



Please check the appropriate servicing address of the underwriting company:

- Lincoln Life & Annuity Company of New York, Life Service Office: PO Box 21008, Greensboro, NC 27420-1008
- Lincoln Life & Annuity Company of New York, Annuity Service Office: PO Box 2348, Fort Wayne, IN 46801-2348 (hereinafter referred to as "the Company")

### AUTHORIZATION FOR RELEASE OF INFORMATION

I (the undersigned) authorize any licensed physician, medical practitioner, hospital, clinic or any other medically related facility, insurance support organizations, insurance company, Medical Information Bureau (MIB), or other organization, institution or person that has any records or knowledge of:

Proposed Insured/Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

or the proposed insured's health, including but not limited to transaction records, employment records, financial records, and complete medical records (including information regarding insurance, demographics, referral documents and records from other facilities) or if other, indicate here: \_\_\_\_\_

to give all such information to Lincoln Life & Annuity Company of New York (the Company), their licensed representatives and/or their reinsurers, MediConnect.net Inc, GiS, or if other, indicate here: \_\_\_\_\_

I understand that an authorization for release or disclosure of psychotherapy notes may not be combined with an authorization for release or disclosure of any other information (a separate authorization must be completed for release or disclosure of psychotherapy notes).

I understand that the information obtained may be used by the Company to determine eligibility for insurance, or to administer my coverage. The Company may not give the information to any person or entity except: 1) a reinsurer, or other insurers to whom I have applied or may apply; 2) MIB; or 3) any other person or entity who performs business or legal services in connection with the administration of my insurance coverage. I understand that some of these people or entities may not be covered by federal or state privacy regulations and that the information they receive may be redisclosed, however the Company contractually requires them to protect the information we disclose to them. Information may be disclosed as allowed by law or regulation.

I understand this consent may be revoked in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my policy with that Company. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signing. To initiate revocation of this Authorization direct all correspondence to the address above.

I understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application.

I agree that a copy of the Authorization shall be as valid as the original. I may have a copy upon request.

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

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(Proposed insured/patient or legal representative (Next-of-kin or legal guardian to sign only if patient is a minor, legally incompetent, or deceased))

Relationship to proposed insured/patient of personal/legal representative signing for proposed insured/patient: \_\_\_\_\_



# Lincoln Life & Annuity Company of New York

Life Service Office: PO Box 21008, Greensboro, NC 27420-1008 • (800) 487-1485

## AUTHORIZATION TO DISCLOSE POLICY INFORMATION

### Letter of Notification:

In accordance with New York Insurance Department Regulation 60, please furnish the information needed for completing the enclosed Disclosure Statement.

Please forward the information to:

Agent or Broker's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Agent or Brokers's Telephone Number: \_\_\_\_\_ Agent or Brokers's Fax Number: \_\_\_\_\_

I authorize the release of information on the below mentioned policy(ies), as is needed to complete New York's required Disclosure Statement. This authorization is valid until revoked by me in writing.

1) _____	_____	_____	
Policyowner's Signature	Date	Print Name of Policyowner	
_____	_____	_____	_____
Address		Policy Owner Date of Birth	SSN
_____	_____	_____	_____
City		State	Zip Code

2) _____	_____	_____	
Policyowner's Signature	Date	Print Name of Policyowner	
_____	_____	_____	_____
Address		Policy Owner Date of Birth	SSN
_____	_____	_____	_____
City		State	Zip Code

### Replaced Company Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Replaced Policy(ies) Information:

Replaced Policy No. 1: \_\_\_\_\_ Replaced Policy No. 2: \_\_\_\_\_

Replaced Policy No. 3: \_\_\_\_\_ Replaced Policy No. 4: \_\_\_\_\_

Note to Agent or Broker: Provide one copy each to the replacing insurer identified at the top of this form, the policy owner, and for each replaced company identified at the bottom of this form.



## LINCOLN FINANCIAL GROUP® PRIVACY NOTICE FOR PERSONAL HEALTH INFORMATION

### **THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

You have received this notice because you have applied for, or have, life insurance coverage with one of the Lincoln Financial Group insurance companies\* (“Company”) that contains a long-term care benefit; or you have applied for, or have, medical and/or dental coverage (“Coverage”). This Notice refers to the Company by using the terms “us,” “we,” or “our.” We value our relationship with you and are committed to protecting the confidentiality and security of information we collect about you, especially health information.

We collect, use and disclose information about you to evaluate and process any requests for coverage and claims for benefits you may make regarding your Coverage. This notice describes how we protect the personal health information we have about you which relates to your Coverage (“Personal Health Information”), and how we may use and disclose this information. Personal Health Information includes individually identifiable information that relates to your past, present or future health, treatment or payment for health care services. This notice also describes your rights with respect to the Personal Health Information and how you can exercise those rights.

We are required to provide you with this Notice in accordance with federal health privacy regulations that were issued as a result of the Health Insurance Portability and Accountability Act (“HIPAA”). We are required by law to maintain the privacy of your Personal Health Information; to provide you this notice of our legal duties and privacy practices with respect to your Personal Health Information; and to follow the terms of this Notice.

We reserve the right to change the terms of this Notice. Any such changes will apply to all Personal Health Information we already have about you as well as any Personal Health Information we may receive in the future. If we make a material change to the terms of the Notice, we will promptly send the revised Notice to you should you still maintain coverage with us when the revised Notice becomes effective.

### **USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION**

The following describes when we may use and disclose your Personal Health Information with your written authorization and without your authorization:

**Authorization:** Except as described below, we will not use or disclose your Personal Health Information for any reason unless we have a signed authorization from you or your legal representative to use or disclose your Personal Health Information. You or your legal representative has the right to revoke an authorization in writing, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Coverage.

**Treatment:** We may use and disclose your Personal Health Information as necessary for your treatment. For instance, a doctor or health facility involved in your care may request Personal Health Information that we hold about you in order to make decisions about your care.

**Payment of Claims:** We may use and disclose your Personal Health Information to pay for benefits under your Coverage. For example, when you present a claim for benefits, we may obtain medical records from the doctor or health facility involved in your care to determine if you are eligible for benefits under the insurance policy and to reimburse you for services provided. Other payment-related uses and disclosures that are permitted and we may engage in include: making claim decisions, coordinating benefits with other insurers or payers, billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing.

**Health Care Operations:** We may use and disclose your Personal Health Information for our insurance operations. Our insurance operations may include underwriting, premium rating, and other activities related to the issuance, renewal or replacement of Coverage, or for reinsurance purposes. For example, when you apply for insurance we may collect medical information from your doctor (health care provider) or a medical facility that provided you health care services to determine if you qualify for insurance. We may also use and disclose Personal Health Information to conduct or arrange for medical review, legal services, contract for reinsurance, business planning and development regarding the management and operation of our Coverage processes, or auditing, including fraud and abuse detection and compliance programs. Personal Health Information may also be disclosed for customer service, servicing our current and future customer relationships permitted by law, resolution of internal grievances and as part of a potential sale, transfer, merger, or consolidation in order to make an informed business decision regarding any such prospective transaction. For group plans Personal Health Information may be disclosed to your Plan Sponsor for purposes of administering your Plan or other health plan maintained by your employer to facilitate claims payments under the plan.

**Business Associates:** We may also disclose Personal Health Information to non-affiliated business associates, but only if the receipt of Personal Health Information is necessary to provide a service to us and the business associate agrees to protect the Personal Health Information according to HIPAA rules. Examples of business associates are: billing companies, data processing companies, auditors, claims processing companies and companies that provide general administrative services.

**Where Required by Law, for Public Health or Similar Activities:** We may also disclose Personal Health Information where required by law, for public health or similar activities. Examples include:

- Releasing Personal Health Information to state or local health authorities, as required by law, of particular communicable diseases, injury, birth, death, and for other required public health investigations;
- Releasing Personal Health Information to a governmental agency or regulator with health care oversight responsibilities;
- Releasing Personal Health Information to a coroner, medical examiner or funeral director to assist in identifying a deceased individual or to determine the cause of death;
- Releasing Personal Health Information to public health or other appropriate authorities, as required by law, when there is reason to suspect abuse, neglect, or domestic violence;
- Releasing Personal Health Information to the Food and Drug Administration (FDA) for purposes related to quality, safety or effectiveness of FDA-regulated products or activities;
- Releasing Personal Health Information if required by law to do so by a court or administrative ordered subpoena or discovery request, or for law enforcement purposes as permitted by law. We will make efforts to notify you of such requests or to obtain an order protecting the Personal Health Information requested. We may disclose Personal Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination;
- Releasing Personal Health Information for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- Releasing Personal Health Information if you are a member of the military as required by armed forces services;
- Releasing Personal Health Information to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- Releasing Personal Health Information to worker's compensation agencies if necessary for your worker's compensation benefit determination;

- Releasing Personal Health Information to avert a serious threat to someone's health or safety, including the disclosure of Personal Health Information to government or privacy disaster relief or assistance agencies to allow such entities to carry out their responsibilities to specific disaster situations.
- Uses and Disclosures to Family, Friends or Others Involved in Your Care: With your written approval, we may disclose your Personal Health Information to designated family, friend, personal representative, or other individual that you may identify as involved in your care or involved in the payment for your care. Should you become incapacitated or be in the face of an emergency medical situation and not able to provide us with your written approval, we may disclose Personal Health Information about you that is directly relevant to such person's involvement in your care or payment for such care.

## **YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION**

You have the following rights as a consumer under HIPAA concerning the Personal Health Information we have about you in our records. Any request to exercise your rights as described below should be made in writing and sent to **Lincoln Financial Group, Attn: Enterprise Services Compliance – Privacy 6C-00, 1300 S Clinton Street, Fort Wayne IN 46802**. Also, should you wish to terminate a request that has been accommodated, such termination request must also be in writing and sent to the same address listed above. Your request should include the following information: your full name, address, and policy number. Generally, we will respond to these requests within 30 days of receipt.

