# 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, 7C-01
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 Financial Investment Services Corporation
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

# LINCOLN FINANCIAL GROUP® PRIVACY NOTICE FOR PROTECTED 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 currently have, insurance coverage or an annuity ("Coverage"), that contains benefit provisions subject to the federal privacy regulations that were issued as a result of the Health Insurance Portability and Accountability Act, as amended ("HIPAA"). This is Coverage that has been, or will be issued with one of the Lincoln Financial Group insurance companies* ("Company"). 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 protected health information we have about you which relates to your Coverage ("Protected Health Information"), and how we may use and disclose this information. Protected 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 Protected 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 HIPAA. We are required by law to maintain the privacy of your Protected Health Information; to provide you this Notice of our legal duties and privacy practices with respect to your Protected 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 Protected Health Information we already have about you as well as any Protected 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 PROTECTED HEALTH INFORMATION

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

**Authorization:** Except as described below, we will not use or disclose your Protected Health Information for any reason unless we have a signed authorization from you or your legal representative to use or disclose your Protected 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 Protected Health Information as necessary for your treatment. For instance, a doctor or health facility involved in your care may request Protected Health Information that we hold about you in order to make decisions about your care.

**Payment of Claims:** We may use and disclose your Protected 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 Protected 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 Protected 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. Protected 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 Protected 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 Protected Health Information to non-affiliated business associates, but only if the receipt of Protected Health Information is necessary to provide a service to us and the business associate agrees to protect the Protected 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 Protected Health Information where required by law, for public health or similar activities. Examples include:

- Releasing Protected 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 Protected Health Information to a governmental agency or regulator with health care oversight responsibilities;
- Releasing Protected 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 Protected 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 Protected Health Information to the Food and Drug Administration (FDA) for purposes related to quality, safety or effectiveness of FDA-regulated products or activities;
- Releasing Protected 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 Protected Health Information requested. We may disclose Protected Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination;
- Releasing Protected Health Information for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- Releasing Protected Health Information if you are a member of the military as required by armed forces services;
- Releasing Protected Health Information to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- Releasing Protected Health Information to worker's compensation agencies if necessary for your worker's compensation benefit determination;

- Releasing Protected Health Information to avert a serious threat to someone's health or safety, including the disclosure of Protected 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 Protected 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 Protected 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 PROTECTED HEALTH INFORMATION

You have the following rights as a consumer under HIPAA concerning the Protected 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 Compliance – Corporate Privacy Office - 7C-01, 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 Protected 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 Protected 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 Protected 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 Protected 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 Protected Health Information:** In most instances, you have the right to inspect and obtain a copy of the Protected 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 Protected Health Information, for example psychotherapy notes and Protected 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 Protected 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 Protected Health Information:** You have the right to request that we amend your Protected 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 Protected Health Information. We may deny your request if you ask us to amend Protected Health Information that is accurate and complete; was not created by us, unless the creator of Protected Health Information is no longer available to make the amendment; is not part of the Protected Health Information kept by or for us; or is not part of the Protected 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 Protected Health Information:** You have the right to request an accounting or list of disclosures we have made of your Protected 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 Compliance – Corporate Privacy Office - 7C-01, 1300 S Clinton Street, Fort Wayne IN 46802, or call 1-877-275-5462.**

**Effective Date:** This Notice is effective June 1, 2011.

*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

**Please check the appropriate servicing address of the underwriting company:**
☐ **The Lincoln National Life Insurance Company,** Life Service Office: PO Box 21008, Greensboro, NC 27420-1008
☐ **The Lincoln National Life Insurance Company,** Annuity Service Office: PO Box 2348, Fort Wayne, IN 46801-2348
(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 The Lincoln National Life Insurance Company (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 (12 months in Kansas) 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:______________
______________________________

**Please check appropriate underwriting company:**
☐ **The Lincoln National Life Insurance Company,** Life Service Office: PO Box 21008, Greensboro, NC 27420-1008
☐ **The Lincoln National Life Insurance Company,** Annuity Service Office: PO Box 2348, Fort Wayne, IN 46801-2348

## APPROPRIATENESS VERIFICATION STATEMENT

**The Lincoln National Life Insurance Company (Lincoln) Replacement Position Statement:** Lincoln does not encourage the replacement of a long-term care policy, life insurance policy or annuity contract. Replacements should only occur when it is in the client's best interest. Therefore, Lincoln expects each producer selling its products to determine the appropriateness of each replacement according to Lincoln's guidelines prior to submitting an application to Lincoln. Before issuing a replacement policy, Lincoln must be reasonably satisfied that the product meets the client's needs and objectives; that the client was fully educated on the advantages and disadvantages of a policy or contract replacement to have the knowledge necessary to make an informed decision; and that the client received complete and accurate replacement forms as required by state regulations.

