Lincoln Financial Group®

APPLICATION FOR LIFE INSURANCE

JEFFERSON-PILOT LIFE
INSURANCE COMPANY

JEFFERSON PILOT FINANCIAL
INSURANCE COMPANY

THE LINCOLN NATIONAL LIFE
INSURANCE COMPANY

LFF06300-32
(TEXAS)

10/06

Lincoln Financial Group®

Jefferson-Pilot Life Insurance Company, Service Office: PO Box 21008, Greensboro, NC 27420-1008
Jefferson Pilot Financial Insurance Company, Service Office: PO Box 515, Concord, NH 03302-0515
The Lincoln National Life Insurance Company, Service Office: PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as "the Company")

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.

COMPLETING THE APPLICATION

- If applying for Variable Life Insurance, the completed VUL/SVUL Fund Allocations Form or Premium Allocation and Disclosure Form for Variable Life (as applicable) must accompany the application.
- **When applying for the JPF Ensemble® EXEC 2006 policy and completing the question applicable to the deduction of monthly insurance and administrative charges:** Please note that the Long Term Fixed Account may not be designated as the **only** account for the deduction of monthly insurance and administrative charges, **nor** can it be used for these deductions on a pro-rata basis with the General Account and the divisions of the Separate Account. The deduction of monthly insurance and administrative charges will only be deducted from the Long Term Fixed Account if there is insufficient value in the divisions of the Separate Account or the General Account to cover the monthly deduction.
- If applying for an Advantage Platform product, the billing options are: DRAFT/PAC; List Bill - 5 or more insureds; Direct - Annual only. Please refer to product specifications for complete details and billing options.
- Answer all questions on each page, and record each answer in complete detail using black or blue ink.
- While completion of the General Risk Information is not required if a full paramedical or medical examination is necessary, answering all medical questions (including the full name, address and phone number for each physician consulted) will enable the underwriter to promptly begin the underwriting process. Please complete the General Risk Information if a full paramedical or medical exam is over 90 days old but less than 180 days old.
- **DO NOT USE WHITEOUT.** If you need to change an answer put a line through the mistake and have the change initialed by the Owner. If a health question is changed, draw a line through the mistake and have the change initialed by the Proposed Insured.
- Have the Proposed Insured(s) and Owner 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.**

AUTHORITY

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

TEMPORARY INSURANCE AGREEMENT (TIA)

If payment is made with the application, you must give a copy of the TIA to the Owner. Do not accept money orders or cash, only checks payable to the applicable Lincoln National Corporation affiliate checked at the top of page 1a are acceptable. If you are submitting applications for alternate or multiple, only one TIA per proposed may be in effect at one time. Please refer to the TIA for details.

- **Payment with Application May Not Be Submitted if:**
  1. The Life insurance applied for exceeds $3,000,000 on any one life including optional benefit riders.
  2. Any Proposed Insured's age is less than 15 days or in excess of 70 years.
  3. Any of the questions at the beginning of the TIA is answered YES or LEFT BLANK.
- **If the Payment with Application Rules allow payment to be submitted, please follow these guidelines:**
  1. Submit payment with application only in the form of a currently dated check made payable to the applicable Lincoln National Corporation affiliate checked at the top of page 1a.
  2. TIA must be signed and dated by the licensed agent, broker or registered representative taking the application along with the Proposed Insured(s) and Owner.
  3. Give a copy of the TIA to the Owner and submit the original with the application.
  4. Submit the payment with the application.

SPECIAL INSTRUCTIONS

For question 22 and/or question 35: If any person (insured, owner/applicant, beneficiaries, etc.) or entity on that person's behalf (trust, charity, corporation, limited liability company, partnership, etc.) who has been solicited to purchase this policy has been paid, or has been provided with a promise to pay, any compensation as an inducement for the issuance of this policy, then answer this question "Yes." The prohibited compensation may be in the form of cash, property, and/or the expectation of receiving a percentage of the death benefit.

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(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 Proposed Insured.)

THE UNDERWRITING PROCESS

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

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 incontestability 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: Box 105 Essex Station, Boston, MA 02112. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)

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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.