**Right to Request Restrictions:** You have the right to request that we restrict or limit our use or disclosure of your Personal Health Information that would otherwise be permitted for purposes related to treatment, payment or our health care operations, including disclosure to someone who may be involved in your care or payment for your care, like a family member, friend or personal representative. While we will consider your request, we are not required to agree to your restriction. If we do agree to the restriction, we will not use or disclose your Personal Health Information as requested but reserve the right to terminate the agreed to restriction if we deem appropriate. In your request to restrict use and disclosure, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on Personal Health Information uses or disclosures that are legally required, or which are necessary to administer our business.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about Personal Health Information in a certain way or using a certain address or email address, if you make such a request in writing and send it to the address provided above. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

**Right to Inspect and Copy Your Personal Health Information:** In most instances, you have the right to inspect and obtain a copy of the Personal Health Information that we maintain about you. Your request must be in writing and sent to the address provided above. We will deny inspection and copying of certain Personal Health Information, for example psychotherapy notes and Personal Health Information collected by us in connection with, or in reasonable anticipation of, any claim or legal proceeding. We reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. In those limited circumstances that we deny your request to inspect and obtain a copy of your Personal Health Information, you have the right to request a review of our denial. Your request to review our denial should be submitted in writing and sent to the address provided above.

**Right to Amend Your Personal Health Information:** You have the right to request that we amend your Personal Health Information in our records if you believe it is inaccurate or incomplete. Your request must be in writing and sent to the address provided above. Your request must provide your reason(s) for seeking the amendment or correction. If an amendment or correction request is accepted, we will amend or correct all appropriate records as well as notify others with whom we have disclosed the erroneous Personal Health Information. We may deny your request if you ask us to amend Personal Health Information that is accurate and complete; was not created by us, unless the creator of Personal Health Information is no longer available to make the amendment; is not part of the Personal Health Information kept by or for us; or is not part of the Personal Health Information which you would be permitted to inspect and copy. If we deny your request, we will provide you with an explanation for our denial and any further rights you may have regarding your request to amend.

**Right to Receive an Accounting of Disclosures of Your Personal Health Information:** You have the right to request an accounting or list of disclosures we have made of your Personal Health Information. This list will not include disclosures

- For treatment;
- For payment or health care operations;
- To law enforcement, for purposes of national security
- To department of corrections personnel;
- Pursuant to your authorization;
- or directly to you.

To request this list, you must submit your request in writing to the address provided above. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. We reserve the right to charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to a Paper Copy of this Notice:** You have the right to obtain a paper copy of this notice upon request, even if you received this notice electronically.

**Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, you must submit a written complaint to the address provided above. You can be assured that the Company will not retaliate against you for filing a complaint.

**For Further Information:** For further information regarding this Notice or the Company's privacy practices, please contact **Lincoln Financial Group, Attn: Enterprise Services Compliance – Privacy 6C-00, 1300 S Clinton Street, Fort Wayne IN 46802.**

**Effective Date:** This Notice is effective April 14, 2003.

\*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company  
Lincoln Life & Annuity Company of New York  
The Lincoln National Life Insurance Company

## MoneyGuard® Reserve – Submitting the Ticket

1. Complete the pre-qualifying questions.
2. Provide a client-specific description of product performance.
  - Obtain full illustration signed by representative and client, or,
  - Simplified quote (unsigned)
3. Obtain one of the following forms of client commitment.
  - Signed Temporary Insurance Agreement (TIA) and check for at least 1% of premium, or,
  - Signed replacement forms, or,
  - Identification of the funds that will be used to purchase *MoneyGuard Reserve*® and authorization to move those funds if approved for coverage.
4. Explain the Underwriting process and expectations to client.
  - Instruct them to complete the Personal History Interview (PHI) preparation tool
5. Complete all sections of the *MoneyGuard*® Reserve ticket.
  - Ticket needs to be signed only by the representative
6. Confirm that the representative has a *MoneyGuard* selling appointment with The Lincoln National Life Insurance Company.
7. Mail the following to *MoneyGuard* New Business or as otherwise instructed by your firm or MGA:
  - Fully completed ticket
  - Signed full illustration or unsigned Simplified quote
  - Authorization for Disclosure of Information (if desired)
  - Signed TIA and check, if applicable
  - Signed replacement forms, if applicable
8. Give the following to your client:
  - Copy of illustration or Simplified quote
  - Outline of Coverage
  - Personal History Interview (PHI) preparation tool
  - For replacements — a copy of Important Notice
  - Privacy Practice Notice
9. Keep a copy of all information for the representative's file.

***Any tickets that are not submitted in good order will result in delays in processing as the Underwriting process cannot begin until all requirements are received in good order by Lincoln's home office.***

**This checklist does not need to be submitted with the ticket but should be retained in the client's file.**

## MoneyGuard® Reserve – Completing the Ticket

When submitting a MoneyGuard® Reserve ticket, fill out the following information as appropriate. Be aware that there may be firm-specific versions of this form; follow the instructions provided by your firm. *Be sure to write clearly.* The Agent must be licensed and appointed in the Contract state; forms must be signed by the client in that state.

**The underwriting process will not begin until the ticket is in good order. Any missing information on this ticket will result in the application being deemed "Not in Good Order" and result in a significant delay in the streamlined underwriting process.**

**Note: Attach a Cover Letter with any information that might help the underwriting process. Include an explanation of any resident/signed-in state differences. All paperwork used in the sales process must be signed in the same state. Submit the entire Illustration (signed, if a full illustration was used) or simplified quote along with the ticket.**



### MONEYGUARD® RESERVE TICKET INSURED INFORMATION

350 Church St.  
Hartford, CT 06103

**Insured Contact Information:**

- Indicate the phone numbers for the client. Do not indicate specific times here. The first attempt to reach the client may be done 48 hours after the ticket is received at Lincoln.
- Allow for back-office processing time as well.

Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Gender:  Male  Female  Smoker or  Non-Smoker Date of Birth: \_\_\_\_\_

~~RED CONTACT INFORMATION - (This Information Will Be Critical To Complete The Underwriting Process!!)~~

Primary Phone Number: \_\_\_\_\_ ext. \_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_

**CONTRACT INFORMATION**

Contract Owner (if different than Insured): \_\_\_\_\_ Owner SSN: \_\_\_\_\_  
 Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_ Beneficiary SSN: \_\_\_\_\_  
 Contract State: \_\_\_\_\_ Specified Amount of Death Benefit: \$ \_\_\_\_\_  
 Premium Frequency:  Single Premium  Annual  Semi-Annually  Quarterly  Monthly (PA)  
 Premium Amount (indicate single premium amount or modal premium for flex pays): \$ \_\_\_\_\_  
 Inflation Protection Option:  Rejected  Opt. 1: Simple Inflation  Opt. 2: Compound Inflation  
 You will automatically receive Compound Inflation unless you select otherwise  
 Term Duration:  2 yrs. (2+0)  3 yrs. (3+0)  4 yrs. (2+2)  5 yrs. (3+2)  6 yrs. (2+4)  7 yrs. (3+4)  
 Dating: Note - Insured's Issue Age Will Be Determined By Age On The Date The Ticket Is Received By Lincoln

Contract State must match illustration and signed-at state.

**Contract Information :**

- Enter complete Beneficiary information; attach additional sheets if necessary. It is helpful to collect the social security number at this time (this will save time during the PHI).
- Make sure contract information matches that shown on the illustration.

**REPLACEMENT INFORMATION - (Required State Replacement Paperwork Must Be Submitted With Ticket) - Needs to be completed if client is replacing ANY kind of coverage or will be taking funds from another policy to pay the premium on the MoneyGuard Reserve contract.**

Replacement:  Yes  No If No, please proceed to the Financial Advisor Information Section  
 1035 exchange:  Yes  No  
 Coverage being replaced:  Long Term Care  Life Ins.  Annuity  
 Replaced Policy Issued by (Company): \_\_\_\_\_ Contract Number: \_\_\_\_\_

**FINANCIAL ADVISOR INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ SSN/TIN: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ SSN/TIN: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ SSN/TIN: \_\_\_\_\_  
 Primary Case Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

NOTE: We will send all correspondence concerning this case to the address listed below. This includes where the agent is sent for the Financial Advisor to deliver to the client.

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

MGA/Firm associated with this business (if applicable): \_\_\_\_\_

I certify that my client has answered the 8 Pre-Screening questions and to the best of my knowledge he/she is a good candidate for MoneyGuard Reserve. In addition, I certify that I have presented my client with the Outline of Coverage (Required Disclosure Statement in NY) and Simplified Quote (Single Premium Only) or a fully signed illustration. If I have not submitted premium and TIA or replacement paperwork, my client and I have identified funds to purchase MoneyGuard Reserve and I have received authorization to move funds if my client is approved for coverage.

BE SURE TO SIGN and DATE THE TICKET

Signature of Agent \_\_\_\_\_ Date \_\_\_\_\_

**Financial Advisor Info:**

- If more than 3 advisors, attach additional sheets. Make sure to enter social security #'s for all listed, and that all are licensed and appointed in the Contract state.

**Replacement Information:**

- Replacement? Be sure to check "yes" or "no".
- If Yes, complete the applicable State Replacement Form for the state signed. The Replacement Form for the NAIC states would also fulfill this requirement.
  - Be sure to include all replacement information or Reg. 60 requirements for New York cases.

**Correspondence/Contact Instructions:**

- Make sure to indicate the correct address for all mailings. Email is used for any follow-up done by the New Business/Underwriting department; be sure to enter the complete email address.

