Card Holder) or ☐ Neither?
If "Neither," a. What is your country of citizenship? _____
b. What is your National Identification Number (in country of citizenship)? _____

15. Individual Annual Earned Income: $_____ 16. Net Worth *(Assets minus Liabilities)*: $_____
17. Do you have any other sources of recurring income? ☐ Yes ☐ No
If "Yes," a. Source(s) of Income: _____ b. Annual amount(s) received: $_____

30. a. Payment Method: ☐ Electronic Funds Transfer (EFT) ☐ Direct Bill *(Quarterly and Monthly restrictions apply)*
☐ Other *(Include List Bill Number if applicable.)*: _____
b. Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly (Term–EFT only)
☐ Monthly (All products–EFT only) ☐ Lump Sum

32. a. Select Premium Payor: *(Check one only.) (If Other is checked, complete Questions 32b through 32e.)*
☐ Proposed Insured(s) at residence ☐ Owner ☐ Beneficiary in Question: ☐ 25 ☐ 26 ☐ 27 ☐ Other
b. Payor Name *(Select One)*:
☐ Individual: _____ / ____ / _____ / _____
(First) (M.I.) (Last) (Suffix)
☐ Entity: _____
c. Payor Address *(Street)*: _____ Apt. or Suite: _____
(City/State/ZIP): _____ / ____ / _____
d. SSN/TIN: _____ e. Relationship to Proposed Insured(s): _____

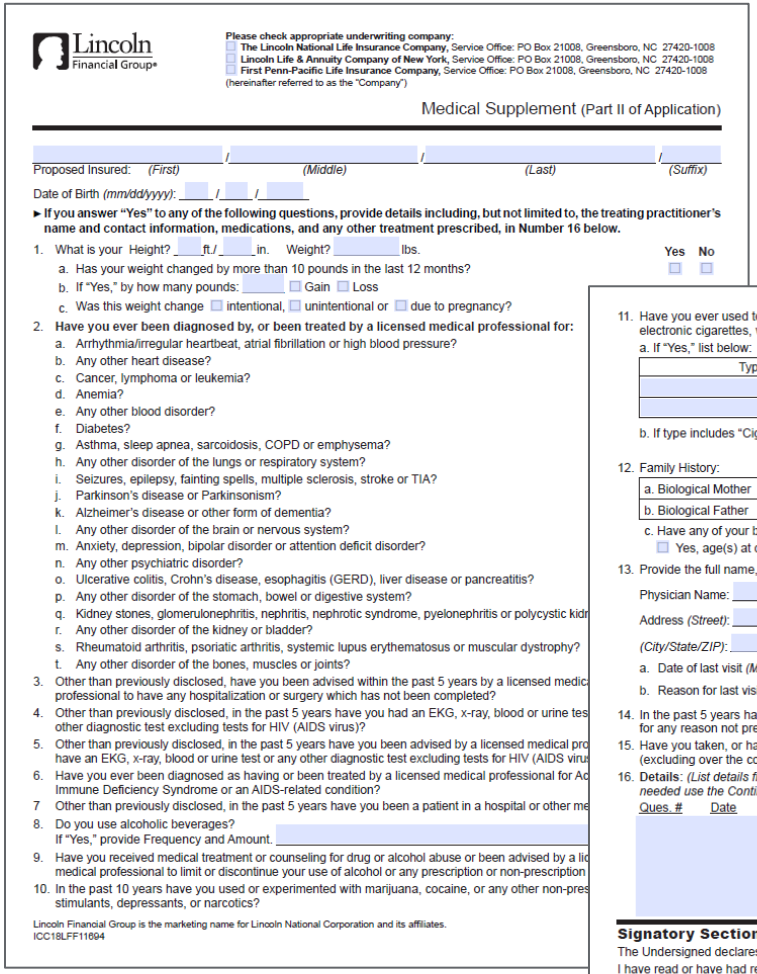
Key Changes

- Application design and question wording has been updated to align with Optical Character Recognition (OCR) technology creating more efficient processing of paperwork