**Guidelines:** Lincoln expects that each producer will discuss at least the following replacement issues and concerns with the client prior to submitting a replacement application to Lincoln:

- Potential reduction of current cash value due to new acquisition costs **-** how long will it take to recover the costs associated with the proposed policy or annuity contract.
- Potential tax implications of replacing the existing policy or annuity contract.
- Potential impact on client's immediate liquidity needs.
- Potential impact of surrender charges on existing and proposed policy or annuity contract
- Potential increase in cost of insurance due to insured's increased age.
- Potential for new contestability/suicide periods.
- Potential impact of variable factors on planned premiums.
- Circumstances under which the existing and proposed policy could lapse.
- Duration of coverage under the existing and proposed policy.
- Differences in features and benefits between the existing and proposed coverage or annuity contract.
- Differences in loan features and benefits between the existing and proposed coverage or annuity contract.

**Producer Verification:**

- I have discussed the advantages and disadvantages of discontinuing or modifying the existing long-term care policy, life insurance policy or annuity contract with my client, including the replacement concerns and issues mentioned above.

- I have determined that the existing coverage or annuity contract no longer meets the client's insurance needs and objectives and that the proposed replacement is appropriate in accordance with the Lincoln Replacement Position Statement.

- I have used only company approved sales material in conjunction with this sale; and,

- I have left copies of all sales material with the applicant(s) at the time the application was submitted.

______________________________ ______________________________
Producer's Name (please print) Signature

______________________________
Date

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

**Please check the appropriate servicing address of the underwriting company:**
☐ **The Lincoln National Life Insurance Company,** Life Service Office: 350 Church Street - MMG1, Hartford, CT 06103-1106
☐ **The Lincoln National Life Insurance Company,** 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 The Lincoln National Life Insurance Company. 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:

| Insurance Company | Name of Insured | Policy/Certificate Number |
|---|---|---|
| | | |
| | | |

The above "Notice to Applicant" was delivered to me on: ____________________ ______________________________

Date Applicant's Signature

______________________________ ______________________________

Agent's Signature Printed Name/Address of Agent

**OVERNIGHT TO:**
MoneyGuard Streamlined Underwriting Unit
350 Church St.
Hartford, CT 06103

# MONEYGUARD® RESERVE PLUS TICKET

## INSURED INFORMATION

First Name: ______________________ MI ____ 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: ____________________

Reference # for Scheduled Phone Interview: __________________________________________________________

## CONTRACT INFORMATION

**NOTE: Policy will be issued if approved with Specified Amount, Premium amount and frequency, Inflation Option, Benefit Duration and Non-Forfeiture Benefit Option as indicated on illustration or simplified quote accompanying this ticket.**

Contract State: __________________________________

Owner (if not Insured): ___________________________________ DOB: ____________ SSN: ______________________

Primary Beneficiary: __________________________ Relationship: ___________________ SSN: ______________________

Contingent Beneficiary: ________________________ Relationship: ___________________ SSN: ______________________

*Use additional page to list additional owner/beneficiary information.*

**Policy Dating: Note - Insured's Issue Age Will Be Determined By Age On The Date The Ticket Is Received By Lincoln**

## 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):** __________________________________________________

Commission Option (as applicable): ☐ No Trails ☐ Trails Client Account Number: ___________________________

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

Lincoln Financial Group℠

**FAX TO:** (860) 466-3010 **OR**
**OVERNIGHT TO:**
MoneyGuard Streamlined Underwriting Unit
350 Church St.
Hartford, CT 06103

# *ABGA CHANNEL* MONEYGUARD® RESERVE PLUS TICKET

## INSURED INFORMATION

First Name: ______________________ MI ____ 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: ______________________

Reference # for Scheduled Phone Interview: ______________________________________________________________

## CONTRACT INFORMATION

**NOTE: Policy will be issued if approved with Specified Amount, Premium amount and frequency, Inflation Option, Benefit Duration and Non-Forfeiture Benefit Option as indicated on illustration or simplified quote accompanying this ticket.**

Contract State: ___________________________________

Owner (if not Insured): ____________________________________ DOB: ____________ SSN: ______________________

Primary Beneficiary: ___________________________ Relationship: ____________________ SSN: ______________________