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## **MoneyGuard® Reserve – Completing the Ticket**

**General Instructions: Be sure to write clearly.**

### **Insured/Owner Information:**

State the full, legal name of the Insured and Owner (no nicknames), or Trust Name (if Owner), address, Social Security or Tax Identification Number (if a Trust is the Owner), date of birth and gender. Indicate whether the Insured is a Smoker or Non-Smoker; one of these boxes *must* be checked. The policy is issued at the actual age of the Insured, so the date of birth is very important.

If the client prefers to use a P.O. Box, a physical address is still required. A notation may be made in the Cover Letter if the P.O. Box should be used for correspondence to the client.

It is not generally recommended that a *MoneyGuard® Reserve* policy be owned by an irrevocable trust. In certain circumstances, adverse estate and income tax consequences may apply when the policy is owned by a client's irrevocable life insurance trust (ILIT).

If a Trust is the Owner, copies of the Title and Signature Pages of the Trust Document are required. These pages must show the Trust name, Date of the Trust, Trustee Names and their signatures.

### **Insured Contact Information:**

Enter both a primary and secondary phone number for the Insured. The first attempt to reach the Insured may occur as early as 48 hours after receiving the ticket at Lincoln. No calls will be made prior to 48 hours. Do not write any contact dates/times on the ticket. Allow for any back-office or firm processing time for submitting the ticket to Lincoln. Also, if the client plans on being away during this time, do not submit the ticket until they become available.

### **Primary Beneficiary:**

Designate the person(s) to receive the death benefit, upon the death of the Insured, and indicate the relationship to the policy Owner(s), and the Social Security number. It is helpful to have the social security number on the ticket as this will save time in the Personal History Interview (PHI). If the beneficiary is a trust, indicate the name of the Executor or Trustee and the date of the trust. Attach additional sheets, if necessary. If more than one primary beneficiary is listed, indicate the percentages for each. *If blank, or if there is information missing, the contract will be issued with the estate as the beneficiary. A change of beneficiary form will be sent with the contract for delivery to the client.*

Some clients are reluctant to give any social security numbers over the telephone. When the social security numbers are provided on the ticket, the phone interviewer will confirm the numbers instead of asking for them.

### **Contingent Beneficiary:**

Attach an additional sheet if a Contingent Beneficiary is desired. Designate the person(s) to receive the death benefit (if any) upon the death of the Insured if the Primary Beneficiary(ies) predeceases the Insured. Indicate the relationship to the Owner(s), and the Social Security number.

### **Contract State:**

Policy situs determines what state laws will apply, what application and policy forms must be used, and what agent licensing and appointment requirements apply. Policy situs is based on the state in which the application is signed by the owner/applicant – this is the Contract state. The application should be signed in the state where the principal solicitation and delivery of the policy occurs. Refer to the Life Insurance Policy Situs Guidelines for more information. The Contract state must match the state shown in the Illustration. Attach a Cover Letter with an explanation of any situs issues.

### **Specified Amount:**

Write in the amount of the Specified Amount. This amount must match what is shown on the illustration.

### **Premium Information:**

Check one box, indicating the premium frequency. Write in the amount of the premium.

### **Writing Agent's Statement**

The Advisor *must sign and date* this section.

## Temporary Insurance Agreement (TIA) Information

The Temporary Insurance Agreement immediately provides coverage for the Insured relative to the death benefit (only), provided the form is filled out completely and answered properly. There is no long-term care coverage provided for under this agreement.

<b>TEMPORARY LIFE INSURANCE AGREEMENT</b>		B44
<b>THE LINCOLN NATIONAL LIFE INSURANCE COMPANY ("Company")</b>		
<i>ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY-DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.</i>		
<b>If any of the questions below are answered yes or left blank with respect to a Proposed Insured(s), no representative of the Company is authorized to accept money, and <u>NO COVERAGE</u> will take effect under this Agreement with respect to such Proposed Insured(s).</b>		
Has Proposed Insured(s): Questions apply to <b>all</b> Proposed Insured(s) shown on application.		
1. Does Amount applied for exceed \$3,000,000?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Within the past 90 days, has any Proposed Insured been admitted to a hospital or other medical facility, been advised to be admitted or had surgery performed or recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Within the past 2 years has any Proposed Insured been treated for heart trouble, stroke, or cancer, or had such treatment recommended by a physician or other medical practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A if applying for a <b>MoneyGuard®</b> product.	
4. Is Age of Proposed Insured under 15 days old or over age 70?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A if applying for a <b>MoneyGuard®</b> product.	
This Agreement provides a <b>Limited Amount</b> of Life Insurance protection for a <b>Limited Period</b> of time, subject to the terms of this Agreement, in consideration of advance payment in the amount of \$ _____ in connection with the Application dated _____ made on the life of: 1) _____, or on the life of all		
Name(s) of Proposed Insured(s)		
individuals who are to be insured in the Pension or Profit Sharing Plan of 2) _____.		
Name of Pension or Profit Sharing Plan of Participants to be insured (the Proposed Insureds)		

*MoneyGuard® Reserve is issued by The Lincoln National Life Insurance Company, Fort Wayne, IN, on policy form LN850 and state variations thereof. Products and features are subject to state availability.*

*Policies sold in New York are issued by Lincoln Life & Annuity Company of New York, Syracuse, NY.*

**Contractual obligations are backed by the claims-paying ability of the issuing insurance company.**

<b>Not a deposit</b>	<b>Not FDIC-Insured</b>	<b>Not insured by any federal government agency</b>
<b>Not guaranteed by any bank or savings association</b>	<b>May go down in value</b>	

*Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. Affiliates are separately responsible for their own financial and contractual obligations.*



# *MoneyGuard*<sup>®</sup> Reserve Administrative Kit

## **Administrative materials included:**

- Step-by-Step Guide
- Prequalifying Tool



## **MONEYGUARD® RESERVE STEP-BY-STEP OUTLINE**

**Key point** - You must be licensed and appointed with Lincoln before submitting business. Turnaround times are guaranteed for validated producers only.

- Step 1-** Identify Prospect.
  
- Step 2** - Conduct field underwriting by having client answer the prequalification questions. Unfortunately, if the individual answers “yes” to any of the prequalifying questions, *MoneyGuard®* is not the right fit for them. Be sure to keep a copy of the client’s answers for their file.
  
- Step 3** - If ALL questions on the prequalification tool are answered “no,” then:
  - Complete the *MoneyGuard®* Reserve Ticket (advisor signature required).
  - Obtain a full illustration or simplified quote. Signatures are required on full illustrations.
  - Provide outline of coverage - The state specific form along with the Outline of Coverage Table from the illustration or quote must be given to the client for their files.  
Important notice for NAIC states: Replacement of Life Insurance or Annuities Form 33503 is required when a client has life insurance or annuities whether the client is replacing or not.
  - If the contract state is New York, you are required to follow Reg 60 guidelines. Reg 60 forms must be submitted in good order with the ticket. Please contact your Lincoln Representative for more information.
  - Ensure that the client is committed to the sale by:
    - 1 Collecting premium and completing a Temporary Insurance Agreement.  
Note: The Temporary Life Insurance Agreement must be signed by the client and witnessed by the advisor; or,
    - 2 Executing a 1035 Policy Exchange Agreement/Absolute Assignment. The following paperwork is required to be completed:
      - Policy Exchange Agreement/Absolute Assignment Form LF06591 (state variations apply; this form is not required for a Nonqualified Replacement).
      - Replacement Appropriateness Form 33555
      - Important Notice: Replacement of Life Insurance or Annuities Form 33503 is required by some states. Check the forms bundles in your state regarding whether this form is required and the appropriate state variation of this form. **(This document must be signed by the client and the advisor. A copy must also be left with the client.)**
      - Internal Exchanges ONLY — Life Policy Exchange Form 32462 (state variations apply).
      - If policy is replacing a LTC policy or another linked benefit life/LTC product — Long Term Care Replacement Form LTC06291 (state variations apply); or,
    - 3 Identifying the funds to purchase *MoneyGuard®* Reserve and obtaining authorization to move those funds if approved for coverage.
  
- Step 4** - Explain to the individual that a Personal History Interview (PHI) will be conducted in order to determine whether or not Lincoln will accept the application. This call will take at least 45 minutes. During this time, the application will be completed and all information needed to complete the underwriting process will be obtained. It is imperative that the client be prepared for this interview. Provide the Personal History Interview Instructions to your client. **Questions in the PHI will cover the following:**
  - Medical History (as stated on the application)
  - Environment
  - Lifestyle
  - Cognitive ability
  - Activity level/Activities of daily living

**Note:** Our underwriting process hinges on the client’s ability to answer questions in English over the phone. If your client is hearing or speech impaired, we will make a reasonable effort to conduct the PHI through alternate means. If your client is unable or unwilling to participate in the interview, we may be unable to offer *MoneyGuard®* Reserve. If your client does not speak English fluently, we may be unable to offer *MoneyGuard®* Reserve as there are many important disclosure documents (which are currently only available in English) that the client needs to read and understand before making the decision to purchase *MoneyGuard®* Reserve.

**Note: If we have difficulty reaching the client to conduct the PHI we will contact you for assistance.**

- Step 5** - Overnight the following to your company as listed on the *MoneyGuard*<sup>®</sup> Reserve Ticket.
  - A copy of the full illustration or simplified quote  
Note: If the full illustration was presented to the client, that is what should be submitted. The full illustration **MUST BE SIGNED** by the client and the advisor.
  - The following paperwork is required depending on the type of commitment obtained:
    - Premium with Temporary Life Insurance Agreement
    - 1035 Exchange paperwork
  - If required by the state - Important Notice: Replacement of Life Insurance or Annuities
  - In New York, any additional paperwork associated with the NY Reg 60 Guidelines is needed
  
- Step 6** - If the case is approved, the policy and application package will be sent to the contact individual noted on the ticket within 6-8 days of when Lincoln received the initial paperwork. Deliver the policy and application package to the client and obtain necessary signatures.
  
