The Lincoln National Life Insurance Company
(hereinafter referred to as "the Company")
New Business Service Office: PO Box 2616
Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177
E-mail: clientservices@LFG.com

Customer Service Office: PO Box 21008
Greensboro, NC 27420-1008
Phone: (855) 393-2847 Fax: (336) 335-2054
E-mail: LifePolicyHolderService@LFG.com

LINCOLN UNIVERSAL LIFE APPLICATION

SECTION 1

☐ Initial Application (Complete all SECTIONS)	Group ID:	State where solicitation occurred:

☐ Policy Change (Check Type of Change and include Policy Number below.) Policy Number: _____	☐ Increase to Base Policy Coverage (Complete all SECTIONS except for SECTIONS 4a., 4c., 5 & 6.)	☐ Decrease to Base Policy Coverage (Complete SECTIONS 2 & 4b.)	☐ Addition/Increase/ Decrease/Termination of Riders (Complete SECTIONS 2, 4b., and if applicable 4c.)	☐ Change to Non-Tobacco Rate Class (Complete SECTION 2.)

SECTION 2 - APPLICANT INFORMATION

Applicant/Employee (EE) (First Name / Middle Initial / Last Name)	Social Security Number	Date of Birth	☐ Male ☐ Female
Street Address / City / State / ZIP		Applicant E-Mail Address	
Home Phone *(include area code)*	Work Phone *(include area code)*	Are you a US Citizen or legally working in the US? ☐ Yes ☐ No	
Spouse (First Name / Middle Initial / Last Name)	Social Security Number	Date of Birth	☐ Male ☐ Female
Spouse Home Phone	Spouse Work Phone	Spouse E-Mail Address	

In the past 12 months, have you smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?	**EE** ☐ Yes ☐ No	**Spouse** ☐ Yes ☐ No

SECTION 3 - APPLICANT/EE WORK INFORMATION

Employer/Company Name			Billing Division/Location	
Avg. Hours Worked Per Week	EE Occupation	Earnings Annually	Date of Hire	Date of Rehire
Premium Mode:		Modal Planned Premium: $		

SECTION 4a. - UNIVERSAL LIFE COVERAGE SELECTION - I AM APPLYING FOR INITIAL COVERAGE:

Insured	**Policy Specified Amount:**	**Terminal Illness Accelerated Death Benefits Rider**	**Accidental Death Benefit Rider**	**Disability Waiver of Monthly Deductions Rider**	**Child's Term Rider (Rider is available on either EE's or Spouse's policy, but not both.)**	**Automatic Increase Rider (*Lincoln Automatic Assurance*®) (Increase will be effective on the policy anniversary unless otherwise noted below.)**
*Applicant/EE	Initial: $_____	☐ Yes ☐ No	☐ Yes ☐ No ☐ 1X ☐ 2X	☐ Yes ☐ No	☐ Yes ☐ No ☐ 5 Units ☐ 10 Units	☐ Yes $1-5 yrs. ☐ No Month of Increase _____
*Spouse	Initial: $_____ (GI Limit) *Amount above GI Limit requires UW approval.	☐ Yes ☐ No	☐ Yes ☐ No ☐ 1X ☐ 2X	☐ Yes ☐ No ☐ Owner (EE) or ☐ Insured (Spouse)	☐ Yes ☐ No ☐ 5 Units ☐ 10 Units	

SECTION 4b. - UNIVERSAL LIFE COVERAGE SELECTION - I AM MAKING POLICY CHANGES TO:

Insured	Policy Specified Amount:	Terminal Illness Accelerated Death Benefits Rider	Accidental Death Benefit Rider	Disability Waiver of Monthly Deductions Rider	Child's Term Rider (Rider is available on either EE's or Spouse's policy, but not both.)	Automatic Increase Rider (*Lincoln Automatic Assurance®*)
Applicant/EE	Increase to: $_____ Decrease to: $_____	☐ Add	☐ Add 1X	☐ Add	☐ Add 5 Units	☐ Terminate
		☐ Terminate	☐ Add 2X	☐ Terminate	☐ Add 10 Units	
			Increase to: $_____ Decrease to: $_____ ☐ Decrease to 1X		Increase to: ☐ 10 Units Decrease to: ☐ 5 Units	
			☐ Terminate		☐ Terminate	
Spouse	Increase to: $_____ Decrease to: $_____	☐ Add	☐ Add 1X	☐ Add Owner (EE)	☐ Add 5 Units	
		☐ Terminate	☐ Add 2X	☐ Add Insured (Spouse)	☐ Add 10 Units	
			Increase to: $_____ Decrease to: $_____ ☐ Decrease to 1X	☐ Terminate	Increase to: ☐ 10 Units Decrease to: ☐ 5 Units	
			☐ Terminate		☐ Terminate	

Premium change due to any policy change(s): $ _____

SECTION 4c. - UNIVERSAL LIFE COVERAGE SELECTION
(For each child insured by the Child's Term Rider provide the required information below.)