- Key questions have been added or updated to reduce the need to re-question and/or make amendments later in the process to better streamline and reduce delays in underwriting
  - **Q6b** – NEW question to align with the foreign national market
  - **Q15 and Q16** – UPDATED to help clarify the exact financial information needed
  - **Q17** – NEW question for underwriting and automated underwriting
  - **Q30** – UPDATED to be more inclusive of all payment methods, modes and any restrictions
  - **Q32** – UPDATED with more options to select and better capture the payor information
  - Added email address field requirement for Unclaimed Property Initiative (UPI)
  - Added additional space added for 'details'

Medical Supplement – PART II of Application

Form ICC18LFF11694; state variations



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Please check appropriate underwriting company:
- The Lincoln National Life Insurance Company, Service Office: PO Box 21008, Greensboro, NC 27420-1008
- Lincoln Life & Annuity Company of New York, Service Office: PO Box 21008, Greensboro, NC 27420-1008
- First Penn-Pacific Life Insurance Company, Service Office: PO Box 21008, Greensboro, NC 27420-1008

(hereinafter referred to as the "Company")

Medical Supplement (Part II of Application)

Proposed Insured: (First) / (Middle) / (Last) / (Suffix)

Date of Birth (mm/dd/yyyy): ____ / ____ / ____

► **If you answer "Yes" to any of the following questions, provide details including, but not limited to, the treating practitioner's name and contact information, medications, and any other treatment prescribed, in Number 16 below.**

	Yes	No
1. What is your Height? ____ ft./ ____ in. Weight? ____ lbs.		
a. Has your weight changed by more than 10 pounds in the last 12 months?		
b. If "Yes," by how many pounds: ____ Gain Loss		
c. Was this weight change intentional, unintentional or due to pregnancy?		
2. Have you ever been diagnosed by, or been treated by a licensed medical professional for:		
a. Arrhythmia/irregular heartbeat, atrial fibrillation or high blood pressure?		
b. Any other heart disease?		
c. Cancer, lymphoma or leukemia?		
d. Anemia?		
e. Any other blood disorder?		
f. Diabetes?		
g. Asthma, sleep apnea, sarcoidosis, COPD or emphysema?		
h. Any other disorder of the lungs or respiratory system?		
i. Seizures, epilepsy, fainting spells, multiple sclerosis, stroke or TIA?		
j. Parkinson's disease or Parkinsonism?		
k. Alzheimer's disease or other form of dementia?		
l. Any other disorder of the brain or nervous system?		
m. Anxiety, depression, bipolar disorder or attention deficit disorder?		
n. Any other psychiatric disorder?		
o. Ulcerative colitis, Crohn's disease, esophagitis (GERD), liver disease or pancreatitis?		
p. Any other disorder of the stomach, bowel or digestive system?		
q. Kidney stones, glomerulonephritis, nephritis, nephrotic syndrome, pyelonephritis or polycystic kidr		
r. Any other disorder of the kidney or bladder?		
s. Rheumatoid arthritis, psoriatic arthritis, systemic lupus erythematosus or muscular dystrophy?		
t. Any other disorder of the bones, muscles or joints?		
3. Other than previously disclosed, have you been advised within the past 5 years by a licensed medic professional to have any hospitalization or surgery which has not been completed?		
4. Other than previously disclosed, in the past 5 years have you had an EKG, x-ray, blood or urine tes other diagnostic test excluding tests for HIV (AIDS virus)?		
5. Other than previously disclosed, in the past 5 years have you been advised by a licensed medical pro have an EKG, x-ray, blood or urine test or any other diagnostic test excluding tests for HIV (AIDS viru		
6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Ac Immune Deficiency Syndrome or an AIDS-related condition?		
7 Other than previously disclosed, in the past 5 years have you been a patient in a hospital or other me		
8. Do you use alcoholic beverages? If "Yes," provide Frequency and Amount. ____		
9. Have you received medical treatment or counseling for drug or alcohol abuse or been advised by a lic medical professional to limit or discontinue your use of alcohol or any prescription or non-prescription		
10. In the past 10 years have you used or experimented with marijuana, cocaine, or any other non-pres stimulants, depressants, or narcotics?		