Contingent Beneficiary: _________________________ Relationship: ____________________ SSN: ______________________

*Use additional page to list additional owner/beneficiary information.*

**Policy Dating: Note - Insured's Issue Age Will Be Determined By Age On The Date The Ticket Is Received By Lincoln**

## 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 ABGA/Writing Agent to deliver to the client.**

Name: _________________________________________________________________________________

Address: ______________________________________________________________________________

City: ____________________________________________________ State: ____________________ Zip: ______________

**ABGA associated with this business (if applicable):** ______________________________________________________

Commission Option (as applicable): ☐ No Trails ☐ Trails Client Account Number: ____________________________

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

Lincoln Financial Group[SM]

**Please check appropriate underwriting company:**

☐ **The Lincoln National Life Insurance Company,** Life Service Office: PO Box 21008, Greensboro, NC 27420-1008

☐ **The Lincoln National Life Insurance Company,** Annuity Service Office: PO Box 2348, Fort Wayne, IN 46801-2348

# REPLACEMENT OF LIFE INSURANCE

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ YES ☐ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy will be replaced or used as a source of financing:

| Insurer Name | Contract or Policy # | Insured or Annuitant | Replaced (R) or Financing (F) |
|---|---|---|---|
| 1. ______ | ______ | ______ | ______ |
| 2. ______ | ______ | ______ | ______ |
| 3. ______ | ______ | ______ | ______ |

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

______________________________________________

I certify that the responses herein are, to the best of my knowledge, accurate:

______________________ ______________________ ______________

Applicant's Signature Applicant's Printed Name Date

**AGENT CERTIFICATION**

Does the applicant have any existing life insurance policies or annuity contracts? ☐ Yes ☐ No

Will the proposed contract replace or change any existing annuity or life insurance? ☐ Yes ☐ No

______________________ ______________________ ______________

Producer's Signature Producer's Printed Name Date

I do not want this notice read aloud to me. ________ (Applicants must initial only if they do not want the notice read aloud.)

Should you have any questions regarding this form, please contact your insurance representative or the Company at the address or telephone number shown on your application.

Note: Certificate will replace policy or contract in some states.

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

**Premiums:**

Are they affordable?
Could they change?
You're older – are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

**Policy values:**

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

**Insurability:**

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

**If You are keeping the Old Policy as well as the New Policy:**

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

**If You are Surrendering an Annuity or Interest Sensitive Life Product:**

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

**Other Issues to Consider for All Transactions:**

What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

# INSTRUCTIONS FOR REPLACEMENT REGULATIONS

New replacement regulations have been adopted in a number of states. The following steps are necessary to comply with the new regulations.

**1. Existing Insurance**

For each application, a producer is required to ask an applicant if he or she has any existing life insurance policies or annuity contracts. The producer and the applicant must complete and sign the statement on the application regarding existing policies or contracts.

**2. Replacement Notice**

If there are existing policies or contracts, the producer or the applicant must also complete and sign "Important Notice: Replacement of Life Insurance or Annuities", Form LF10087NJ. This form must accompany the application whether or not a replacement is proposed. A copy must be provided to the applicant.

If there is a replacement, all policies and contracts to be replaced must be listed on the form in detail, including the reason for replacement. The producer is required to read the form aloud to the applicant or the applicant must initial the form to indicate that the reading was waived.

**3. Sales Material**

We require that only approved sales material be used. The regulations define "sales material" as a sales illustration and any other written, printed or electronically presented information created, completed or provided by the producer that is used in the presentation to the applicant. (A printed hard copy of any electronically presented sales material must be given to the applicant no later than the time of contract delivery.)

If there is a replacement, a producer must complete and sign "Appropriateness Verification Statement", Form 33555, certifying that only company approved sales material was used and that copies were left with the applicant.

The producer must maintain documentation of all sales materials used.

The replacement regulations require that we contact the applicant after the contract is issued to affirm that you left copies of all sales materials used with the applicant. We make this contact via a letter. If the contract is mailed to you for delivery, it is your responsibility to provide this letter to the applicant with the contract. The regulations require this letter to be provided to the applicant within 10 days of the issue date.