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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: Box 105 Essex Station, Boston, MA 02112. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)

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APPLICATION FOR LIFE INSURANCE - PART I

PROPOSED INSURED A

1. Name *(First)* *(Middle)* *(Last)*
2. ☐ Male ☐ Female
3. Date of Birth *(mm/dd/yy)*
4. Place of Birth *(State, Country)*
5. Social Security Number *(xxx-xx-xxxx)*
6. Driver License # & State
7a. Home Address *(Street)* *(City)* *(State)*
7b. Home Address Zip Code
8. Employer
9. Occupation/Duties
10a. Business Address *(Street)* *(City)* *(State)*
10b. Business Address Zip Code:
11. Phone Number *(check most convenient time to contact)*
Primary: _____ ☐ AM ☐ PM
Work: _____ ☐ AM ☐ PM
Email: _____
12. Annual Earned Income: $
13. Annual Unearned Income: $
14. Total Assets: $
15. Total Liabilities: $
16. Net Worth: $
17. In the last 5 years have you filed for bankruptcy? ☐ Yes ☐ No
If "Yes", complete the Financial Supplement.

18. 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? ☐ Yes ☐ No
(If "Yes", please complete and sign all required replacement forms and complete Question 19.)

19. What is the total amount of all inforce insurance on your life? *(Please list in the box below.)* **If none, check this box:** ☐

Company	Face Amount	Policy Number	Issue Date *(mm/dd/yy)*	Replacement or Change of Policy?	Check here if 1035Exchange
	$			☐ Yes ☐ No	☐
	$			☐ Yes ☐ No	☐
	$			☐ Yes ☐ No	☐
	$			☐ Yes ☐ No	☐

20. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide details in Question 26.)* ☐ Yes ☐ No
21. 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" to Question 21, complete with details below.)* ☐ Yes ☐ No

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	$		
	$		
	$		

22. Will you, the proposed insured and/or beneficiary, and/or any entity on your behalf, receive any compensation, whether via the form of cash, property, an agreement to pay money in the future, a percentage of the death benefit, or otherwise, if this policy is issued? *(If "Yes", provide details in Question 26.)* ☐ Yes ☐ No
23. Have you, the proposed insured, been involved in any discussion about the possible sale or assignment of this policy or a beneficial interest in a trust, LLC or other entity created or to be created on your behalf? *(If "Yes", provide details in Question 26.)* ☐ Yes ☐ No
24. Have you, the proposed 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? *(If "Yes", provide details in Question 26.)* ☐ Yes ☐ No
25. 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.)* ☐ Yes ☐ No
26. **Details:** *(List details from questions above; please include question number details pertain to.)*

Lincoln Financial Group®

APPLICATION FOR LIFE INSURANCE - PART I

PROPOSED INSURED B

1. Name *(First)* *(Middle)* *(Last)*
2. ☐ Male ☐ Female
3. Date of Birth *(mm/dd/yy)*
4. Place of Birth *(State, Country)*
5. Social Security Number *(xxx-xx-xxxx)*
6. Driver License # & State
7a. Home Address *(Street)* *(City)* *(State)*
7b. Home Address Zip Code
8. Employer
9. Occupation/Duties
10a. Business Address *(Street)* *(City)* *(State)*
10b. Business Address Zip Code:
11. Phone Number *(check most convenient time to contact)*
Primary: _____ ☐ AM ☐ PM
Work: _____ ☐ AM ☐ PM
Email: _____
12. Annual Earned Income: $
13. Annual Unearned Income: $
14. Total Assets: $
15. Total Liabilities: $
16. Net Worth: $
17. In the last 5 years have you filed for bankruptcy? ☐ Yes ☐ No
If "Yes", complete the Financial Supplement.

18. 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? ☐ Yes ☐ No
(If "Yes", please complete and sign all required replacement forms and complete Question 19.)