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ICC18LFF11694

	Yes	No
11. Have you ever used tobacco or products containing nicotine (including, but not limited to, cigarettes, cigars, electronic cigarettes, vapers, chewing tobacco, snuff, nicotine gum and/or patches)?		

a. If "Yes," list below:

Type:	Last Used:

b. If type includes "Cigars," how many cigars did you smoke in the past year? ____

12. Family History:

	History Unknown	Age if Living	Age at Death	If biological parent died prior to age 65, was cause of death due to coronary artery disease, heart attack, or stroke?
a. Biological Mother				
b. Biological Father				

c. Have any of your biological siblings died prior to age 65 due to coronary artery disease, heart attack, or stroke?
Yes, age(s) at death: ____ No No siblings Unknown

13. Provide the full name, address and phone number of your primary care/personal physician:

Physician Name: ____ Phone: ____ - ____ - ____

Address (Street): ____ Suite: ____

(City/State/ZIP): ____ / ____ / ____

a. Date of last visit (MM/YYYY): ____ / ____

b. Reason for last visit: ____

	Yes	No
14. In the past 5 years have you consulted with, been examined by or been treated by a physician or practitioner for any reason not previously disclosed?		
15. Have you taken, or have you been advised to take, any prescription medication(s) within the past 30 days (excluding over the counter drugs and/or herbal supplements) for any reason(s) not previously disclosed?		

16. **Details**: *(List details from questions answered "Yes" and specify to which question numbers details pertain. If more space is needed use the Continuation of Details Supplement.)*

Ques. # Date Details/Reasons

Signatory Section

The Undersigned declares that:

I have read or have had read to me the completed Medical Supplement before signing below. All statements and answers in this Medical Supplement are correctly recorded and are full, complete and true to the best of my knowledge and belief. I agree that this Medical Supplement constitutes a part of the application for insurance. I understand that if any answers provided on this Medical Supplement 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.

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

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

Printed Name of Proposed Insured

Signature of Witness (Examiner/Licensed Agent/Broker)

Printed Name of Witness (Examiner/Licensed Agent/Broker)

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

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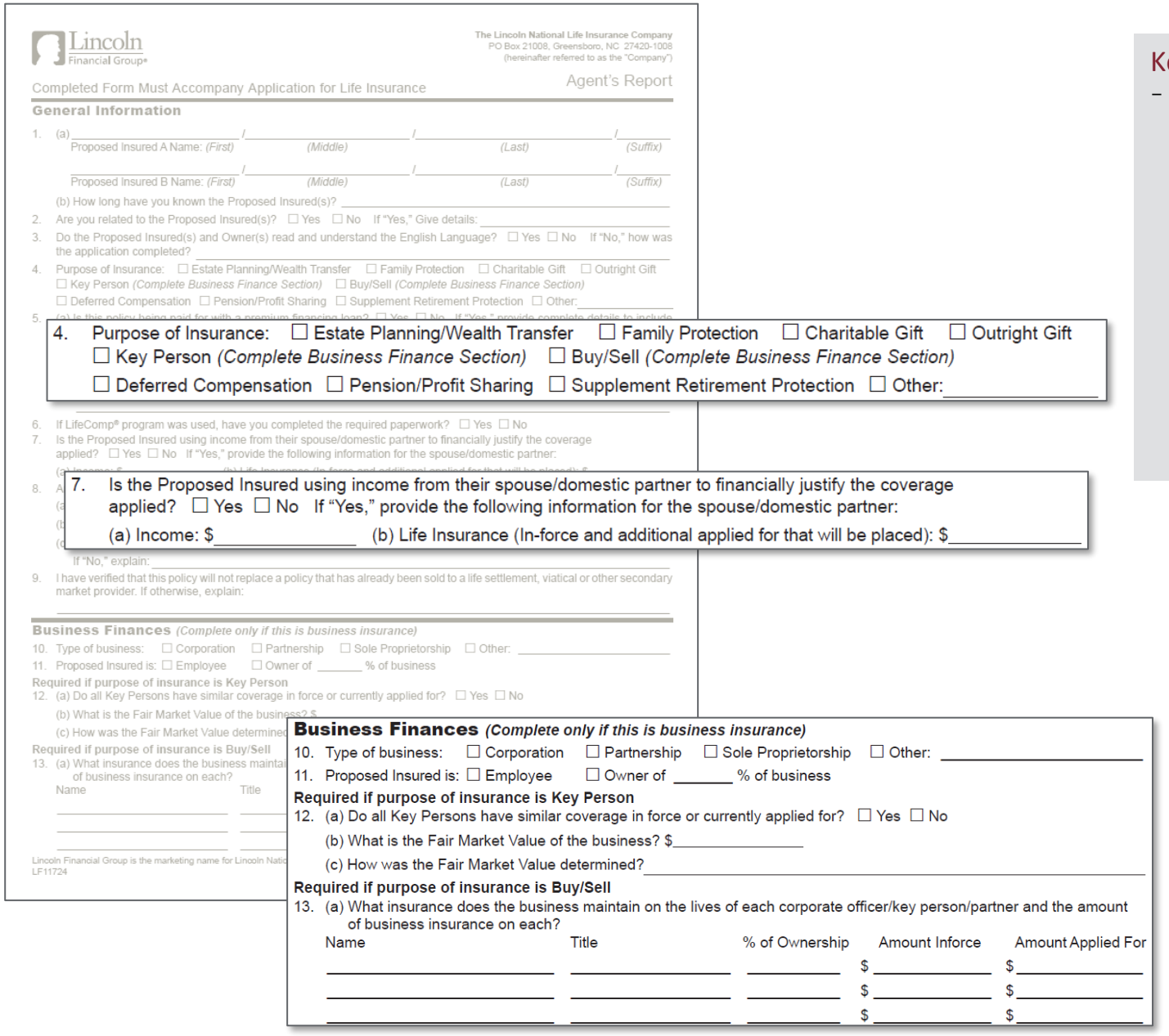
Key Changes