**The Lincoln National Life Insurance Company**
**Service Office:** 350 Church St. - MMG1, Hartford, CT 06103-1106
(hereinafter referred to as "the Company")

# *MONEYGUARD*® TEMPORARY LIFE INSURANCE AGREEMENT

***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 the question below is answered yes or left blank with respect to a Proposed Insured, 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.**

Within the past 90 days, has the Proposed Insured been admitted to a hospital or other medical facility, been advised to be admitted or had surgery performed or recommended? ☐ **Yes** ☐ **No**

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 ***MoneyGuard***® Ticket dated ________________________ made on the life of ____________________________________________.
Name of Proposed Insured

## 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 occurs while this Agreement is in effect, the Company will pay to the beneficiary designated in the Application, or to the estate of the proposed insured if no beneficiary has been designated, the lesser of **a)** the amount of all death benefits applied for in the Ticket(s) with respect to said Proposed Insured, or **b)** $500,000. This total benefit limit applies to all insurance applied for under this and any current Tickets or 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 the ***MoneyGuard***® Ticket(s) has been completed on the same date or not more than 10 days prior to the date of this Agreement.

**DATE COVERAGE TERMINATES – 60 DAY MAXIMUM**

Coverage under this Agreement will terminate automatically on the earliest of**: a)** 30 days from date of this Agreement if a required Phone History Interview is not completed and received by the Company, or **b)** 60 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 the Ticket(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 Ticket(s) or in the answer to the Health Question of this Agreement invalidates this Agreement and the Company's only liability is for refund of any payment made.
- If a Proposed Insured dies by suicide, 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** | **Witness** ***(Licensed Representative/Agent)*** | **Date** |
| ______________________________ | ______________________________ | ______________ |
| **Signature of Applicant/Owner/Trustee**<br>(Provide Officer's Title if policy is owned by a Corporation.) | **Witness** ***(Licensed Representative/Agent)*** | **Date** |

This form is to be used with the ***MoneyGuard***® Streamlined process ONLY.

# The Lincoln National Life Insurance Company

("the Company")
A Stock Company
Service Office: One Granite Place, PO Box 515, Concord, New Hampshire 03302-0515 (800) 962-1654

## LONG-TERM CARE INSURANCE
## OUTLINE OF COVERAGE

For Convalescent Care Benefits Rider LR870 and Extension of Benefits Rider LR871

**CAUTION: The issuance of the Convalescent Care Benefits Rider and Extension of Benefits Rider, if applicable, described in this outline is based on your answers to the questions on your application for such rider(s). A copy of your application should be retained by you when completed. If your answers are incorrect or untrue, the Company may 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 the Company at the Service Office address shown above.**

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

1. **INDIVIDUAL COVERAGE.**
   The Convalescent Care Benefits Rider ("CCBR") and Extension of Benefits Rider ("EOBR"), if applicable, described in this outline are attached to, and made a part of, an individual life insurance policy which was issued in New Jersey.

2. **PURPOSE OF OUTLINE OF COVERAGE.**
   This Outline of Coverage provides a very brief description of the important features of the CCBR and EOBR. You should compare this Outline of Coverage 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. **FEDERAL TAX CONSEQUENCES.**
   The CCBR and EOBR are intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

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

   **Renewability**
   THESE RIDERS ARE NON-CANCELABLE. 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. The Company cannot change any of the terms of your policy and rider(s) on its own and cannot increase the monthly rider charges or monthly Optional Inflation Protection charges, if applicable.

   **Waiver of Premium**
   These riders do not contain a waiver of premium or waiver of rider charge provision. However, the monthly rider charges and monthly Optional Inflation Protection charges, if applicable, will cease and be permanently waived once the cash value of the policy to which these riders are attached has been reduced to less than the required monthly deduction as a result of payments for Covered Services under the CCBR. If there are outstanding loans or withdrawals against the policy and the Cash Value is less than the monthly deductions due, the policy will enter the grace period as described in the Indebtedness provision of the policy.

## 5. TERMS UNDER WHICH THE COMPANY MAY CHANGE RIDER CHARGES.

**The Company cannot increase the monthly rider charges and monthly Optional Inflation Protection charges, as applicable.**

6. **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 the Company at the Service Office address shown above within 30 days after you receive them. If returned, the rider(s) will be considered void from the beginning and the Company will refund all charges paid for these riders.

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

7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**
   If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company. Neither the Company nor its agents represent Medicare, the federal government or any state government.

8. **LONG-TERM CARE COVERAGE.**
   Policies and riders of this category are designed to provide coverage for one or more 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 CCBR.

   The CCBR and EOBR 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.

9. **BENEFITS PROVIDED BY THESE RIDERS.**
   Benefits are provided under the CCBR until that rider's benefit limit has been reached. The EOBR extends the benefits provided by the CCBR after the CCBR's benefit limit has been reached.