19. What is the total amount of all inforce insurance on your life? *(Please list in the box below.)* **If none, check this box:** ☐

Company	Face Amount	Policy Number	Issue Date *(mm/dd/yy)*	Replacement or Change of Policy?	Check here if 1035Exchange
	$			☐ Yes ☐ No	☐
	$			☐ Yes ☐ No	☐
	$			☐ Yes ☐ No	☐
	$			☐ Yes ☐ No	☐

20. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide details in Question 26.)* ☐ Yes ☐ No
21. 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" to Question 21, complete with details below.)* ☐ Yes ☐ No

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	$		
	$		
	$		

22. Will you, the proposed insured and/or beneficiary, and/or any entity on your behalf, receive any compensation, whether via the form of cash, property, an agreement to pay money in the future, a percentage of the death benefit, or otherwise, if this policy is issued? *(If "Yes", provide details in Question 26.)* ☐ Yes ☐ No
23. Have you, the proposed insured, been involved in any discussion about the possible sale or assignment of this policy or a beneficial interest in a trust, LLC or other entity created or to be created on your behalf? *(If "Yes", provide details in Question 26.)* ☐ Yes ☐ No
24. Have you, the proposed 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? *(If "Yes", provide details in Question 26.)* ☐ Yes ☐ No
25. 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.)* ☐ Yes ☐ No
26. **Details:** *(List details from questions above; please include question number details pertain to.)*

OWNER INFORMATION *(If left blank, Proposed Insured(s) will be owner)*

► **If a Trust, provide Trustee Name(s), Trust Name.**

27. Owner Name *(First, Middle, Last)*		28. Citizen of (Country)
29. Owner Address		30. Date of Birth *(if applicable) (mm/dd/yy)*
31. Owner Social Security or Tax ID #	32. Relationship to Proposed Insured(s)	33. Trust Date *(only if Trust is Owner)*

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

35. Will you, the proposed owner and/or beneficiary, and/or any entity on your behalf, receive any compensation, whether via the form of cash, property, an agreement to pay money in the future, a percentage of the death benefit, or otherwise, if this policy is issued? *(If "Yes", provide details in Question 38.)* ☐ Yes ☐ No

36. Have you, the proposed owner, been involved in any discussion about the possible sale or assignment of this policy or a beneficial interest in a trust, LLC or other entity created or to be created on your behalf? *(If "Yes", provide details in Question 38.)* ☐ Yes ☐ No

37. 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.)* ☐ Yes ☐ No

38. **Details:** *(List details from questions above; please include question number details pertain to.)*

COVERAGE INFORMATION

39. Plan of Insurance _____ *(If you are applying for MoneyGuard Long Term Care, please complete the MoneyGuard LTC Supplement to Application. If you are applying for variable life insurance, please complete Premium Allocation and Disclosure form.)*

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

41. (i) Death Benefit Option *(Complete for Universal Life and Variable Universal Life Product only - not required for Term or Whole Life.)*

☐ Level ☐ Increase by Cash Value ☐ Increase by Premium ☐ Increase by Premium Less Policy Factor

(ii) Death Benefit Qualification Test - For IRS purposes, premiums will be tested using the Guideline Premium Test unless ☐ Cash Value Accumulation Test is checked (not available on all products). **Cannot be changed after issue.**

42. Additional Benefits and Riders *(if applicable)*

☐ Waiver of Premium ☐ Accelerated Benefit Rider ☐ Disability Income Rider *(Complete DI Supplement)*

☐ Waiver Monthly Deductions ☐ Waiver Specified Premium $_____

☐ Term on Spouse/Other Insured Rider $_____ ☐ Children's Term Insurance Rider *(Complete Child's Supplement)*

☐ Supplemental Coverage $_____

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

43. Save Age *(Not applicable to MoneyGuard)* ☐ Yes ☐ No *(If not saving age, policy will be current dated.)*

44. **Complete only if applying for Variable Life Insurance with the Company. Submit Premium Allocation and Disclosure Form for Variable Universal Life with Application:**

Suitability

	Yes	No
1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	☐	☐
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?	☐	☐
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?	☐	☐
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?	☐	☐

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.