- Medical Supplement design has been shortened and simplified with more concise questions
- Questions have been re-ordered to help facilitate a more efficient Tele-App interview process

Agent's Report

Form LF11724



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PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as the "Company")

Completed Form Must Accompany Application for Life Insurance — Agent's Report

General Information

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

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

(b) How long have you known the Proposed Insured(s)? _____

2. Are you related to the Proposed Insured(s)? ☐ Yes ☐ No If "Yes," Give details: _____

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

4. Purpose of Insurance: ☐ Estate Planning/Wealth Transfer ☐ Family Protection ☐ Charitable Gift ☐ Outright Gift
☐ Key Person *(Complete Business Finance Section)* ☐ Buy/Sell *(Complete Business Finance Section)*
☐ Deferred Compensation ☐ Pension/Profit Sharing ☐ Supplement Retirement Protection ☐ Other: _____

5. (a) Is this policy being paid for with a premium financing loan? ☐ Yes ☐ No If "Yes," provide complete details to include _____

6. If LifeComp® program was used, have you completed the required paperwork? ☐ Yes ☐ No

7. Is the Proposed Insured using income from their spouse/domestic partner to financially justify the coverage applied? ☐ Yes ☐ No If "Yes," provide the following information for the spouse/domestic partner:
(a) Income: $_____ (b) Life Insurance (In-force and additional applied for that will be placed): $_____

8. A
(a
(b
(c
If "No," explain: _____

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

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

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

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

Required if purpose of insurance is Key Person

12. (a) Do all Key Persons have similar coverage in force or currently applied for? ☐ Yes ☐ No
(b) What is the Fair Market Value of the business? $
(c) How was the Fair Market Value determined

Required if purpose of insurance is Buy/Sell

13. (a) What insurance does the business maintai
of business insurance on each?
Name Title

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LF11724

4. Purpose of Insurance: ☐ Estate Planning/Wealth Transfer ☐ Family Protection ☐ Charitable Gift ☐ Outright Gift
☐ Key Person *(Complete Business Finance Section)* ☐ Buy/Sell *(Complete Business Finance Section)*
☐ Deferred Compensation ☐ Pension/Profit Sharing ☐ Supplement Retirement Protection ☐ Other: _____

7. Is the Proposed Insured using income from their spouse/domestic partner to financially justify the coverage applied? ☐ Yes ☐ No If "Yes," provide the following information for the spouse/domestic partner:
(a) Income: $_____ (b) Life Insurance (In-force and additional applied for that will be placed): $_____

Business Finances *(Complete only if this is business insurance)*
10. Type of business: ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other: _____
11. Proposed Insured is: ☐ Employee ☐ Owner of _____ % of business
Required if purpose of insurance is Key Person
12. (a) Do all Key Persons have similar coverage in force or currently applied for? ☐ Yes ☐ No
(b) What is the Fair Market Value of the business? $_____
(c) How was the Fair Market Value determined? _____
Required if purpose of insurance is Buy/Sell
13. (a) What insurance does the business maintain on the lives of each corporate officer/key person/partner and the amount of business insurance on each?