   The Company 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 in any one calendar month for any Covered Service or combination 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 CCBR and for the EOBR, if applicable, are shown in the table attached to this Outline of Coverage.

   The Company 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 jurisdiction licenses such facilities. If the jurisdiction does not license Assisted Living Facilities, then the facility must meet the criteria described in the CCBR.

**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 days each calendar 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 jurisdiction licensing agency or authority as a Nursing Home, if the jurisdiction licenses such facilities. If the jurisdiction does not license Nursing Homes, then the facility must meet the criteria described in the Convalescent Care Benefits Rider.

**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 criteria described in the CCBR.

**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 all Caregiver Training provided while the Insured is covered under the CCBR and under the EOBR, if applicable, is limited to no more than the amount shown in the table attached to this Outline of Coverage.

**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 entity 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 CCBR.

**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 days each calendar 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 the Company 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. The amount payable for this benefit in any calendar year cannot exceed the maximum monthly benefit of the rider then in effect.

## 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 CCBR, the total benefits paid under that rider must not have reached the CCBR's benefit limit. To qualify for benefits under the EOBR:

   1. payments for Covered Services under the CCBR must have reached the CCBR's benefit limit; and

   2. the total benefits paid under the EOBR must not have reached the EOBR's benefit limit.

b. 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 at least 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.

c. The Licensed Health Care Practitioner must prescribe 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 plan of care while these riders are in force.

d. 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 caused by 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 prescribe 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- 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, including 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).

## 10. LIMITATIONS AND EXCLUSIONS.

### Pre-Existing Conditions

These riders do not exclude pre-existing conditions.

**Non-eligible 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.

**Non-eligible Levels of Care**
These riders do not cover services that do not constitute qualified long-term care services as defined in the CCBR.

**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, as described above. **This exclusion does NOT apply to qualifying stays or care resulting from a clinical diagnosis of Alzheimer's Disease or similar forms of irreversible dementia**;

b. treatment for alcoholism or drug addiction (unless the drug addiction is a result of medication taken in doses as prescribed by a physician);

c. treatment arising out of an attempt (while sane or insane) at suicide or an intentionally self-inflicted injury;

d. treatment provided in a Veteran's Administration or government facility, unless the Insured or the Insured's estate is charged for the confinement or services or unless otherwise required by law;

e. loss to the extent that benefits are payable 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 or its territories and possessions, other than benefits for Nursing Home Care Services and Assisted Living Facility Services provided under the CCBR as described below;

g. 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; 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.

**International Benefits**
The CCBR provides for limited benefits for Nursing Home Care Services or Assisted Living Facility Services received outside of the United States or its territories and possessions (collectively, "United States"), subject to the terms and conditions described in the CCBR. The amount payable each calendar month for such services is limited to an amount equal to 50% of any maximum monthly benefit available under the CCBR. No benefits are payable under the CCBR for any Covered Services received outside of the United States other than Nursing Home Care Services or Assisted Living Facility Services.

No benefits are payable under the EOBR for any Covered Service, confinement or care received outside of the United States.

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

## 11. 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 CCBR and EOBR provide for Optional Inflation Protection coverage. If you *don't* reject Optional Inflation Protection by signing the rejection statement in the application for these riders, the maximum monthly benefit and benefit limit for the CCBR and the EOBR, if applicable, will automatically increase on each policy anniversary while the rider(s) are in force. The amount of the annual increase will depend upon the Optional Inflation Protection option that is in effect. The available options are 3% Simple Increases, 3% Compound Increases, and 5% Compound Increases.

The monthly rider charges and monthly Optional Inflation Protection charges will remain level and will not increase annually as rider benefits increase.

