REINSTATEMENT or CHANGE APPLICATION for LIFE INSURANCE

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK

FIRST PENN-PACIFIC LIFE INSURANCE COMPANY

LFF06363-32
(TEXAS)

6/09

Lincoln Financial Group®

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")

Policy Number

REINSTATEMENT OR CHANGE APPLICATION FOR LIFE INSURANCE

GENERAL INSTRUCTIONS FOR COMPLETING THE APPLICATION

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

Please complete the check boxes in the Signatory Section to indicate which Sections of the Application you are submitting.

COMPLETING THE APPLICATION

- Answer all questions on each page, and record each answer in complete detail using black or blue ink.
- **DO NOT USE correction fluid/tape or any similar item.** If you need to change answers draw a line through the mistake and have the change initialed by the Owner(s). If a health question is changed, draw a line through the mistake and have the change initialed by the Original Insured.
- Have the Original Insured(s) and Owner(s) read the application to confirm that all questions are answered accurately, sign and date the application.
- The **LICENSED AGENT OR BROKER** must complete and date the **AGENT'S REPORT** (as applicable).
- If applying for Variable Life Insurance please complete the Suitability Section on Page 5 of 6, the completed VUL/SVUL Allocations form must accompany the application.
- If applying for a term product, the billing options are: EFT; List Bill - 5 or more insureds; or Direct - Annual only.
- Please refer to product specifications for complete details and billing options.

AUTHORITY

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

SPECIAL INSTRUCTIONS

- **This application is broken out in Sections (A-B) and you can either "tear-out" or not print those sections that you do not use. Please indicate in the Signatory Section (via check boxes) which Sections of the Application you are submitting.**
- If there is only 1 original insured, then you do not need to send in Section A for Original Insured B. This section is not needed and the application will be in good order without it. Please indicate on Page 6 of 6 in the Signatory Section which Sections you are including.
- Section B, Defined Age Questionnaire, needs to be completed if either Original Insured is age 70 or older.
- Question 31 and 37; enter Owner(s) information here, including the name of the trust, trust date and trustees.
- Questions 62 – 64; please include the full name, address and phone number for each physician consulted, as this will assist with the underwriting process.

Lincoln Financial Group®

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")

IMPORTANT NOTICE

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

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

THE UNDERWRITING PROCESS (if applicable)

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

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

INVESTIGATIVE CONSUMER REPORT (if applicable)

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)

Lincoln Financial Group®

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")

IMPORTANT NOTICE

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

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

THE UNDERWRITING PROCESS (if applicable)

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

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

INVESTIGATIVE CONSUMER REPORT (if applicable)

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)

Lincoln Financial Group®

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")

REINSTATEMENT OR CHANGE APPLICATION FOR LIFE INSURANCE - PART I

Original Insured A *(First, Middle, Last)*	**Policy Number**

NON-UNDERWRITTEN POLICY CHANGES *(In addition to this section; please complete questions 1-18 on page 2, questions 1-18 on page 6Ai (if applicable); and the Signatory Section.)*

A. ☐ Decrease Face/Specified Amount to:
$ _____

B. ☐ Change Premium to: $ _____
(Based on change(s) in this section.)

C. ☐ Correct Date of Birth to: *(mm/dd/yyyy)*
_____

D. ☐ Cancel Benefits or Riders: *(Please provide full details.)*

E. ☐ Decrease Benefits or Riders: *(Please provide full details.)*
_____

F. ☐ Change Death Benefit Option to:
☐ Level ☐ Increasing/Decrease Current Face Amount
(To maintain original face, complete full application and Underwritten Policy Changes Section.)