BILLING INSTRUCTIONS AS AVAILABLE PER PRODUCT

45. Planned Premium: $ _____ 46. Lump Sum: $ _____ ☐ 1035 Exchange

47. Premium Frequency: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly (EFT) ☐ Other _____

48. Special Billing: *(check one, if applicable)* ☐ New List Bill ☐ Existing List Bill *(provide #)* _____

49. Automatic Premium Loan *(Complete for Whole Life only.)* ☐ Yes ☐ No

50. Premium Notices To: *(check all that apply.) (Please note we cannot bill to your agent.)*

☐ Insured at Residence ☐ Insured at Business ☐ Owner ☐ Other _____

51. Special Instructions:

BENEFICIARY DESIGNATION *Beneficiaries share equally unless otherwise indicated.*

► **If a Trust, provide Trustee Name(s), Trust Name and date of Trust.**

52. Primary Beneficiary(ies):	53. Social Security or Tax ID #:	54. Relationship to Proposed Insured:
55. Contingent Beneficiary(ies):	56. Social Security or Tax ID #:	57. Relationship to Proposed Insured:
58. Beneficiary for Spouse/Other Insured Term Rider:	59. Social Security or Tax ID #:	60. Relationship to Spouse/Other Insured:

GENERAL RISK INFORMATION - PROPOSED INSURED A

61. 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? ☐ Yes ☐ No
(If "Yes", an Aviation Supplement is required.)

62. 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? ☐ Yes ☐ No
(If "Yes", an Avocation Supplement is required.)

63. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? ☐ Yes ☐ No
(If "Yes", a Foreign Travel or Residence Supplement is required.)

64. Have you ever used tobacco or products containing nicotine? *(If "Yes", check all that apply.)* ☐ Yes ☐ No

Type:	Cigarettes ☐	Cigar ☐	Pipe ☐	Chew Tobacco ☐	Snuff ☐	Nicotine Patches/ Gum ☐
Date First Used: *(month/year)*						
Date Last Used: *(month/year)*						
Amount and Frequency:						

► **If you answer "Yes" to any of the following questions, please give details in the space provided below.**

65. 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? ☐ Yes ☐ No
(If "Yes", please indicate what type and dates in space provided below.)

66. 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? ☐ Yes ☐ No
(If "Yes", provide details below.)

67. 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.)* ☐ Yes ☐ No

68. 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 space provided below.)* ☐ Yes ☐ No

69. Are you a citizen of the United States? ☐ Yes ☐ No
(If "No", please provide country, type of visa, expiration date and green card information in space provided below.)

70. **Details:** *(List details from questions above; please include question number details pertain to.)*

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

► **If you answer "Yes" to any of the following questions, please give details in the space provided on the next page.**

71. Provide full name/address/phone number of personal physician(s) and any other physicians seen:

_____

_____

a. Date and reason of last visit: _____

b. Tests performed & treatment received: _____

72. Height _____ ft. / _____ in. Weight _____ lbs.

a. Has your weight changed by more than 10 pounds during the past 12 months? ☐ Yes ☐ No

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

	Yes	No
73. Have you had or been advised 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?	☐	☐
74. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised to have any hospitalization or surgery which has not been completed?	☐	☐
75. **Have you ever had any indication of, or been treated 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, shortness of breath, 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 complication 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 medically or surgically treated condition not listed above?	☐	☐
76. Have you ever been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐
77. Do you use alcoholic beverages?	☐	☐
(If "Yes", provide Type, Frequency & Amount.) Type _____ Frequency _____ Amount _____		
78. Have you ever been treated for drug or alcohol abuse or been advised by your doctor to limit your use of alcohol or any medication, prescribed or not?	☐	☐
79. Have you ever used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐

80. 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.

_____

_____

_____

_____

_____

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

81. **Details** *(List details from "Yes" answered Medical Information questions; please include question number.)*

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

SERVICE OFFICE ENDORSEMENTS *(Attach an additional sheet of paper, if necessary.)*

GENERAL RISK INFORMATION - PROPOSED INSURED B

61. 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? ☐ Yes ☐ No
(If "Yes", an Aviation Supplement is required.)

62. 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? ☐ Yes ☐ No
(If "Yes", an Avocation Supplement is required.)

63. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? ☐ Yes ☐ No
(If "Yes", a Foreign Travel or Residence Supplement is required.)

64. Have you ever used tobacco or products containing nicotine? *(If "Yes", check all that apply.)* ☐ Yes ☐ No

Type:	Cigarettes ☐	Cigar ☐	Pipe ☐	Chew Tobacco ☐	Snuff ☐	Nicotine Patches/ Gum ☐
Date First Used: *(month/year)*						
Date Last Used: *(month/year)*						
Amount and Frequency:						

► **If you answer "Yes" to any of the following questions, please give details in the space provided below.**

65. 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? ☐ Yes ☐ No
(If "Yes", please indicate what type and dates in space provided below.)