- Step 7** - If **NO** premium is due: Fax back all delivery requirements (as noted on the checklist sent with the policy and application package) to the company listed on the *MoneyGuard*<sup>®</sup> Reserve Ticket. This paperwork must be faxed back within 30 calendar days of the date the policy was sent to you via overnight mail. If they are not received within 30 calendar days, the case will be closed and any money received will be refunded to the client.

If premium **IS** due: Within 30 calendar days of the date of the policy was sent to you via overnight mail, you should overnight mail the check, along with all delivery requirements (as noted on the checklist sent with the policy and application package) to the company listed on the *MoneyGuard*<sup>®</sup> Reserve Ticket. We will not inforce the case until the entire single premium is received.

## **MONEYGUARD® RESERVE PRE-QUALIFYING TOOL**

Clients who have not been previously declined for long-term care coverage (by Lincoln or any other carrier) and can answer “NO” to ALL of the following questions are good candidates for *MoneyGuard®*. All others should be directed to alternative solutions.

(Note: This form is to be used as a reference for you and does not need to be submitted to Lincoln.)

**Has your client ever been diagnosed with:**

	<b>YES</b>	<b>NO</b>
Alzheimer’s Disease or Dementia, or taking any medication for memory loss?	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema, chronic obstructive pulmonary disease (COPD) or congestive heart failure?	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson’s Disease, Multiple Sclerosis or Muscular Dystrophy?	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis or taking methotrexate, prednisone, enbrel or remicade for joint pain?	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis that is untreated or with a history of compression fractures or height loss of two inches or more?	<input type="checkbox"/>	<input type="checkbox"/>
A Stroke or Transient Ischemic Attack (TIA) within the last 24 months or heart attack, heart or carotid artery surgery within the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (other than non-melanoma skin cancer) within the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
Type 1 diabetes?	<input type="checkbox"/>	<input type="checkbox"/>

**Is your client:**

	<b>YES</b>	<b>NO</b>
Currently being treated for a medical condition or having medical treatment, a pending consult or surgery recommended but not yet completed?	<input type="checkbox"/>	<input type="checkbox"/>
On dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
Using Oxygen for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
The recipient of an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>

**Does your client:**

	<b>YES</b>	<b>NO</b>
Use a cane of any variety, walker or wheelchair on a regular or intermittent basis?	<input type="checkbox"/>	<input type="checkbox"/>
Take any narcotic drug or prescription pain medication on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
Have an implantable defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>
Currently collect disability benefits?	<input type="checkbox"/>	<input type="checkbox"/>
Have a handicap parking permit?	<input type="checkbox"/>	<input type="checkbox"/>

**Clients who can answer “No” to all questions are good candidates for MoneyGuard Reserve.**

NOTE: If your client has any surgery scheduled in the next two months, or if he/she has recently been advised to have surgery, you should wait to submit the case until the client is at least three months post-operation, fully recovered, back to 100% full activity, and released from doctors’ care.

**MONEYGUARD® RESERVE TICKET**

**INSURED INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Gender:  Male  Female  Smoker or  Non-Smoker Date of Birth: \_\_\_\_\_

**INSURED CONTACT INFORMATION - (This Information Will Be Critical To Complete The Underwriting Process!!)**

Primary Phone Number: \_\_\_\_\_ ext. \_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_

**CONTRACT INFORMATION**

Owner (if different than Insured): \_\_\_\_\_ Owner SSN: \_\_\_\_\_  
Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_ Beneficiary SSN: \_\_\_\_\_  
Contract State: \_\_\_\_\_ Specified Amount of Death Benefit: \$ \_\_\_\_\_  
Premium Frequency:  Single Premium  Annually  Semi-Annually  Quarterly  Monthly (PAC/EFT)  
Premium Amount (indicate single premium amount or modal premium for flex pays): \$ \_\_\_\_\_  
Inflation Protection Option:  Rejected  Opt. 1: Simple Inflation  Opt. 2: Compound Inflation  
**You will automatically receive Compound Inflation unless you select otherwise**  
Benefit Duration:  2 yrs. (2+0)  3 yrs. (3+0)  4 yrs. (2+2)  5 yrs. (3+2)  6 yrs. (2+4)  7 yrs. (3+4)  
**Policy Dating: Note - Insured's Issue Age Will Be Determined By Age On The Date The Ticket Is Received By Lincoln**

**REPLACEMENT INFORMATION - (Required State Replacement Paperwork Must Be Submitted With Ticket) - Needs to be completed if client is replacing ANY kind of coverage or will be taking funds from another policy to pay the premium on the MoneyGuard Reserve contract.**

Replacement:  Yes  No **If No, please proceed to the Financial Advisor Information Section**  
1035 exchange:  Yes  No  
Coverage being replaced:  Long Term Care  Life Ins.  Annuity  
Replaced Policy Issued by (Company): \_\_\_\_\_ Contract Number: \_\_\_\_\_

**FINANCIAL ADVISOR INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ SSN/TIN: \_\_\_\_\_ Split % \_\_\_\_\_  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ SSN/TIN: \_\_\_\_\_ Split % \_\_\_\_\_  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ SSN/TIN: \_\_\_\_\_ Split % \_\_\_\_\_  
**Primary Case Contact:** \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**NOTE: We will send all correspondence concerning this case to the address listed below. This includes where the policy is sent for the Financial Advisor to deliver to the client.**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
**MGA/Firm associated with this business (if applicable):** \_\_\_\_\_

I certify that my client has answered the Pre-Screening questions and to the best of my knowledge he/she is a good candidate for MoneyGuard Reserve. In addition, I certify that I have presented my client with the Outline of Coverage (Required Disclosure Statement in NY) and Simplified Quote (Single Premium Only) or a fully signed illustration. If I have not submitted premium and TIA or replacement paperwork, my client and I have identified funds to purchase MoneyGuard Reserve and I have received authorization to move funds if my client is approved for coverage.

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_  
Date

**FOR AGENT BROKER USE ONLY. NOT TO BE USED WITH THE PUBLIC.**



Please check the appropriate servicing address of the underwriting company:

Lincoln Life & Annuity Company of New York, Life Service Office: 350 Church Street - MMG1, Hartford, CT 06103-1106

Lincoln Life & Annuity Company of New York, Annuity Service Office: PO Box 2348, Fort Wayne, IN 46801-2348 (hereinafter referred to as "the Company")

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

### SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with a long-term care insurance policy, rider or certificate to be issued by Lincoln Life & Annuity Company of New York. Your new coverage provides thirty (30) days within which you may decide, without cost, whether you desire to keep the coverage. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

### STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE): Use additional sheets, as necessary.

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, where as a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The accident and sickness insurance or long-term care insurance to be replaced as a result of this transaction:

<u>Insurance Company</u>	<u>Name of Insured</u>	<u>Policy/Certificate Number</u>
_____	_____	_____
_____	_____	_____

The above "Notice to Applicant" was delivered to me on: \_\_\_\_\_  
Date Applicant's Signature

\_\_\_\_\_  
Agent's Signature Printed Name/Address of Agent

# Lincoln Life & Annuity Company of New York

A Stock Company

Executive Office: 100 Madison Street, Suite 1860, Syracuse, NY

Administrator Mailing Address: 350 Church Street, Hartford, Connecticut 06103-1106 (800) 962-1654

## **LONG-TERM CARE INSURANCE REQUIRED DISCLOSURE STATEMENT**

For Convalescent Care Benefits Rider LR851 (8/05) and Extension of Benefits Rider LR852 (8/05), if applicable

**CAUTION:** The issuance of the Convalescent Care Benefits Rider and Extension of Benefits Rider, if applicable, described in this disclosure is based on your answers to the questions on your application for such rider(s). A copy of your application is enclosed. If your answers fail to include all material medical information requested, Lincoln Life & Annuity Company of New York has the right to deny benefits or rescind these rider(s). The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the Administrator Mailing Address shown above.

**NOTICE TO OWNER:** The riders described in this disclosure may not cover all of the costs associated with long-term care incurred by the Insured during the period of coverage. You are advised to carefully review all policy and rider limitations.

### **1. INDIVIDUAL COVERAGE.**

The Convalescent Care Benefits Rider and Extension of Benefits Rider, if applicable, described in this disclosure statement are attached to, and made a part of, an individual life insurance policy issued in New York.

### **2. PURPOSE OF REQUIRED DISCLOSURE STATEMENT.**

This disclosure statement provides a very brief description of the important features of the Convalescent Care Benefits Rider and Extension of Benefits Rider. You should compare this disclosure statement to outlines of coverage for other policies and riders available to you.

**This is not an insurance contract, but only a summary of coverage.** Only the riders and the individual life insurance policy to which they are attached contain the governing contractual provisions. This means that the riders and the policy set forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY AND RIDERS CAREFULLY!**

### **3. TERMS UNDER WHICH THE RIDERS MAY BE RETURNED AND RIDER CHARGES REFUNDED.**

These riders may be returned for any reason to the insurance agent through whom they were purchased or to us at the Administrator Mailing Address shown above within 30 days after you receive them. If returned, the rider(s) will be considered void from the beginning and we will refund all charges paid for these riders.

**4. THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.**

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from us. Neither Lincoln Life & Annuity Company of New York nor its agents represent Medicare, the federal government or any state government.

**5. LONG-TERM CARE INSURANCE.**

Policies and riders of this category are designed to provide coverage for not less than twenty-four (24) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis and provides coverage of all levels of care in a nursing home and home care benefits. In addition to nursing home and home care services, this rider also provides coverage for other necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. These services are referred to as Covered Services and are more fully defined in the riders.

These riders provide coverage by reimbursing costs incurred by the Insured during the period of coverage for Covered Services, subject to the terms and conditions of the riders.