G. ☐ Other:
_____

UNDERWRITTEN POLICY CHANGES *(Based on this change, complete pages 2 - 8 of application (and Sections A & B as applicable).)*

H. ☐ Reinstatement

I. ☐ Change Death Benefit Option to Increasing/Maintain Current Face Amount

J. ☐ Increase/Add Benefits/Riders: *(please provide full details)*
_____

K. ☐ Change to Non-Tobacco Rates:_____

L. ☐ Increase Face/Specified Amount to:
$ _____

M. ☐ Rate/Premium Class Change: _____

N. ☐ Other:_____

O. ☐ Exercise Exchange of Insured/Substitute Life Rider

P. ☐ Change Premium to: $_____
(Based on change(s) in this section)

SPECIAL INSTRUCTIONS *(List details from questions above; please include question number details pertain to. If more space is required use the "Continuation of Details Supplement.")*

TERM CONVERSION / GUARANTEED INSURABILITY OPTION **Owner of Original Policy must sign page 8.**
(Please complete questions below, questions 1-48 on pages 2 and 3, and the Signatory Section. Please also complete Section A questions 1-19 and Section B as applicable.)

Q. Conversion/Option Type: *(Check one)*
- i. ☐ Child ☐ Spouse Rider ☐ Partial Policy Conversion *(Check one)*
  - ☐ Keep Balance of Policy/Rider in Force
  - ☐ Terminate Balance of Policy/Rider
- ii. ☐ Full Policy Conversion
- iii. ☐ Guaranteed Insurability Regular Option
- iv. ☐ Guaranteed Insurability Alternate Option
- v. ☐ Other: _____

R. Conversion/Option Effective Date: _____

Lincoln Financial Group®

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")

PART I Continued

Policy Number

APPLICANT INFORMATION - ORIGINAL INSURED A (Required Section)

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

COVERAGE INFORMATION *(For New Coverage as available per product)*

(Any request for increased coverage may require underwriting. Please complete entire application.)

19. Plan of Insurance _____
(If applying for variable life insurance please complete allocation form(s).)

20. Amount of Insurance $ _____
(Specified Amount, if UL or VUL)

21. (i) Death Benefit Option *(Complete for Universal Life and Variable Universal Life Product only - not required for Term.)*
☐ Level ☐ Increase by Cash Value/Accumulated Value (as applicable)

(ii) Death Benefit Qualification Test (DBQT) - For IRS purposes, premiums will be tested using the Guideline Premium Test unless ☐ Cash Value Accumulation Test is checked (not available on all products or with all riders).
The DBQT cannot be changed after issue unless the terms of the policy require a change.

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

23. Additional Benefits and Riders: *(If applicable)*

- ☐ Accelerated Benefit Rider
- ☐ Supplemental Coverage $ _____
- ☐ Term on Spouse/Other Insured Rider $ _____
  (Please complete Section B - Applicant Information - Original Insured B)
- ☐ Children's Term Insurance Rider
  (Complete Child's Supplement)
- ☐ Waiver of Premium
- ☐ Waiver of Monthly Deductions
- ☐ Waiver of Specified Premium $ _____

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

PART I Continued

Policy Number

BILLING INSTRUCTIONS ***(As available per product) (For New Coverage)***

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

25. Modal Planned Premium: $ _____ 26. Lump Sum: $ _____ ☐ 1035 Exchange

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

28. Source of Premium: _____ *(inheritance, loan, business activity)* 29. Automatic Premium Loan: ☐ Y ☐ N *(Complete for Whole Life only.)*

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

☐ Owner in Question 31 ☐ Owner in Question 37 ☐ Insured at Business ☐ Insured at Residence ☐ Other *(indicate below)*

OWNER INFORMATION ***(If left blank, Original Insured(s) will be owner) (For New Coverage)***

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

43. Is this policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? ☐ Y ☐ N

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

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

44. ☐ P ☐ C	a. Beneficiary Name (Trust Name, Date & Trustees)	b. Soc. Sec. No./TIN c. Relationship to Original Insured
45. ☐ P ☐ C	a. Beneficiary Name (Trust Name, Date & Trustees)	b. Soc. Sec. No./TIN c. Relationship to Original Insured
46. ☐ P ☐ C	a. Beneficiary Name (Trust Name, Date & Trustees)	b. Soc. Sec. No./TIN c. Relationship to Original Insured
47. ☐ P ☐ C	a. Beneficiary Name (Trust Name, Date & Trustees)	b. Soc. Sec. No./TIN c. Relationship to Original Insured