List Children's Names	Gender	Date of Birth	List Children's Names	Gender	Date of Birth
	☐M ☐F			☐M ☐F	
	☐M ☐F			☐M ☐F	
	☐M ☐F			☐M ☐F	
	☐M ☐F			☐M ☐F	
	☐M ☐F			☐M ☐F	

SECTION 5 - REPLACEMENT QUESTIONS FOR APPLICANT

	Yes	No
1) Do you, the Applicant/EE, currently own any existing life insurance or annuity contracts?	☐	☐
2) Are you, the Applicant/EE, considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing benefits under an existing life or annuity contract, or are you considering using or borrowing funds from an existing life or annuity contract to pay premiums due on the new or applied for policy(ies)? (If "Yes," please list company name and policy number below and complete and sign all required replacement forms.)	☐	☐

Company Name	Policy Number	Company Name	Policy Number

SECTION 6 - ***APPLICANT/EE'S ESTATE WILL BE THE BENEFICIARY FOR APPLICANT/EE COVERAGE UNLESS INDICATED OTHERWISE BELOW:

Select Primary (P) or Contingent (C) Beneficiary for each line completed in the "Type" column.			Type P/C	%
Beneficiary (First Name / Middle Initial / Last Name)	Relationship of Beneficiary	Social Security Number		
Beneficiary (First Name / Middle Initial / Last Name)	Relationship of Beneficiary	Social Security Number		
Beneficiary (First Name / Middle Initial / Last Name)	Relationship of Beneficiary	Social Security Number		

*** Applicant will be the beneficiary for any spouse and/or child coverage(s) unless indicated otherwise below:

SECTION 7 - ELIGIBILITY QUESTION FOR APPLICANT/EE

	Yes	No
1. Are you, the Applicant/EE, actively at work now and able to perform the regular duties of your occupation? (If "No", you are not eligible for coverage. However, your Spouse and dependents may still continue and apply for coverage.)	☐	☐

SECTION 8 - EVIDENCE OF INSURABILITY QUESTIONS FOR APPLICANT(S) QUALIFYING FOR MODIFIED GUARANTEE ISSUE

	EE		Spouse	
	Yes	No	Yes	No
2. **In the past 12 months**, have you, due to illness or disease (excluding colds, flu, allergies, back problems, or pregnancy) been:				
a) Hospitalized more than five consecutive days, or if employed, missed more than ten consecutive days from work?	☐	☐	☐	☐
b) Disabled, had a recurrent disability or are you disabled now?	☐	☐	☐	☐
3. **Within the past 7 years**, have you had, or been told by a member of the medical profession that you had, or been treated for a condition listed below?				
a) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐	☐	☐

SECTION 9 - EVIDENCE OF INSURABILITY QUESTIONS FOR APPLICANT(S) QUALIFYING FOR SIMPLIFIED ISSUE

	EE	Spouse
4. Provide the Height and Weight for each Proposed Insured.	Height: _____ Ft. _____ In. Weight: _____ lbs.	Height: _____ Ft. _____ In. Weight: _____ lbs.

	EE		Spouse	
	Yes	No	Yes	No
5. **Within the past 7 years**, have you been diagnosed by a physician with or treated by a physician for:				
a) Stroke, heart disease, heart surgery or attack, blood pressure controlled by more than two prescribed medications, diabetes (treated with insulin), hepatitis (other than Type A), cirrhosis of the liver, cancer or malignancy (excluding basal cell skin cancer), systemic lupus or connective tissue disease?	☐	☐	☐	☐
b) Chronic lung disease (excluding asthma), alcohol or drug abuse, kidney failure, Crohn's disease or ulcerative colitis or transient ischemic attack (TIA)?	☐	☐	☐	☐

SECTION 10 - SERVICE OFFICE ENDORSEMENTS *(For Company Use Only. We will attach additional documentation as needed.)*

PROTECTION AGAINST UNINTENDED LAPSE

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 understand that notice will not be given until 30 days after a premium is due and unpaid. I also understand that I will be given the opportunity to change this written designation at any time. My selection is as follows:

☐ I elect NOT to designate another person to receive notice of lapse or termination.

☐ I designate the person(s) listed below to receive copies of any notice of lapse or termination.

Third Party Name: _____ Phone Number: _____

Address: _____

AGREEMENT AND ACKNOWLEDGEMENT

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

I understand that the effective date of coverage/Policy Date as shown in the contract is contingent on the application being accepted under the Company's rules, limits and standards and the insurance is, or would have been issued as applied for. The effective date of coverage will be the Policy Date. For each child listed on this application, I confirm that I am liable for at least 50% of his/her support.

We strongly encourage 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.