**6. BENEFITS PROVIDED BY THESE RIDERS.**

Benefits are provided under the Convalescent Care Benefits Rider until that rider's benefit limit has been reached. The Extension of Benefits Rider extends the benefits provided by the Convalescent Care Benefits Rider after the Convalescent Care Benefits Rider benefit limit has been reached.

We will pay an amount up to the maximum monthly benefit to reimburse the costs incurred by the Insured during the period of coverage for any Covered Service or combination of Covered Services listed below, subject to the terms and conditions of the rider then in effect. The benefits paid for any one month of Covered Services will not exceed the maximum monthly benefit for the rider then in effect. The total benefits paid will not exceed the benefit limit as defined in each rider. The benefit limit and maximum monthly benefit for the Convalescent Care Benefits Rider and for the Extension of Benefits Rider, if applicable, are shown in the table attached to this disclosure statement.

Benefits paid under the Convalescent Care Benefits Rider are subject to a 90 day deductible period during which time this rider does not provide certain benefits which would otherwise be payable, as described in the rider. This 90 day deductible period applies to all Covered Services listed below except for Bed Reservation, Caregiver Training, Care Planning Services, Respite Care Services, and Non-Continual Alternative Care Services.

Benefits paid under the Extension of Benefits Rider are not subject to a deductible period.

These riders will cover qualified long-term care services resulting from Alzheimer's Disease or demonstrable organic brain disease.

We will reimburse expenses incurred by the Insured for the following Covered Services to the extent that such services are qualified long-term care services:

## **INSTITUTIONAL BENEFITS**

### **Assisted Living Facility Services**

Services that are provided to the Insured while he or she is confined or living in an Assisted Living Facility. An Assisted Living Facility is a separate facility (or a specially dedicated wing of a facility) which is licensed as an Assisted Living Facility, if the state licenses such facilities. If the state does not license Assisted Living Facilities, then the facility must meet the other criteria described in the riders.

### **Bed Reservation**

The expense incurred by the Insured to reserve the Insured's bed in a Nursing Home while he or she is temporarily absent during a stay in a Nursing Home and is charged to reserve accommodations. The temporary absence can be for any reason with the exception of discharge. This includes, but is not limited to, a hospital stay or spending holidays or other time with family. This benefit is limited to no more than 30 calendar days each policy year. The amount payable for this benefit cannot exceed 1/30th of the maximum monthly benefit of the rider then in effect for each day that the bed is reserved.

### **Nursing Home Care Services**

Services that are provided to the Insured while he or she is confined to a Nursing Home. A Nursing Home is a facility or distinctly separate part of a hospital or other institution which is licensed by the appropriate state licensing agency as a Nursing Home, if the state licenses such facilities. If the state does not license Nursing Homes, then the facility must meet the other criteria described in the riders.

## **NON-INSTITUTIONAL BENEFITS**

### **Adult Day Care Services.**

A program for 6 or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

### **Care Planning Services**

Services provided for the Insured by a Care Planning Agency under the direction of the Licensed Health Care Practitioner. A Care Planning Agency is an agency or organization which is primarily engaged in providing care planning on behalf of its clients. The agency or organization must be licensed by the appropriate state licensing agency as a Care Planning Agency, if the state licenses such agencies. If the state does not license Care Planning Agencies, then the agency must meet the other criteria described in the riders.

### **Caregiver Training**

Training given to the primary caregiver by a properly accredited medical or instructional institution or by a qualified individual such as a licensed nurse to provide the primary caregiver with the knowledge and skills necessary to care for the Chronically Ill Insured. The amount payable for this benefit is limited to no more than \$500 for all Caregiver Training provided while the Insured is covered under the Convalescent Care Benefits Rider and under the Extension of Benefits Rider, if applicable.

### **Home Health Care Services**

Skilled nursing or other professional care services provided by a Home Health Care Agency at the Insured's place of residence which must be outside of a

hospital, a Nursing Home or an Assisted Living Facility. A Home Health Care Agency is an agency that is primarily engaged in providing residential health care services under policies and procedures established by a group of professionals, including at least one physician and one nurse. The agency must meet at least one of the licensing, accrediting or certification criteria described in the riders.

### **Hospice Services**

Services given to provide palliative care to alleviate the physical, emotional, social, and spiritual discomforts of the Insured who is in the terminal phases of life. These services also include supportive care given to the primary caregiver and the Insured's immediate family.

### **Personal Care Services**

Services provided at the Insured's place of residence which must be outside of a hospital, Nursing Home or Assisted Living Facility, to assist with Activities of Daily Living, including activities such as using a telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry, and housekeeping or homemaking activities to allow the Insured to remain in his or her residence. These services may be provided by skilled or unskilled persons.

### **Respite Care Services**

Short-term care services provided for the Insured in an institution, in the home, or in a community-based program to provide temporary relief for the primary caregiver. Such services may be provided by skilled or unskilled persons. This benefit is limited to no more than 21 calendar days each policy year. The amount payable for this benefit cannot exceed 1/30th of the maximum monthly benefit of the rider then in effect for each day of Respite Care Services.

### **Alternative Care Services**

Qualified long-term care services that are not covered under any of the Covered Services listed above, but which your Licensed Health Care Practitioner and we mutually agree would be appropriate to meet the Insured's long-term care needs. These services must be provided as an alternative to other Covered Services that would otherwise be required by the Chronically Ill Insured.

### **Non-Continual Alternative Care Services**

Alternative Care Services which are received on a one-time basis, such as expenses for durable medical equipment or for modifications to the home to accommodate a wheelchair or other device. This benefit is limited to no more than one claim per calendar year.

## **ELIGIBILITY FOR PAYMENT OF BENEFITS**

The following conditions must be met to qualify for benefits under these riders:

- a. To qualify for benefits under the Convalescent Care Benefits Rider, the total benefits paid under the Convalescent Care Benefits Rider must not have reached that rider's benefit limit.
- b. To qualify for benefits under the Extension of Benefits Rider:
  1. Payments for Covered Services under the Convalescent Care Benefits Rider must have reached that rider's benefit limit; and
  2. the total benefits paid to date under the Extension of Benefits Rider must not have reached that rider's benefit limit.
- c. The Licensed Health Care Practitioner must certify that the Insured is

Chronically Ill and that the illness is expected to continue for at least 90 days. Chronically Ill means that the Insured has been certified, within the preceding 12 months, by a Licensed Health Care Practitioner as:

1. Being unable to perform (without Substantial Assistance as defined below from another individual) at least 2 of the Activities of Daily Living described below, for a period of 90 days due to loss of functional capacity; or
  2. Requiring Substantial Supervision to protect the Insured from threats to health and safety due to Severe Cognitive Impairment, as defined below.
- d. The Licensed Health Care Practitioner must approve a plan of care in writing, prescribing services including Covered Services that are to be provided to the Insured. The Insured must receive the Covered Services prescribed under the approved plan of care while these riders are in force.
- e. At least once every 12 months thereafter, and for as long as the Insured continues to be Chronically Ill, the Licensed Health Care Practitioner must again:
1. certify that the Insured is Chronically Ill. If the Insured's chronic illness is due to loss of functional capacity, the Licensed Health Care Practitioner must again certify that the Insured's chronic illness is expected to continue for at least 90 days; and
  2. either approve a new plan of care, or reconfirm the existing plan of care in writing.

Activities of Daily Living are the 6 basic functional abilities which relate to the Insured's ability to live independently. They are:

- a. Bathing: The Insured's ability to wash himself or herself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
- b. Continence: The Insured's ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- c. Dressing: The Insured's ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
- d. Eating: The Insured's ability to feed himself or herself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
- e. Toileting: The Insured's ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene.
- f. Transferring: The Insured's ability to move into or out of a bed, chair, or wheelchair.

Severe Cognitive Impairment means a loss or deterioration in the Insured's intellectual capacity that is:

- a. comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and

- b. measured and confirmed by clinical evidence and standardized tests that reliably measure impairment in the following areas:
  1. the Insured's short-term or long-term memory;
  2. the Insured's orientation as to person (such as who they are), place (such as their location), and time (such as day, date, and year); and
  3. the Insured's deductive or abstract reasoning or judgment as it relates to safety awareness.

Substantial Assistance means hands-on assistance or the presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to the Insured while the Insured is performing the Activities of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Severely Cognitively Impaired Insured from threats to his or her health or safety (such as may result from wandering).

## 7. LIMITATIONS AND EXCLUSIONS.

### **Pre-Existing Conditions**

These riders do not exclude pre-existing conditions.

### **Ineligible Facilities or Providers**

These riders do not cover services provided by a facility or an agency that does not meet the rider definition for such facility or agency, except as provided under Alternative Care Services. These riders do not cover services provided by unlicensed providers, or services provided by a member of the Insured's immediate family or for which no charge is normally made in the absence of insurance. These riders do not cover services provided in facilities operated primarily for the treatment of mental or nervous disorders, which include neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

### **Ineligible Levels of Care**

These riders do not cover services that do not constitute qualified long-term care services as defined in the riders.

### **Exclusions, Exceptions and Limitations**

These riders will not pay benefits for:

- a. care provided in facilities operated primarily for the treatment of mental or nervous disorders, which include neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder. **This exclusion does NOT apply to qualifying stays or care resulting from Alzheimer's Disease or demonstrable organic brain disease;**
- b. treatment for alcoholism, drug addiction or chemical dependency (unless the drug addiction or chemical dependency is a result of medication taken in doses as prescribed by a physician);
- c. treatment arising out of an attempt at suicide or an intentionally self-inflicted injury;
- d. treatment provided in a Veteran's Administration or government facility, unless otherwise required by law;
- e. loss to the extent that benefits are provided under any of the following:

Medicare (including that which would have been payable but for the application of a deductible or a coinsurance amount), other governmental programs (except Medicaid), workers compensation laws, employer's liability laws, occupational disease laws, and motor vehicle no-fault laws;

- f. confinement or care received outside the United States and its possessions;
- g. services provided by a facility or an agency that does not meet the rider definition for such facility or agency, except as provided in the Alternative Care Services provision in the riders; and
- h. services provided by a member of the Insured's immediate family or for which no charge is normally made in the absence of insurance.