48. Special Instructions *(List details from questions answered "Yes" and please specify to which question numbers details pertain. If more space is required use the "Continuation of Details Supplement.")*

Policy Number

PART I Continued

APPLICANT INFORMATION - ORIGINAL INSURED A

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

50. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*
If none, check this box: ☐
(Include Disability Insurance if disability reinstatement or exercise of GPI Rider.)
Please indicate the Type of coverage: Business (**B**); Key Person (**K**); or Personal (**P**).

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

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

Company	Amount	Type (Life or Disability)	Purpose of Insurance (Business, Personal)
	$		
	$		

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

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

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

55. Are you currently receiving, or within the past 10 years have you received or applied for, any disability benefits, including Worker's Compensation, Social Security Disability Insurance or any other form of disability insurance? *(If "Yes", provide further information in the "Details" space provided.)* ☐Y ☐N

GENERAL RISK INFORMATION - ORIGINAL INSURED A

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

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

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

59. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? *(If "Yes," please indicate what type and dates in the "Details" space provided.)* ☐Y ☐N

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

61. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.)* ☐Y ☐N

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

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

PART I Continued

Policy Number

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

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

a. Date and reason of last visit:

b. Tests performed & treatment received:

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

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

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

Lincoln Financial Group®

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")

HEALTH SUMMARY - PART I continued

Policy Number

APPLICANT INFORMATION - ORIGINAL INSURED A

► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.

	Yes	No
67. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	☐	☐
68. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	☐	☐
69. **Have you ever had any indication of, or been treated by a licensed medical professional for:**		
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	☐	☐
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	☐	☐
c. Anemia, leukemia, clotting disorder or any other blood disorder?	☐	☐
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	☐	☐
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	☐	☐
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	☐	☐
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	☐	☐
i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☐
k. Any disorder of the eyes, ears, nose or throat?	☐	☐
l. Any mental or physical disorder or medically or surgically treated condition not listed above?	☐	☐
70. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐
71. Do you use alcoholic beverages? *(If "Yes", provide Type, Frequency & Amount.)*	☐	☐
Type _____ Frequency_____ Amount _____		
72. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	☐	☐
73. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐

74. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.

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

Lincoln Financial Group®

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")

SECTION A - ADDITIONAL INSURED

Policy Number

APPLICANT INFORMATION - ORIGINAL INSURED B

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

19. Beneficiary for applicable Rider: *(For New Coverage)* (Include Trust Name, Date & Trustees) a. Name	
b. Soc Sec. No./TIN	c. Relationship to Original Insured B

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

21. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*
If none, check this box: ☐
(Include Disability Insurance if disability reinstatement or exercise of GPI Rider.)
Please indicate the Type of coverage: Business (**B**); Key Person (**K**); or Personal (**P**).

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

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

Company	Amount	Type (Life or Disability)	Purpose of Insurance (Business, Personal)
	$		
	$		

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

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

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

26. Are you currently receiving, or within the past 10 years have you received or applied for, any disability benefits, including Worker's Compensation, Social Security Disability Insurance or any other form of disability insurance? *(If "Yes", provide further information in the "Details" space provided.)* ☐ Y ☐ N

Policy Number

GENERAL RISK INFORMATION - ORIGINAL INSURED B

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

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

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

30. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? *(If "Yes," please indicate what type and dates in space provided below.)* ☐Y ☐N

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

32. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; on the space provided below.)* ☐Y ☐N

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

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

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

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

a. Date and reason of last visit:

b. Tests performed & treatment received:

35. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? ☐Y ☐N

Weight _____ lbs. b. If "Yes," by how many pounds? _____ ☐Gain ☐Loss

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

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

Lincoln Financial Group®

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")

Policy Number

HEALTH SUMMARY - SECTION A continued

APPLICANT INFORMATION - ORIGINAL INSURED B

► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.