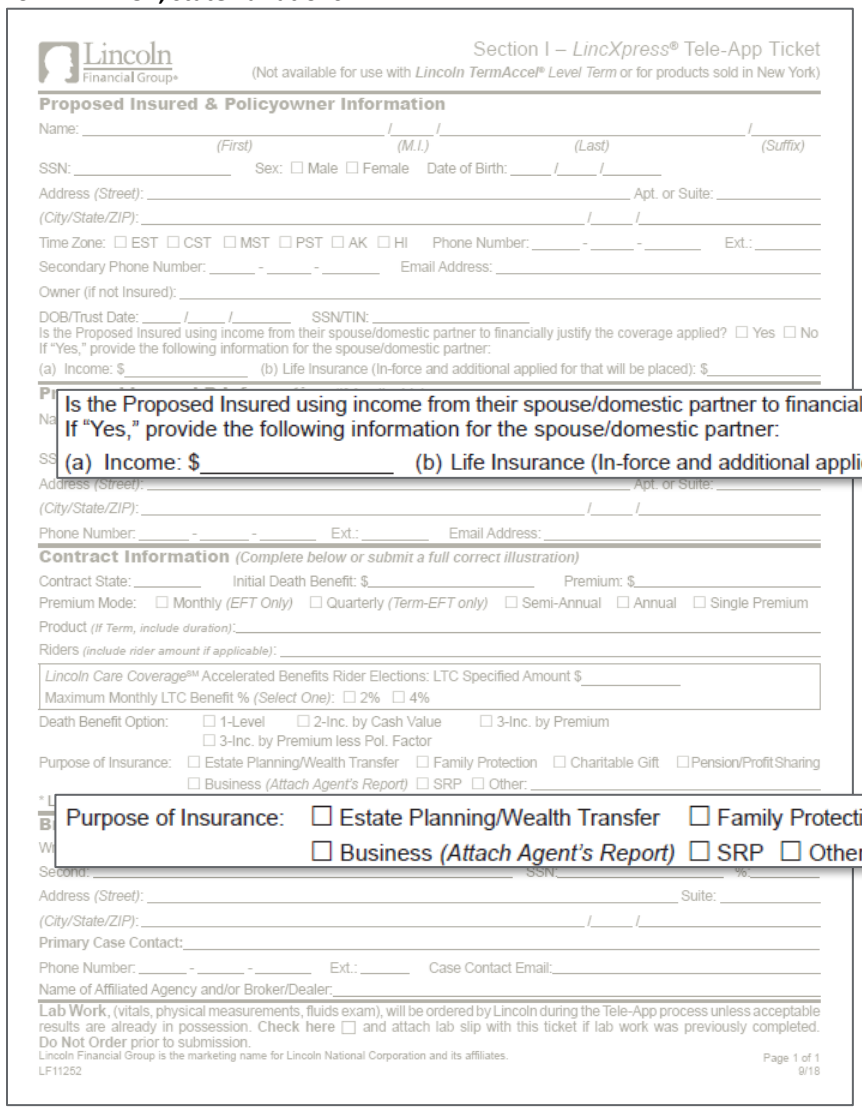
Name	Title	% of Ownership	Amount Inforce	Amount Applied For
			$	$
			$	$
			$	$

Key Changes

- Key questions have been added or updated to reduce the need to re-question and/or make amendments later in the process to better streamline and reduce delays in underwriting
  - **Q4 –** UPDATED Purpose of Insurance to include reminders to also complete the Business Finances section
  - **Q7 –** NEW conditional questions for spouse/domestic partner income and insurance to assist in justification of coverage amount
  - **Q10 -13 –** UPDATED Business Finances section to enable the collection of more complete information at the point of sale

LincXpress® Tele-App Paper Ticket

Form LF11252; state variations



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Section I – *LincXpress*® Tele-App Ticket

(Not available for use with *Lincoln TermAccel® Level Term* or for products sold in New York)