THESE RIDERS MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

#### **8. RELATIONSHIP OF COST OF CARE AND BENEFITS.**

Because the cost of long-term care services will likely increase over time, you should consider whether and how the benefits provided under these riders may be adjusted.

The Extension of Benefits Rider provides for Optional Inflation Protection coverage. If you elect Optional Inflation Protection, the maximum monthly benefit and benefit limit for the Extension of Benefits Rider will automatically increase on each policy anniversary while the rider is in force. The amount of the annual increase will depend upon the Optional Inflation Protection option that is in effect. The available options are described below. The monthly rider charge and monthly Optional Inflation Protection charge will remain level and will not increase annually as the Extension of Benefits Rider's benefits increase.

If you do not elect Optional Inflation Protection, you will not be able to increase your benefits later. These riders do not provide a guaranteed option to buy additional insurance.

The available options are as follows:

**Option 1. Simple Increases:** If Option 1 is in effect, on each policy anniversary the maximum monthly benefit and benefit limit for the Extension of Benefits Rider will automatically increase by an amount equal to 3% of the rider's benefit limit at issue adjusted for withdrawals and loan activity.

**Option 2. Compound Increases:** If Option 2 is in effect, on each policy anniversary the maximum monthly benefit and benefit limit for the Extension of Benefits Rider will automatically increase by an amount equal to 5% of the rider's benefit limit at issue adjusted for withdrawals and loan activity, compounded by the number of years the policy has been in effect.

The chart below gives examples of the monthly Optional Inflation Protection charges for both Option 1 (Simple Increases) and Option 2 (Compound Increases) for the Extension of Benefits Rider. The example shown is for a maximum monthly benefit of \$3,000 with a 2 year Convalescent Care Benefits Rider duration and a 2 year Extension of Benefits Rider duration.

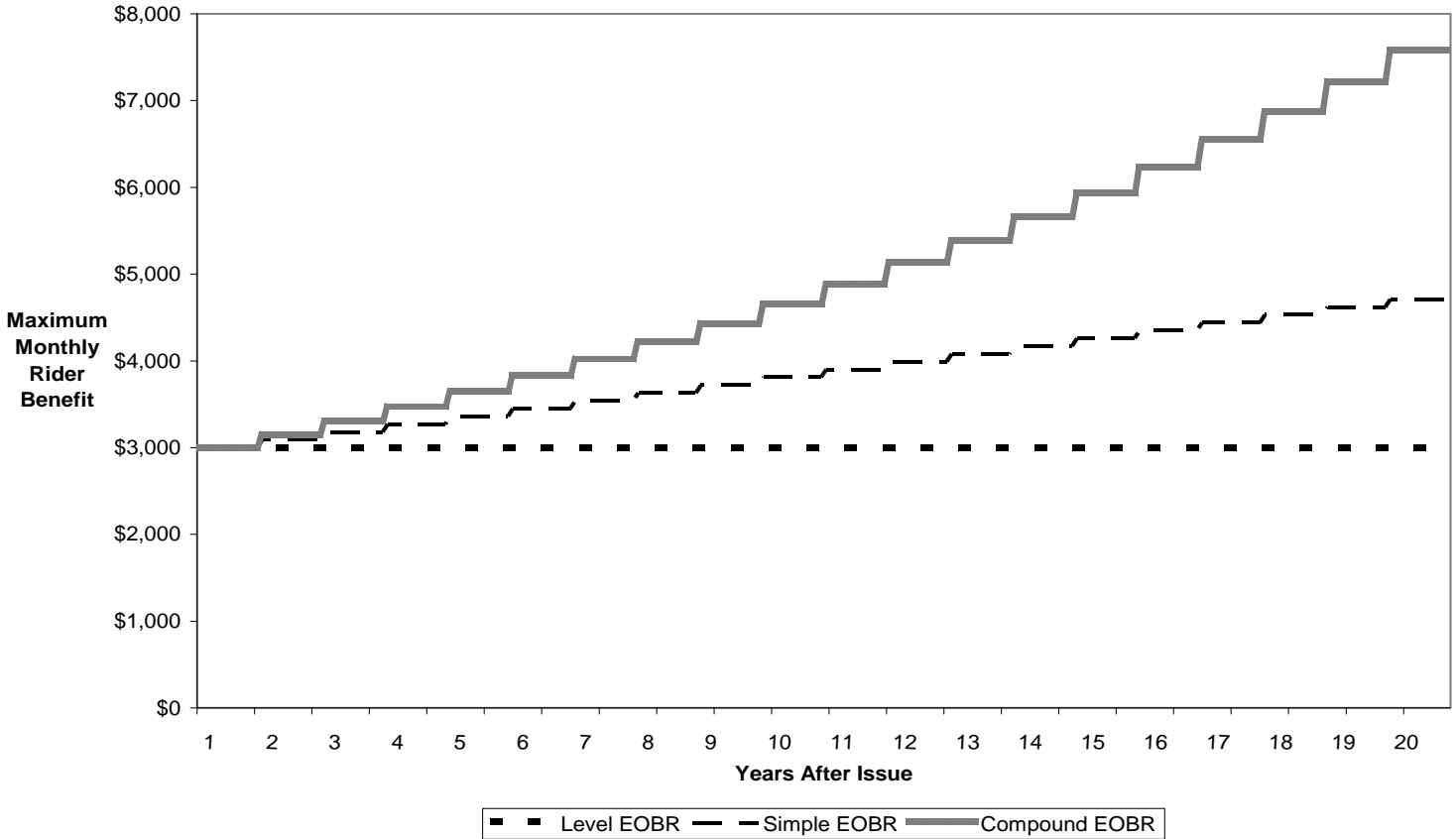
Your actual monthly Optional Inflation Protection charge will be different from the examples shown if you select a different combination of Convalescent Care Benefits Rider duration and Extension of Benefits Rider duration. We will quote

your Optional Inflation Protection charge based upon the rider durations and Optional Inflation Protection option, if any, you choose.

EOBR Monthly Optional Inflation Protection Charges for \$ 3,000 of Maximum Monthly Benefit Convalescent Care Benefits Rider ("CCBR") Duration is 2 Years Extension of Benefits Rider ("EOBR") Duration is 2 Years					
Issue Age	EOBR Inflation Protection		Issue Age	EOBR Inflation Protection	
	Option 1	Option 2		Option 1	Option 2
50	\$6.26	\$30.74	70	\$18.58	\$50.40
60	10.58	42.19	80	35.06	63.07

The chart below provides a comparison of the maximum monthly benefit provided by the Extension of Benefits Rider with the options available to you: level benefits (no Optional Inflation Protection); benefits that increase annually by 3% simple interest (Option 1: Simple Increases); and benefits that increase annually by 5% compound interest (Option 2: Compound Increases).

**Extension of Benefits Rider (EOBR)**



The monthly Optional Inflation Protection charge for the Extension of Benefits Rider, if applicable, will be calculated based on your age at issue, the rider's benefit limit at issue, the Convalescent Care Benefits Rider duration selected, the Extension of Benefits Rider duration selected, and the Optional Inflation Protection option selected. This charge will change only if the rider's benefit limit changes as a result of withdrawals or loan activity.

## **9. TERMS UNDER WHICH THESE RIDERS MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

### **Renewability**

THE CONVALESCENT CARE BENEFITS RIDER IS GUARANTEED RENEWABLE. THE EXTENSION OF BENEFITS RIDER IS GUARANTEED RENEWABLE AND NONCANCELLABLE. This means that you have the right, subject to the terms of your policy and rider(s), to continue these riders in force for as long as your policy stays in force. Lincoln Life & Annuity Company of New York cannot change any of the terms of your rider(s) on its own and cannot increase the monthly rider charges or monthly Optional Inflation Protection charge, if applicable.

### **Right to Purchase a Long-Term Care Policy**

Subject to the limitations and conditions described in the Right to Purchase a Long-Term Care Policy Endorsement, if applicable, you will become eligible for the right to purchase a qualified long-term care insurance policy as described in that endorsement without evidence of insurability under any of the following conditions: if long-term care coverage under the Extension of Benefits Rider is reduced as a result of indebtedness below the minimum required by New York State regulation; if the life insurance policy to which the Extension of Benefits Rider is attached lapses; if you request to terminate the Extension of Benefits Rider or the Convalescent Care Benefits Rider (this does not include return of either rider under the 30 Day Right to Return provision); or if the Extension of Benefits Rider terminates as a result of electing paid-up life insurance under the life insurance policy's Paid-Up Insurance provision.

## **10. RIDER CHARGES.**

The monthly rider charges for the Convalescent Care Benefits Rider and the Extension of Benefits Rider, if applicable, and the monthly Optional Inflation Protection charge, if applicable, for the Extension of Benefits Rider, will be deducted each month from the cash value of the policy to which the riders are attached. These charges and the total annual rider charges are shown in the table attached to this disclosure statement, and will also be shown on the Policy Schedule of the issued policy.

We cannot increase the monthly rider charges or the monthly Optional Inflation Protection charge, if applicable, shown on the Policy Schedule of the issued policy. However, the monthly rider charges and the monthly Optional Inflation Protection Charge, if applicable, may change as a result of loans, withdrawals, or repayment of loans or loan interest, as described in the riders.

These riders do not contain provisions providing for a refund or partial refund of rider charges or the Optional Inflation Protection charge, if applicable, upon the death of the Insured or upon the surrender of the rider(s) or policy.