	Yes	No
38. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	☐	☐
39. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	☐	☐
40. **Have you ever had any indication of, or been treated by a licensed medical professional for:**		
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	☐	☐
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	☐	☐
c. Anemia, leukemia, clotting disorder or any other blood disorder?	☐	☐
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	☐	☐
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	☐	☐
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	☐	☐
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	☐	☐
i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☐
k. Any disorder of the eyes, ears, nose or throat?	☐	☐
l. Any mental or physical disorder or medically or surgically treated condition not listed above?	☐	☐
41. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐
42. Do you use alcoholic beverages? *(If "Yes", provide Type, Frequency & Amount.)*	☐	☐
Type _____ Frequency_____ Amount _____		
43. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	☐	☐
44. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐

45. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.

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

Lincoln Financial Group®

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")

Policy Number

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

1. Original Insured A *(First, Middle, Last)* _____

2. Original Insured B *(First, Middle, Last)* _____

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

OWNER INFORMATION

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

Policy Number

PART I Continued

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

SUITABILITY

Complete only if applying for Variable Life Insurance and submit allocation form(s) with this Application:

1. Have you, the Original Insured(s) and the Owner, if other than the Original Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	☐Y ☐N
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	☐Y ☐N
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	☐Y ☐N
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	☐Y ☐N

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

AGREEMENT AND ACKNOWLEDGEMENT

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

Each of the Undersigned declares that:

1. Any new, reinstated 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 a part of this request are correct at the time of such payments and approval. Blank spaces in questions 31-43 (Owner Information) and/or 44-47 (Beneficiary Designation) of Part I of the application and question 19 of Section A of the application indicate no change from the previous designation.
2. 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.
3. I/WE HAVE READ, or have had read to me/us, the completed Reinstatement or Change Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
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. 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.
6. This application shall amend and be a part of the original application and the policy. The incontestability and suicide provisions in the policy are amended to apply to any new or increased coverage from the date the new or increased coverage is made to be in effect by the Company. Upon reinstatement, the period of contestability with respect to statements made in this application shall begin anew as of the date the new or increased coverage is made to be in effect by the Company.
7. For Universal Life and Variable Life, the effective date of any change in death benefit or any Rider requested on pages 1 and 2 shall be the Monthly Anniversary Day which coincides with or next follows the date the Company approves this application.
8. If applicable, I understand that I am applying for an equity index product. The values of the product may be affected by an external index however, the product does not directly participate in any stock, bond or equity investments.

STATE DISCLOSURE

Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

Policy Number

PART I Continued

TRUST VERIFICATION

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

AUTHORIZATION

Each of the undersigned declares that:

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

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

For Non-Underwritten Changes - The Company will not obtain medical information on this authorization for Non-Underwritten Policy Changes questions A-G.

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

SIGNATORY SECTION

This Application consists of: a) Part I (including Sections A-B if needed); b) Part II Medical Application, if required; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which a re required by the Company for the plan, amount and benefits applied for. This Reinstatement or Change Application for Life Insurance - Part I shall be complete when it includes Applicant Information - Original Insured A, and any or none of the following (please check, as applicable, included Sections A-B):

☐ **Section A- Applicant Information -Original Insured B,**
☐ **Section B - Defined Age Questionnaire.**

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

Signature of Original Insured A (Parent or Guardian if under 14 years of age)

Signature of Original Insured B (If coverage applied for)
(Parent or Guardian if under 14 years of age)

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

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

TO BE COMPLETED BY AGENT ONLY

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

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

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

I declare that I have provided each Original Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative (Please Print)

APPLICABLE TO VARIABLE LIFE ONLY

I have reviewed the Application, Supplements, New Account Form and allocation forms and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

Lincoln Financial Group®

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

AGENT'S REPORT (Completed Form Must Accompany Application for Life Insurance)

GENERAL INFORMATION

1. (a) Name of Proposed Insured(s) | (b) How long have you known the Proposed Insured(s)?