66. 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? ☐ Yes ☐ No
(If "Yes", provide details below.)

67. 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.)* ☐ Yes ☐ No

68. 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 space provided below.)* ☐ Yes ☐ No

69. Are you a citizen of the United States? ☐ Yes ☐ No
(If "No", please provide country, type of visa, expiration date and green card information in space provided below.)

70. **Details:** *(List details from questions above; please include question number details pertain to.)*

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

► **If you answer "Yes" to any of the following questions, please give details in the space provided on the next page.**

71. Provide full name/address/phone number of personal physician(s) and any other physicians seen:

_____

_____

a. Date and reason of last visit: _____

b. Tests performed & treatment received: _____

72. Height _____ ft. / _____ in. Weight _____ lbs.

a. Has your weight changed by more than 10 pounds during the past 12 months? ☐ Yes ☐ No

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

	Yes	No
73. Have you had or been advised 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?	☐	☐
74. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised to have any hospitalization or surgery which has not been completed?	☐	☐
75. **Have you ever had any indication of, or been treated 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, shortness of breath, 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 complication 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 medically or surgically treated condition not listed above?	☐	☐
76. Have you ever been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐
77. Do you use alcoholic beverages?	☐	☐
(If "Yes", provide Type, Frequency & Amount.) Type _____ Frequency _____ Amount _____		
78. Have you ever been treated for drug or alcohol abuse or been advised by your doctor to limit your use of alcohol or any medication, prescribed or not?	☐	☐
79. Have you ever used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐

80. 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.

_____

_____

_____

_____

_____

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

81. **Details** *(List details from "Yes" answered Medical Information questions; please include question number.)*

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

SERVICE OFFICE ENDORSEMENTS *(Attach an additional sheet of paper, if necessary.)*

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, declare that my tax identification or social security number as shown is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Part I Application; b) Part II Medical Application, if required; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. If the application includes no secondary insured (insured B), the application shall be complete without pages 1b, 4b, 5b, and 6b.
2. I/We further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me/us; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured(s); and 3) the Proposed Insured(s) remain in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.

   I/We have paid $ _____ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I/we acknowledge that I/we fully understand and accept its terms.
3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true.
5. 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.
6. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURE

Any person who, with intent to defraud or knowing that he/she is facilitating a 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.

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 medical information 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.

The 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.

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

SIGNATORY SECTION

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

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

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

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

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

_____
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, New Account Form and Premium Allocation and Disclosure Form and find the transaction suitable.

_____
Signature of Registered Principal of Broker/Dealer

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

Lincoln Financial Group®

Jefferson-Pilot Life Insurance Company, PO Box 21008, Greensboro, NC 27420-1008
Jefferson Pilot Financial Insurance Company, PO Box 515, Concord, NH 03302-0515
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 under age 18.
   (a) Father's Life Insurance: Amount In Force: $ Amount Applied for: $

   (b) Mother's Life Insurance: Amount In Force: $ Amount Applied for: $

   (c) Are siblings also being insured? ☐ Yes ☐ No If "No", please explain:

8. (a) Does the applicant have any existing life insurance policies or annuities? ☐ Yes ☐ No

   (b) If there are existing life insurance policies or annuities, do you know or have any reason to believe that replacement of a life insurance policy or annuity is involved? ☐ Yes ☐ No If "Yes", please provide details, such as company, face amount, policy number and date of issue. _____

   (c) 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)

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

15. Proposed Insured is: ☐ Employee ☐ Owner of % of business

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

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

18. 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 In Force	Amount Applied For
			$	$
			$	$
			$	$

AGENT INFORMATION

19. Agents who participated in this application:

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

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

21. Primary Agent's E-mail Address:

22. Primary Agent's Phone Number:

23. Name of Managing General Agency (MGA) or Brokerage General Agency (BGA):

AGENT CERTIFICATION

- ► I declare that I asked the Proposed Insured(s) each question on the application. I have recorded the answers exactly as stated and I know of nothing affecting the insurability of the Proposed Insured(s) which is not fully recorded in this application.
- ► I declare that I have provided each Proposed Insured and Owner with the Important Notice as well as a copy of the Privacy Practices Notice.
- ► 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**