Proposed Insured & Policyowner Information

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

SSN: _____ Sex: ☐ Male ☐ Female Date of Birth: _____/_____/_____

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

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

Time Zone: ☐ EST ☐ CST ☐ MST ☐ PST ☐ AK ☐ HI Phone Number: _____ - _____ - _____ Ext.: _____

Secondary Phone Number: _____ - _____ - _____ Email Address: _____

Owner (if not Insured): _____

DOB/Trust Date: _____/_____/_____ SSN/TIN: _____

Is the Proposed Insured using income from their spouse/domestic partner to financially justify the coverage applied? ☐ Yes ☐ No
If "Yes," provide the following information for the spouse/domestic partner:

(a) Income: $_____ (b) Life Insurance (In-force and additional applied for that will be placed): $_____

Is the Proposed Insured using income from their spouse/domestic partner to financially justify the coverage applied? ☐ Yes ☐ No
If "Yes," provide the following information for the spouse/domestic partner:
(a) Income: $_____ (b) Life Insurance (In-force and additional applied for that will be placed): $_____

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

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

Phone Number: _____ - _____ - _____ Ext.: _____ Email Address: _____

Contract Information *(Complete below or submit a full correct illustration)*

Contract State: _____ Initial Death Benefit: $_____ Premium: $_____

Premium Mode: ☐ Monthly *(EFT Only)* ☐ Quarterly *(Term-EFT only)* ☐ Semi-Annual ☐ Annual ☐ Single Premium

Product *(If Term, include duration)*: _____

Riders *(include rider amount if applicable)*: _____

Lincoln Care Coverage℠ Accelerated Benefits Rider Elections: LTC Specified Amount $_____
Maximum Monthly LTC Benefit % *(Select One)*: ☐ 2% ☐ 4%

Death Benefit Option: ☐ 1-Level ☐ 2-Inc. by Cash Value ☐ 3-Inc. by Premium
☐ 3-Inc. by Premium less Pol. Factor

Purpose of Insurance: ☐ Estate Planning/Wealth Transfer ☐ Family Protection ☐ Charitable Gift ☐ Pension/Profit Sharing
☐ Business *(Attach Agent's Report)* ☐ SRP ☐ Other: _____

Purpose of Insurance: ☐ Estate Planning/Wealth Transfer ☐ Family Protection ☐ Charitable Gift ☐ Pension/Profit Sharing
☐ Business *(Attach Agent's Report)* ☐ SRP ☐ Other: _____

Address *(Street)*: _____ Suite: _____

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

Primary Case Contact: _____

Phone Number: _____ - _____ - _____ Ext.: _____ Case Contact Email: _____

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

Lab Work, (vitals, physical measurements, fluids exam), will be ordered by Lincoln during the Tele-App process unless acceptable results are already in possession. **Check here** ☐ and attach lab slip with this ticket if lab work was previously completed. **Do Not Order** prior to submission.