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

3. Purpose of Insurance: (check one) ☐ Buy/Sell ☐ Key Person ☐ Charitable Gift ☐ Deferred Compensation ☐ Estate Planning ☐ Family Income ☐ Outright Gift ☐ Pension/Profit Sharing ☐ Other:

4. (a) Is this policy being paid for with a premium financing loan? ☐ Yes ☐ No If "Yes", provide complete details to include the name of the financing plan being used, name and address of institution providing loan, name and phone number of the lending officer:

   (b) Is this policy being paid for with funds from any person or entity whose only interest in the policy is the potential for earnings based on the provision of funding for the policy? ☐ Yes ☐ No If "Yes", provide details below:

   Details:

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

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

7. Answer only if Proposed Insured is a Homemaker	Amount Inforce	Amount Applied For
(a) Spouse's Life Insurance:	$	$
8. Answer only if Proposed Insured is under age 18.		
(a) Father's Life Insurance:	$	$
(b) Mother's Life Insurance:	$	$
(c) Are siblings also being insured? ☐ Yes ☐ No	$	$

If "No", please explain:

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

BUSINESS FINANCES (Complete only if this is business insurance)

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

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

12. Total Business Assets:	Total Business Liabilities:	Total Business Net Worth:
$	$	$

13. Net Income (Profit) for the past 2 years: Last year $ Previous year $

14. What insurance does the business maintain on the lives of each corporate officer/key person/partner and the amount of business insurance on each?

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

AGENT INFORMATION (To ensure proper payment of commissions, please fully complete the following sections. Incomplete or incorrect information may delay compensation payment.)

15. Name of Managing General Agency (MGA), Brokerage General Agency (BGA), or Independent Marketing Organization (IMO):

16. Have you recently submitted paperwork for a change in reporting hierarchy or commission set-up? ☐ Yes ☐ No
If "Yes" please describe the change requested: _____

17. Agents who participated in this application: *(please print)*

Full Name of Agent(s) entitled to commission:		SSN (xxx-xx-xxxx)	Agent Number or Sa/Pc Code Share	% Comm.
Writing				%
Second				%
Third				%

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

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

Please check appropriate commission schedule as applicable - select one: (Election is irrevocable; contact upline/hierarchy for details.)	As applicable to selected Rider: (Election is irrevocable.)
☐ A- Heaped ☐ B - Mod-Heaped ☐ C - Trails	☐ D - Level ☐ E - Semi-Heaped

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

20. MGA/RD/RLS Name:

21. Broker Dealer Client/Owner Account #: Broker Dealer Affiliation:

AGENT CERTIFICATION

- ► I have reviewed all the questions on this application and certify that the answers have been recorded accurately. I know of nothing affecting the insurability of the Proposed Insured(s) which is not fully recorded in this application.
- ► I declare that if replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.
- ► I declare I have not been involved in any recommendation regarding the possible sale or assignment of this policy to a life settlement, viatical or other secondary market provider. If otherwise, please explain: _____
- ► I declare that I have verified that all life insurance coverage in force, or in the process of being applied for, on the proposed insured has been disclosed on this application, including any coverage that has been sold or is in the process of being sold to a life settlement, viatical or other secondary market provider.
- ► I declare, to the best of my knowledge, that this policy is not being funded via non-recourse premium financing and is not being paid for with funds from any person or entity whose only interest in the policy is the potential for earnings based on the provision of funding for the policy. If otherwise, please explain: _____
- ► I declare that I have accurately answered all questions contained in the Agent's Report in connection with this application.

Signature of Licensed Agent, Broker or Registered Representative **Date**