I, the Applicant/Employee, am the Owner of all coverage issued under this application. I HAVE READ, or have had read to me, the completed application before signing below. All statements and answers recorded in this application are full, complete and true to the best of my knowledge and belief. I will notify the Company immediately if any information in the application is incorrect. Caution: If the answers in 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. 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 age at issue, amount or benefits unless agreed to in writing. No agent or broker has the authority to make or modify any Company contract or to waive any of the Company's requirements. I authorize my employer to deduct the premiums for this insurance from my earnings (if payroll deduction mode is elected).

I/We acknowledge receipt of the Privacy Notice.

In addition to the above agreement and acknowledgement, if I am increasing or changing coverage, I understand that:

1. Any new or increased coverage will not be in effect unless and until (a) all premiums and charges have been paid to and accepted by the Company; (b) the requested changes have been accepted by the Company; and (c) statements on this form and on any other application submitted as part of this request are correct at the time of such payments and approval. The effective date of any change in death benefit or rider shall be the Monthly Anniversary Day which coincides with or next follows the date the Company approves this application.
2. This application shall amend and be a part of the original application and the policy. The incontestability provision and the suicide provision in the policy are amended to apply to evidence of insurability received as a result of any new or increased coverage from the date the new or increased coverage is made to be in effect by the Company.

TERMINAL ILLNESS ACCELERATED DEATH BENEFITS RIDER DISCLOSURE, APPLICABLE IF RIDER IS ELECTED

Unless I answered "No" to issuance of the Terminal Illness Accelerated Death Benefits Rider (ABR), I acknowledge receipt of the following disclosure applicable to the Rider coverage:

Benefits paid under the Terminal Illness Accelerated Death Benefits Rider may be taxable. If so, you or your beneficiary may incur a tax obligation. As with all tax matters, please consult with your personal tax advisor to assess the impact of this benefit. Review very carefully the Terminal Illness Accelerated Death Benefits Rider for its provisions, limitations and benefits.

An accelerated death benefit is a portion of the policy's death benefit paid because the insured's life expectancy is reduced to 12 months or less. This benefit applies to the death benefit of the base life insurance policy only, and does not include any death benefit provided under any rider attached to the policy. The death benefit under the policy is reduced by the amount of any accelerated death benefits plus accrued interest, and it will be paid to your beneficiary upon the insured's death if the policy is in force at that time.

Up to 75% of the policy's death benefit (Benefit Percentage) may be taken as a lump sum payment. In no event, however, will the Rider benefit paid be greater than $250,000 in total. The maximum amount available on all policies with an accelerated benefits rider in force with Us is $250,000 per Insured. There are no restrictions or limitations on the use of the accelerated death benefit proceeds.

There is no administrative charge and no additional premium charged for the Terminal Illness Accelerated Death Benefits Rider. The policy premiums are waived after taking an accelerated death benefit. The benefit paid will be treated as an interest bearing lien against the policy. Access to the Cash Value of your policy through policy loans or a full surrender will be limited. The amount available for such usage will be limited to any excess of the Cash Value over the sum of any outstanding policy loans and the lien. A portion of any existing policy loan equal to the policy loan times the applicable Benefit Percentage will be repaid from the amount of the accelerated death benefit.

STATE DISCLOSURE

NOTE: A PERSON MAY BE COMMITTING INSURANCE FRAUD IF HE OR SHE SUBMITS AN APPLICATION CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH THE INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

FINANCIAL DISCLOSURE FOR CALIFORNIA RESIDENTS AGE 65 AND OVER

I acknowledge that the agent has informed me of the following details at the time I signed the application for life insurance or annuity:

- The sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this life insurance or annuity product may have tax consequences, early withdrawal penalties or other costs or penalties due to the sale or liquidation.
- I may wish to consult an independent legal or financial advisor before selling or liquidating any assets and prior to the purchase of any life insurance or annuity products being solicited, offered for sale or sold.

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

_____ _____
Signature of Applicant/Employee **Signature of Spouse** (if applicable)

_____
Signature of Child (if applicable)

AGENT'S STATEMENTS

I declare that I have accurately recorded in this application all of the information supplied by the Applicant.

(i) Does the Applicant/EE currently own any existing life insurance policies or annuities? ☐ Yes ☐ No

(ii) Do you know or have you any reason to believe that replacement of insurance is involved? ☐ Yes ☐ No
If a replacement is involved, I declare that only company approved sales materials were used in this sale and if used, that copies of all sales materials were left with the Applicant.

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

_____ _____
Signature of Licensed Agent **Name of Licensed Agent** (Please Print)

_____ _____
License Identification Number **Social Security Number of Licensed Agent**

Lincoln Financial Group®

Please check appropriate underwriting company:

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

NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Applicant's Name (please print)

Applicant's Signature

Date

Joint Applicant's Name (please print)

Joint Applicant's Signature

Date

Insured/Annuitant Printed Name

Agent's Signature

Date

Lincoln Financial Group®

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