## 11. ADDITIONAL FEATURES.

### **Nonforfeiture**

If you purchase the Extension of Benefits Rider, you have the option to also purchase a Nonforfeiture Benefit Rider for an additional charge (shown in the attached table, if applicable) which provides for a limited amount of paid-up long-term care insurance as described in that rider if the policy and the Extension of Benefits Rider have been in force for at least 3 years and the Extension of Benefits Rider terminates for any of the following reasons:

- a. the policy lapses;
- b. you request to terminate the Extension of Benefits Rider or the Convalescent Care Benefits Rider (this does not include return of either rider under the 30 Day Right to Return provision);
- c. we make a benefit payment under the Terminal Illness Accelerated Death Benefit Rider; or
- d. you elect paid-up life insurance under the life insurance policy's Paid-Up Insurance provision.

Any benefit payable under the Nonforfeiture Benefit Rider will be subject to a 90 day deductible period, as described in that rider. This 90 day deductible period applies to all Covered Services listed in paragraph 6 except for Bed Reservation, Caregiver Training, Care Planning Services, Respite Care Services, and Non-Continual Alternative Care Services.

### **Medical Underwriting**

The issuance of these riders is subject to medical underwriting.

### **Federal Tax Consequences**

The riders described in this disclosure statement are intended to be federally tax-qualified long-term care insurance contracts under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

### **Expected Benefit Ratio**

The expected benefit ratio for the Extension of Benefits Rider is 69%. This ratio is the portion of future rider charges which the company expects to return as benefits, when averaged over all people with this policy and rider.

**12. DAILY RATES FOR NURSING HOME CARE IN NEW YORK STATE  
(AS OF 1/1/07)**

NY State Average, Statewide Daily Rate:	\$231.44
NY City Metropolitan, Average Daily Rate:	\$278.71
Western NY-Buffalo, Average Daily Rate:	\$169.01
Western NY-Rochester, Average Daily Rate:	\$188.12
Central Region, Average Daily Rate:	\$162.45
Capital Region, Average Daily Rate:	\$178.28

**CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK IF YOU HAVE SPECIFIC QUESTIONS REGARDING THE CONVALESCENT CARE BENEFITS RIDER OR EXTENSION OF BENEFITS RIDER DESCRIBED IN THIS DISCLOSURE STATEMENT.**

The undersigned acknowledges that he/she has read, understands and has received a copy of this Required Disclosure Statement

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**REQUIRED DISCLOSURE STATEMENT  
TABLE**

**Convalescent Care Benefits Rider (“CCBR”)** .....Monthly Rider Charge: \$ \_\_\_\_\_

CCBR Benefit Limit: \$ \_\_\_\_\_

CCBR Duration: \_\_\_\_\_ Years

Maximum Monthly CCBR Benefit: \$ \_\_\_\_\_

**Extension of Benefits Rider (“EOBR”)**.....Monthly Rider Charge: \$ \_\_\_\_\_

EOBR Benefit Limit: \$ \_\_\_\_\_

EOBR Duration: \_\_\_\_\_ Years

Maximum Monthly EOBR Benefit: \$ \_\_\_\_\_

Optional Inflation Protection.....EOBR Monthly Inflation Charge: \$ \_\_\_\_\_

Option \_\_\_\_\_

**Nonforfeiture Benefit Rider**.....Monthly Rider Charge: ...\$ \_\_\_\_\_

**TOTAL ANNUAL RIDER CHARGES: \$ \_\_\_\_\_**

# Lincoln MoneyGuard® Reserve

## Personal History Interview Instructions

Instructions should be left with the client to prepare for the Personal History Interview. This information DOES NOT need to be sent back to Lincoln!

Dear valued prospective Lincoln MoneyGuard Reserve client:

Preparing in advance for your telephone interview will expedite the interview process. Please complete the Pre-interview worksheet (immediately following this section) prior to your interview. Please allow at least 45 minutes to complete the interview. It will be beneficial for you to be in a place where you are alone and free from distractions.

If you are taking medication, please have your prescription bottles handy for the interview process, so that it will be easy for you to provide the name and dosage of the medication.

Please be prepared to confirm your Social Security number, and the Social Security numbers or tax I.D. numbers of the individuals/entities that will be the owner and beneficiary(ies).

Also, please be ready to confirm your existing life insurance policy information. We'll verify company names, coverage amounts, dates of issue, and if you are replacing the policies, the policy numbers.

You will be asked about your medical history including diagnoses, symptoms, and conditions for which you are or have been treated. Be sure you are prepared to give detailed information about your health.

This interview will require your participation in a series of memory exercises. The outcome of your application will be based on the information given during this interview only. Be sure you take your time and give it your full attention. Lincoln will not contact your doctor or access your medical records in order to make an underwriting offer.

We look forward to our upcoming conversation and thank you for applying for Lincoln MoneyGuard Reserve.

Lincoln Financial Group

Not a deposit
Not FDIC-insured
Not insured by any federal government agency
Not guaranteed by any bank or savings association
May go down in value

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[www.LincolnFinancial.com](http://www.LincolnFinancial.com)

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

LCN0909-2033987

LIF-MGR-09-0008

MGR-PHI-BRC001\_Z01

PEM 9/09 Z01

Order code: MGR-PHI-BRC001



Hello future.®

## Preinterview worksheet

### Important numbers

Your Social Security number

### Additional owner information

If you are not the owner of the policy, please provide the Tax ID or the Social Security number of whoever the owner will be.

Number

### Existing life insurance information

Please list every life insurance policy you currently have in-force AND any life insurance you've applied for which has not yet been issued. Please use another piece of paper if there is not enough room in the space provided.

Company name	Policy number (if available)	Issue date	Face amount

### Third party designation (to receive grace period of lapse notices)

Name	Address	Phone number

### Beneficiary(ies)

	Beneficiary (1)	Beneficiary (2)
Name		
Social Security number		
Relationship		
Trust name		
Trustee name(s)		
Date of trust		
Contingent name		
Social Security number		
Relationship		

## Medications

Please provide the following information about the prescription medication you are currently taking, including vitamins and herbal supplements.

Prescription name	Dosage and frequency
1	
2	
3	
4	
5	
6	

## Social history

Type of residence	Tobacco use	Alcohol use

## Medical history

Please list any medical conditions you have or have ever been diagnosed with. Please use a separate sheet of paper if there is not enough room in the space provided.

Condition	Date of diagnosis	Symptoms	Type and date of treatment	Tests done and results	Date of last doctor visit
1					
2					
3					

Have you had to alter any of your daily activities? Please check Yes or No.

Do you need assistance with:

Cooking  Yes  No

Continence  Yes  No

Dressing  Yes  No

Yard work  Yes  No

Shopping  Yes  No

Cleaning  Yes  No

Carrying groceries  Yes  No

Do you participate in any recreational activities? If so, what are they?

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If you have any of the following conditions, please be ready to provide the following information.

Breast cancer	Size of tumor	Stage	Lymph node involvement	Type of treatment	
Prostate cancer	Pretreatment PSA	Gleason score	Stage	Type of treatment	Posttreatment PSA
Colon cancer	Dukes staging	Lymph node involvement			
Diabetes	Age of diagnosis	Type of treatment	Fasting blood glucose	Blood HgA1C	Confirmation of any of the following: retinopathy, neuropathy, nephropathy
Coronary heart disease	Bypass surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	How many vessels	Angioplasty with or without stent <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No	Last stress test and results

**Important disclosures. Please read.**

Lincoln *MoneyGuard*<sup>®</sup> Reserve is a universal life insurance policy with a rider that accelerates the specified amount of death benefit to pay for covered long-term care expenses. The cost of riders will be deducted from the policy value. **Guarantees are backed by the claims-paying ability of the issuer and are subject to policy terms and conditions.** The insurance policy and riders have limitations, exclusions, and/or reductions.

Lincoln *MoneyGuard*<sup>®</sup> Reserve is issued by The Lincoln National Life Insurance Company, Fort Wayne, IN, on Policy Form LN850 (8/05) with a Convalescent Care Benefits Rider (CCBR) on Rider Form LR851 (8/05). **The Lincoln National Life Insurance Company does not solicit business in the state of New York, nor is it authorized to do so. Contractual obligations are backed by the claims-paying ability of The Lincoln National Life Insurance Company.**

Policies sold in New York are issued by Lincoln Life & Annuity Company of New York, Syracuse, NY, on Policy Form LN850 (8/05) with a Convalescent Care Benefits Rider on Rider Form LR851 (8/05). **Contractual obligations are backed by the claims-paying ability of Lincoln Life & Annuity Company of New York.**

Products and features, including benefits, exclusions, limitations, terms, and definitions, may vary by state.

## MONEYGUARD® RESERVE PRE-QUALIFYING TOOL

Clients who have not been previously declined for long-term care coverage (by Lincoln or any other carrier) and can answer “NO” to ALL of the following questions are good candidates for *MoneyGuard*®. All others should be directed to alternative solutions.

(Note: This form is to be used as a reference for you and does not need to be submitted to Lincoln.)

<b>Has your client ever been diagnosed with:</b>	<b>YES</b>	<b>NO</b>
Alzheimer’s Disease or Dementia, or taking any medication for memory loss?	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema, chronic obstructive pulmonary disease (COPD) or congestive heart failure?	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson’s Disease, Multiple Sclerosis or Muscular Dystrophy?	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis or taking methotrexate, prednisone, enbrel or remicade for joint pain?	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis that is untreated or with a history of compression fractures or height loss of two inches or more?	<input type="checkbox"/>	<input type="checkbox"/>
A Stroke or Transient Ischemic Attack (TIA) within the last 24 months or heart attack, heart or carotid artery surgery within the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (other than non-melanoma skin cancer) within the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
Type 1 diabetes?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Is your client:</b>	<b>YES</b>	<b>NO</b>
Currently being treated for a medical condition or having medical treatment, a pending consult or surgery recommended but not yet completed?	<input type="checkbox"/>	<input type="checkbox"/>
On dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
Using Oxygen for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
The recipient of an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Does your client:</b>	<b>YES</b>	<b>NO</b>
Use a cane of any variety, walker or wheelchair on a regular or intermittent basis?	<input type="checkbox"/>	<input type="checkbox"/>
Take any narcotic drug or prescription pain medication on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
Have an implantable defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>
Currently collect disability benefits?	<input type="checkbox"/>	<input type="checkbox"/>
Have a handicap parking permit?	<input type="checkbox"/>	<input type="checkbox"/>

**Clients who can answer “No” to all questions are good candidates for MoneyGuard Reserve.**

NOTE: If your client has any surgery scheduled in the next two months, or if he/she has recently been advised to have surgery, you should wait to submit the case until the client is at least three months post-operation, fully recovered, back to 100% full activity, and released from doctors’ care.