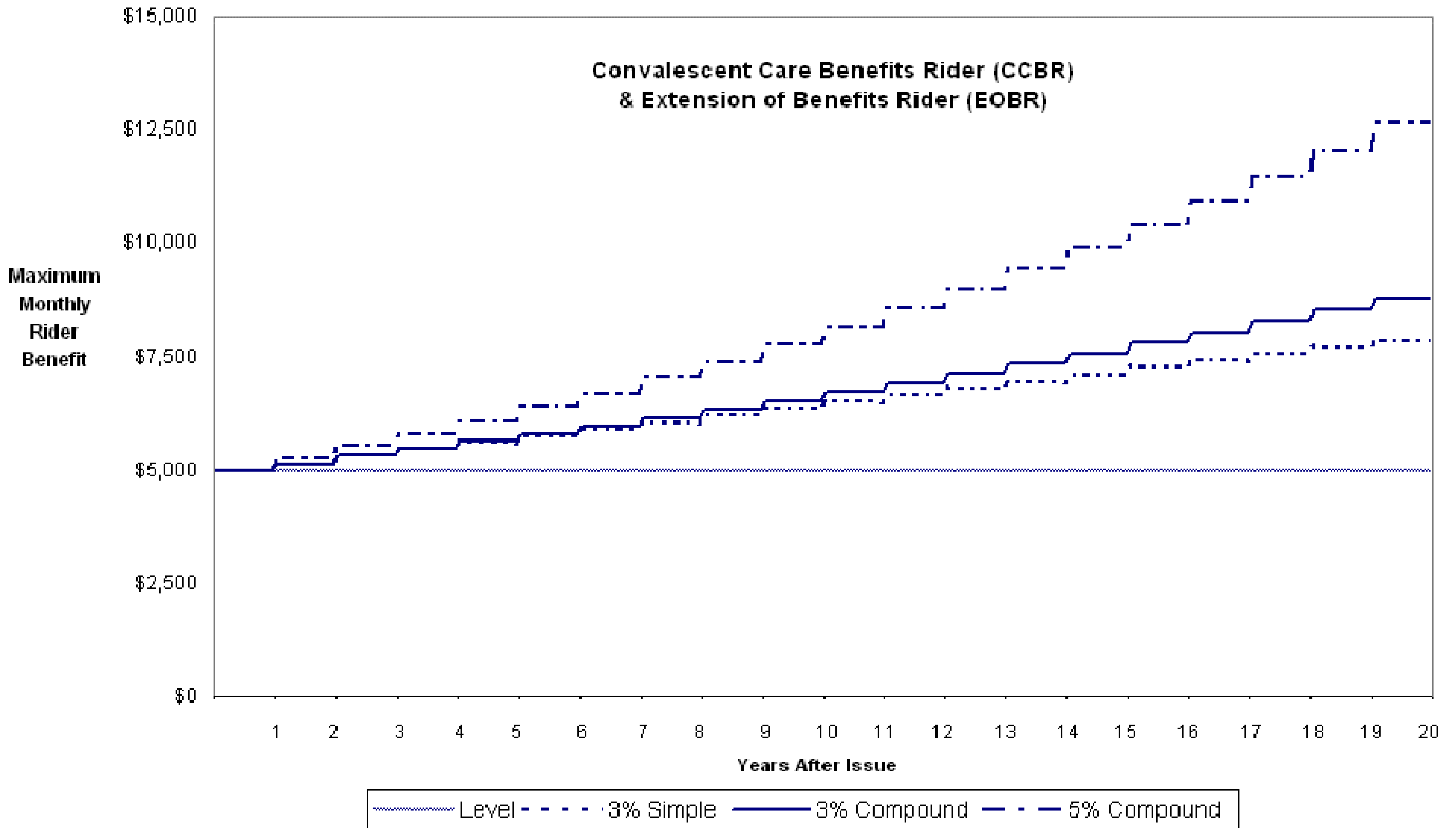
If you *reject* Optional Inflation Protection by signing the rejection statement in the application for these riders, you will not be able to increase your benefits later. These riders do not provide a guaranteed option to buy additional insurance.

The chart below gives examples of the monthly Optional Inflation Protection charges for each available option. The example shown is for a maximum monthly benefit of $5,000 with a 2 year CCBR duration and a 2 year EOBR duration.

Your actual monthly Optional Inflation Protection charges will be different from the examples shown if you select a different combination of CCBR duration and EOBR duration. The Optional Inflation Protection charges based upon the rider durations and Optional Inflation Protection option, if any, you chose are shown in the table attached to this Outline of Coverage.

| **Monthly Optional Inflation Protection Charges for $5,000 of Maximum Monthly Benefit<br>CCBR Duration is 2 Years; EOBR Duration is 2 Years** | | | | | | |
|---|---|---|---|---|---|---|
| **Issue Age** | **Inflation Protection** | | | | | |
| | **3% Simple Increases** | | **3% Compound Increases** | | **5% Compound Increases** | |
| | **CCBR** | **EOBR** | **CCBR** | **EOBR** | **CCBR** | **EOBR** |
| 35 | $23.52 | $14.04 | $27.96 | $29.04 | $40.56 | $77.64 |
| 45 | $29.28 | $19.20 | $34.80 | $38.40 | $53.28 | $93.36 |
| 55 | $60.96 | $24.24 | $70.20 | $43.44 | $98.52 | $100.20 |
| 65 | $78.72 | $30.60 | $84.84 | $46.32 | $120.36 | $122.88 |
| 75 | $229.68 | $41.28 | $235.68 | $69.48 | $337.20 | $156.48 |

The chart below provides a comparison of the maximum monthly benefit provided by each rider with the options available to you: level benefits (no Optional Inflation Protection); 3% Simple Increases; 3% Compound Increases; and 5% Compound Increases.