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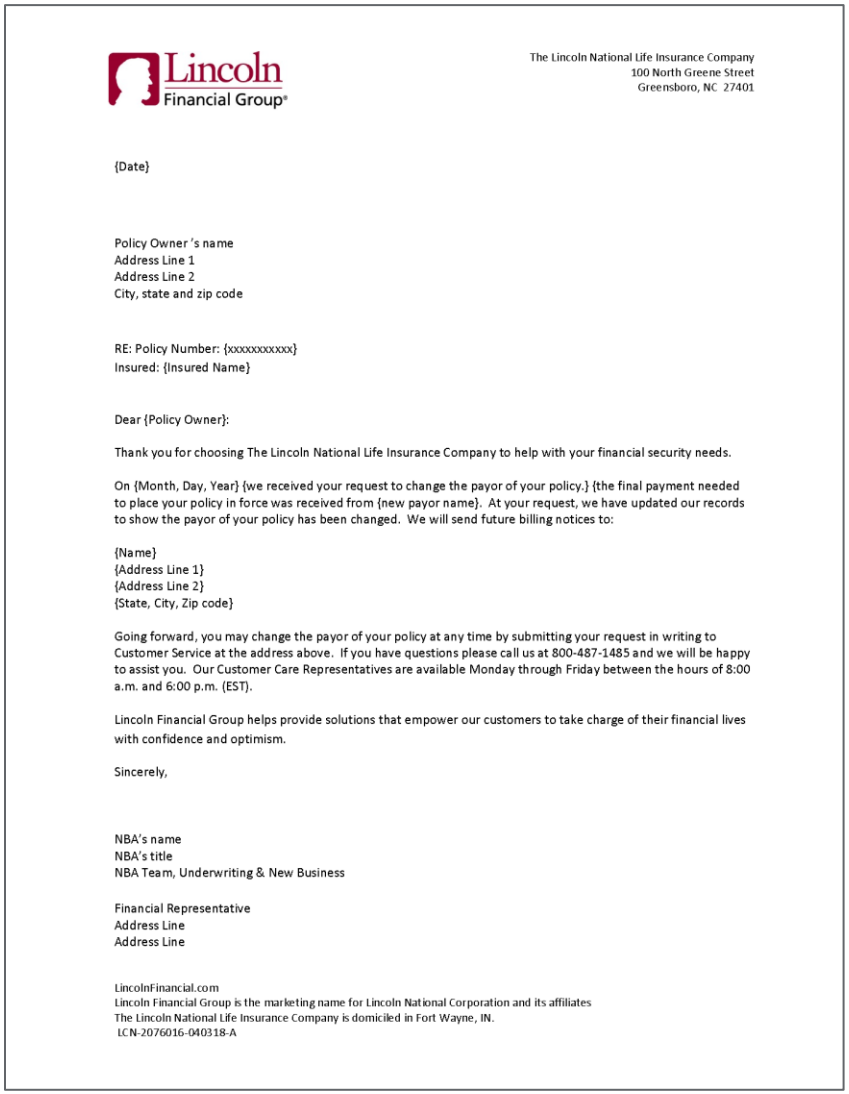
LF11252 Page 1 of 1 9/18

Key Changes

- The paper ticket design and question wording has been updated to align with Optical Character Recognition (OCR) technology creating more efficient processing of paperwork
- One Tele-App script for all products enhances the ease of doing business, if the client is purchasing more than one product or needs to make a change in product
- Key questions have been added or updated to reduce the need to re-question and/or make amendments later in the process to better streamline and reduce delays in underwriting
  - NEW conditional questions for spouse/domestic partner income and insurance to assist in justification of coverage amount
  - NEW "Business" option under 'Purpose of Insurance'
  - REMOVED Driver's License number requirement from the paper ticket and added to this question to the Tele-App interview to streamline the ticket process

Payor Change Letter



Lincoln Financial Group®

The Lincoln National Life Insurance Company
100 North Greene Street
Greensboro, NC 27401

{Date}

Policy Owner 's name
Address Line 1
Address Line 2
City, state and zip code

RE: Policy Number: {xxxxxxxxxx}
Insured: {Insured Name}

Dear {Policy Owner}:

Thank you for choosing The Lincoln National Life Insurance Company to help with your financial security needs.

On {Month, Day, Year} {we received your request to change the payor of your policy.} {the final payment needed to place your policy in force was received from {new payor name}. At your request, we have updated our records to show the payor of your policy has been changed. We will send future billing notices to:

{Name}
{Address Line 1}
{Address Line 2}
{State, City, Zip code}

Going forward, you may change the payor of your policy at any time by submitting your request in writing to Customer Service at the address above. If you have questions please call us at 800-487-1485 and we will be happy to assist you. Our Customer Care Representatives are available Monday through Friday between the hours of 8:00 a.m. and 6:00 p.m. (EST).

Lincoln Financial Group helps provide solutions that empower our customers to take charge of their financial lives with confidence and optimism.

Sincerely,

NBA's name
NBA's title
NBA Team, Underwriting & New Business

Financial Representative
Address Line
Address Line

LincolnFinancial.com
Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates
The Lincoln National Life Insurance Company is domiciled in Fort Wayne, IN.
LCN-2076016-040318-A

Key Changes

- A new Payor Change Letter will be generated to provide the policy owner with confirmation of a change to payor

- If the payor is unanswered on the application or if a payor change is requested prior to policy issue:
  - Lincoln New Business will create a Home Office Correction to be bound within the policy.

- If there is a payor change request received after policy issue:
  - Lincoln New Business will generate and mail this letter to the policy owner as confirmation that the payor on the policy was changed.

The new unified application is not available in New York.