## LINCOLN FINANCIAL GROUP® PRIVACY PRACTICES NOTICE

The Lincoln Financial Group companies\* are committed to protecting your privacy. To provide the products and services you expect from a financial services leader, we must collect personal information about you. **We do not sell your personal information to third parties.** We share your personal information with third parties as necessary to provide you with the products or services you request and to administer your business with us. This Notice describes our current privacy practices. While your relationship with us continues, we will update and send our Privacy Practices Notice as required by law. Even after that relationship ends, we will continue to protect your personal information. **You do not need to take any action because of this Notice, but you do have certain rights as described below.**

### INFORMATION WE MAY COLLECT AND USE

We collect personal information about you to help us identify you as our customer or our former customer; to process your requests and transactions; to offer investment or insurance services to you; to pay your claim; or to tell you about our products or services we believe you may want and use. The type of personal information we collect depends on the products or services you request and may include the following:

- **Information from you:** When you submit your application or other forms, you give us information such as your name, address, Social Security number; and your financial, health, and employment history.
- **Information about your transactions:** We keep information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; and your payment history.
- **Information from outside our family of companies:** If you are purchasing insurance products, we may collect information from consumer reporting agencies such as your credit history; credit scores; and driving and employment records. With your authorization, we may also collect information, such as medical information from other individuals or businesses.
- **Information from your employer:** If your employer purchases group products from us, we may obtain information about you from your employer in order to enroll you in the plan.

### HOW WE USE YOUR PERSONAL INFORMATION

We may share your personal information within our companies and with certain service providers. They use this information to process transactions you have requested; provide customer service; and inform you of products or services we offer that you may find useful. Our service providers may or may not be affiliated with us. They include financial service providers (for example, third party administrators; broker-dealers; insurance agents and brokers, registered representatives; reinsurers and other financial services companies with whom we have joint marketing agreements). Our service providers also include non-financial companies and individuals (for example, consultants; vendors; and companies that perform marketing services on our behalf). Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law.

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners, regulatory authorities and law enforcement officials and to others when we believe in good faith that the law requires disclosure. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or share your information with outside marketers who may want to offer you their own products and services; nor do we share information we receive about you from a consumer reporting agency. You do not need to take any action for this benefit.**

## **SECURITY OF INFORMATION**

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. Our employees are authorized to access your information only when they need it to provide you with products, services, or to maintain your accounts. Employees who have access to your personal information are required to keep it confidential. Employees are trained on the importance of data privacy.

Questions about your personal information should be directed to:

Lincoln Financial Group  
Attn: Enterprise Services Compliance-Privacy, 6C-00  
1300 S. Clinton St.  
Fort Wayne, IN 46802

**Please include all policy/contract/account numbers with your correspondence.**

\*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company  
Lincoln Investment Advisors Corporation  
Lincoln Life & Annuity Company of New York  
Lincoln Variable Insurance Products Trust  
The Lincoln National Life Insurance Company

## ***ADDITIONAL PRIVACY INFORMATION FOR INSURANCE PRODUCT CUSTOMERS***

### **CONFIDENTIALITY OF MEDICAL INFORMATION**

We understand that you may be especially concerned about the privacy of your medical information. We do not sell or rent your medical information to anyone; nor do we share it with others for marketing purposes. We only use and share your medical information for the purpose of underwriting insurance, administering your policy or claim and other purposes permitted by law, such as disclosure to regulatory authorities or in response to a legal proceeding.

### **MAKING SURE MEDICAL INFORMATION IS ACCURATE**

We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you believe that any of our records are not correct, you may write and tell us of any changes you believe should be made. We will respond to your request within 30 business days. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years.

Questions about your personal medical information should be directed to:

Lincoln Financial Group  
Attn: Medical Underwriting  
P.O. Box 21008  
Greensboro, NC 27420-1008

The CONFIDENTIALITY OF MEDICAL INFORMATION and MAKING SURE INFORMATION IS ACCURATE sections of this Notice apply to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company  
Lincoln Life & Annuity Company of New York  
The Lincoln National Life Insurance Company

**REGULATION 60 - APPENDIX 11**  
**INSURANCE DEPARTMENT OF THE STATE OF NEW YORK**  
**DEFINITION OF REPLACEMENT**

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

- (1) LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED?

YES \_\_\_\_ NO \_\_\_\_

- (2) CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES?

YES \_\_\_\_ NO \_\_\_\_

- (3) CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE?

YES \_\_\_\_ NO \_\_\_\_

- (4) REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES?

YES \_\_\_\_ NO \_\_\_\_

(5) ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES?

YES \_\_\_ NO \_\_\_

(6) CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID?

YES \_\_\_ NO \_\_\_

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE DEPARTMENT REGULATION No. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH A COMPLETED DISCLOSURE STATEMENT AND THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

DATE: \_\_\_\_\_

SIGNATURE OF APPLICANT: \_\_\_\_\_

PRINT APPLICANT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE OF APPLICANT: \_\_\_\_\_

PRINT APPLICANT NAME: \_\_\_\_\_

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION:

YES \_\_\_ NO \_\_\_

DATE: \_\_\_\_\_

SIGNATURE OF AGENT  
OR BROKER: \_\_\_\_\_

PRINT AGENT  
OR BROKER NAME: \_\_\_\_\_

**TEMPORARY LIFE INSURANCE AGREEMENT**  
**LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK ("Company")**

B44 NY

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY-DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If any of the questions below are answered yes or left blank with respect to a Proposed Insured(s), no representative of the Company is authorized to accept money, and **NO COVERAGE** will take effect under this Agreement with respect to such Proposed Insured(s).

Has Proposed Insured(s): Questions apply to **all** Proposed Insured(s) shown on application.

1. Does Amount applied for exceed \$3,000,000?  Yes  No
2. Within the past 90 days, has any Proposed Insured been admitted to a hospital or other medical facility, been advised to be admitted or had surgery performed or recommended?  Yes  No
3. Within the past 2 years has any Proposed Insured been treated for heart trouble, stroke, or cancer, or had such treatment recommended by a physician or other medical practitioner?  Yes  No  N/A if applying for a **MoneyGuard®** product.
4. Is Age of Proposed Insured under 15 days old or over age 70?  Yes  No  N/A if applying for a **MoneyGuard®** product.

This Agreement provides a **Limited Amount** of Life Insurance protection for a **Limited Period** of time, subject to the terms of this Agreement, in consideration of advance payment in the amount of \$\_\_\_\_\_ in connection with the Application dated \_\_\_\_\_ made on the life of: \_\_\_\_\_

Name(s) of Proposed Insured(s)

**TERMS AND CONDITIONS**

**AMOUNT OF COVERAGE - \$500,000 MAXIMUM FOR ALL APPLICATIONS OR AGREEMENTS**

If money has been accepted by the Company as advance payment for an application for Life Insurance and death of a Proposed Insured(s) (and death of the surviving Proposed Insured under Survivorship Life Insurance) occurs while this Agreement is in effect, the Company will pay to the beneficiary designated in the Application the lesser of **a)** the amount of all death benefits applied for in the Application(s) with respect to said Proposed Insured(s), including any accidental or supplemental death benefits, if applicable, or **b)** \$500,000. This total benefit limit applies to all insurance applied for under this and any current Applications to the Company and any other Temporary Life Insurance Agreements. Temporary Long-Term Care coverage is **not** available under this Agreement.

**DATE COVERAGE BEGINS**

Coverage under this Agreement will begin on the date of this Agreement but only if Part I of the Application(s) has been completed on the same date or not more than 30 days prior to the date of this Agreement.

**DATE COVERAGE TERMINATES – 90 DAY MAXIMUM**

Coverage under this Agreement will terminate automatically on the earliest of: **a)** 45 days from date of this Agreement if a required Exam or Non medical is not received by the Company, or **b)** 90 days from the date of this Agreement, or **c)** the date the insurance takes effect under the policy applied for, or **d)** the date the Company mails notice of termination of coverage to the premium notice address designated in Part I of the Application(s). The Company may terminate coverage at any time.

**SPECIAL LIMITATIONS**

- This Agreement does not guarantee the Company will issue a life insurance policy or any special riders or endorsement thereto.
- Fraud or material misrepresentations in the Application(s) or in the answers to the Health Questions of this Agreement invalidates this Agreement and the Company's only liability is for refund of any payment made.
- If a Proposed Insured(s) (or the surviving Proposed Insured under Survivorship Life Insurance) dies by suicide **within 2 years**, the Company's liability under this Agreement is limited to a refund of the payment made.
- There is no coverage under this Agreement if the check or draft submitted as payment is not honored by the bank.
- No one is authorized to waive or modify any of the provisions of this Agreement.

I (WE) HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND AND AGREE TO ALL ITS TERMS.

\_\_\_\_\_  
Signature of Proposed Insured A

\_\_\_\_\_  
Witness (Licensed Representative/Agent)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Insured B

\_\_\_\_\_  
Witness (Licensed Representative/Agent)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant/Owner/Trustee (Provide Officer's Title if policy is owned by a Corporation.)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date