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

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

## 12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

These riders will provide benefits for qualified long-term care services resulting from a clinical diagnosis of Alzheimer's Disease or related degenerative and dementing illnesses.

## 13. RIDER CHARGES.

The monthly rider charges and monthly Optional Inflation Protection charges, if applicable, for the CCBR and the EOBR, if applicable, will be deducted each month from the cash value of the policy to which they are attached. These charges are shown in the table attached to this Outline of Coverage, and will also be shown on the policy schedule of the issued policy.

## 14. ADDITIONAL FEATURES.

### Nonforfeiture

The Guaranteed Benefit provision in the CCBR provides for a limited amount of paid-up long-term care insurance if the policy and CCBR lapse after having been in force for at least 3 years, subject to the terms and conditions of the Guaranteed Benefit provision. There is no additional charge for this benefit.

If you purchase the EOBR, you have the option to also purchase a Nonforfeiture Benefit Rider for an additional charge (shown in the attached table, if applicable). The Nonforfeiture Benefit Rider provides for a limited amount of paid-up long-term care insurance if the policy and EOBR lapse after having been in force for at least 3 years, subject to the terms and conditions of the rider. Benefits under the Nonforfeiture Benefit Rider become effective after all benefits available under the CCBR and under the EOBR have been paid.

### Medical Underwriting

The issuance of these riders is subject to medical underwriting.

## 15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE LINCOLN NATIONAL LIFE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING THE CONVALESCENT CARE BENEFITS RIDER OR EXTENSION OF BENEFITS RIDER DESCRIBED IN THIS OUTLINE.

**The New Jersey State Health Insurance Assistance Program (SHIP) is available to provide counseling to seniors interested in purchasing long-term care insurance. SHIP is a statewide program sponsored by the New Jersey Department of Health and Senior Services. You may contact SHIP at:**

**1-800-792-8820**

## OUTLINE OF COVERAGE
## 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** | | CCBR Monthly Inflation Charge: | $ _____ |
| | | EOBR Monthly Inflation Charge: | $ _____ |
| Option: _____________________ | | | |
| **Nonforfeiture Benefit Rider** | | Monthly Rider Charge: | $ _____ |

**TOTAL ANNUAL RIDER CHARGES: $ __________**

# *Long-Term Care Insurance Personal Worksheet*

The Lincoln National Life Insurance Company
Service Office:
One Granite Place
PO Box 515
Concord, NH 03302-0515

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

**Premium Information:**

Policy and Rider Form Numbers:
LN870 – Flexible Premium Adjustable Life Insurance Policy
LR870 – Convalescent Care Benefits Rider
LR871 – Extension of Benefits Rider

The premium for this policy is: (check one)
☐ A one-time Single Premium of $__________; or
☐ A Flexible Premium: Initial premium of $__________then $_______________ per year

**Type of Rider**
Non-cancelable

**The Company's Right to Increase Extension of Benefits Rider Charge:**
The Company cannot raise the rates for the Extension of Benefits Rider.

**Rate Increase History:**
Lincoln has sold long-term care insurance since 1992 and has sold linked benefit policies combining long-term care insurance riders with life insurance policies or annuity contracts since 1992. Lincoln has not raised its long-term care insurance rider rates for this linked benefit policy form or similar policy forms it has sold in this state or in any other state in the last 10 years.

**Questions Related to Your Income**

How will you pay for this policy?
☐ Income ☐ Savings and/or Investments ☐ Family Member ☐ Other_______________

What is your annual income?
☐ Under $10,000 ☐ $10-$20,000 ☐ $20-$30,000 ☐ $30-$50,000 ☐ Over $50,000

How do you expect your income to change over the next 10 years?
☐ No change ☐ Increase ☐ Decrease

*If you will be paying the premium with money received only from your own income, for annual premium policies a rule of thumb is that you may not be able to afford this policy if the premium is more than 7% of your income.*

Will you buy inflation protection?
☐ Yes ☐ No
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
☐ Income ☐ Savings and/or Investments ☐ Family Member Other_______________
*In 2007, the national average annual cost of care (semi-private room in a nursing home) was $66,065. In ten years, the national average annual cost will be approximately $107,685.95 if costs increase 5% annually.*

*(Source: www.longtermcare.gov – U.S. Department of Health and Human Services National Clearinghouse for Long-Term Care Information, March 2008)*

What elimination period are you considering?
Number of days _____ Approximate cost $______ for that period of care

How are you planning to pay for your care during the elimination period?
☐ Income ☐ Savings and/or Investments ☐ Family Member ☐ Not applicable

**Questions Related to Your Savings and Investments**

Not counting your home, automobiles and personal property, what is the approximate value of all of your assets (savings and investments)?
☐ Under $50,000 ☐ $50-$100,000 ☐ $100-$150,000 ☐ Over $150,000

How do you expect your assets to change over the next 10 years?
☐ No change ☐ Increase ☐ Decrease
*If you are buying this policy to protect your assets and your assets are less than $50,000, you may wish to consider other options for financing your long-term care.*

**Disclosure Statement**

*In order for us to complete the processing of your application, please check one of the boxes below, sign, and return form to The Lincoln National Life Insurance Company along with the application. The Company may contact you to verify your answers.*

☐ The answers to the questions above describe my financial situation.

☐ I choose not to complete this information.

I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the monthly rider charges, long-term care rider charge increase history and potential for long-term care rider charge increases in the future. I understand the above disclosures.

---

*Signature of Applicant* *Date*

**Agent's Statement**

I have explained to the Applicant the importance of completing this information.

---

*Signature of Agent* *Date*

Agent's Printed Name:

______________________________________________________________

If applicable, please check box and sign below.

☐ My agent has advised me that this policy does not seem to be suitable for me. However, I still want the Company to consider my application.

---

*Signature of Applicant* *Date*

# Lincoln *MoneyGuard*® Reserve Plus

## 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 Plus client:

Preparing 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 and annuity 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 Plus.



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



Products issued by:
The Lincoln National Life Insurance Company

# Preinterview worksheet

### Important numbers

| Your Social Security number |
|---|
| |

### Additional owner information

If you are not the owner of this policy, please provide the following information for the owner:

| Owner's name | Owner DOB |
|---|---|
| | |
| Relationship to insured | SSN or TIN |
| | |

### Existing life insurance information

Please list every life insurance policy and annuity you currently have in-force AND any life insurance you've applied for that has not yet been issued. Use a separate sheet 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)

Use a separate sheet of paper if there is not enough room in the space provided.

| | Primary beneficiary (1) | Primary beneficiary (2) | Contingent beneficiary |
|---|---|---|---|
| Name | | | |
| SSN/TIN | | | |
| Relationship | | | |
| Trust name | | | |
| Trustee name | | | |
| Date of trust | | | |

## Medications

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

| Prescription name | Dosage and frequency | Reason for usage |
|---|---|---|
| 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. 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

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

| | | | | | |
|---|---|---|---|---|---|
| Breast cancer | Age of diagnosis | Size of tumor | Stage | Lymph node involvement | Type of treatment |
| Prostate cancer | Age of diagnosis and Pretreatment PSA | Gleason score | Stage | Type of treatment | Posttreatment PSA |
| Colon cancer | Age of diagnosis | Dukes staging | Lymph node involvement | Type of treatment | |
| Diabetes | Age of diagnosis | Fasting blood glucose | Blood HgA1C | Type of treatment | |
| Coronary heart disease | Age of diagnosis | Bypass surgery<br>☐ Yes ☐ No<br>If yes, how many vessels? | Angioplasty with or without stent<br>☐ Yes ☐ No | Heart attack<br>☐ Yes ☐ No | Last stress test and results |

Hello future.®

| |
|---|
| 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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**Order code: MGR-PHI-BRC002**

Lincoln
Financial Group℠

Lincoln *MoneyGuard*® Reserve Plus universal life insurance policies are issued by The Lincoln National Life Insurance Company, Fort Wayne, IN, on Policy Form LN870 with the Convalescent Care Benefits Rider (CCBR) on Rider Form.

**All guarantees and benefits of the insurance policy are backed by the claims-paying ability of the issuing insurance company**. They are not backed by the broker/dealer and/or insurance agency selling the policy, or any affiliates of those entities other than the issuing company affiliates, and none makes any representations or guarantees regarding the claims-paying ability of the issuer.

The insurance policy and riders have limitations, exclusions, and/or reductions.

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

Not approved for use in New York. Check state availability.