Lincoln Financial Group®
Lincoln Life

PART III OF APPLICATION FOR INSURANCE

The Lincoln National Life Insurance Company
Administrative Office:
350 Church Street – MMG1
Hartford, CT 06103-1106
(800) 238-6252

Proposed Insured's answers must be recorded by Medical Examiner with no one else present.

PROPOSED INSURED ______________________________ (First Name, Middle Initial, Last Name) Birth Date: __________ (Month, Day, Year)

Question	Yes	No
1. During the past 10 years, has the Proposed Insured:		
a. Had or been advised to have an electrocardiogram, xray, diagnostic test, laboratory test or surgical operation?	☐	☐
b. Had treatment in a clinic, hospital or other medical facility?	☐	☐
c. Received advice or treatment for the use of alcohol or drugs, or been a member of AA?	☐	☐
2. Has the Proposed Insured had, been told they have, been diagnosed or treated by a physician or taken medication for:		
a. Dizziness, syncope, vertigo, seizures, epilepsy, falls, or any disease or disorder of the brain or nervous system?	☐	☐
b. Depression, anxiety, psychosis, mental or nervous disorder or consulted a psychiatrist or psychologist?	☐	☐
c. Chest pain, angina, heart attack, coronary artery disease, heart surgery, congestive heart failure, heart murmur, palpitation, atrial fibrillation, or any other disease or disorder of the heart or circulatory system?	☐	☐
d. High blood pressure, stroke, TIA (transient ischemic attack), peripheral vascular disease, aneurysm, disease or disorder of the blood or arteries?	☐	☐
e. Parkinson's disease, tremor, multiple sclerosis, Alzheimer's disease, dementia, memory loss?	☐	☐
f. Diabetes, disease or disorder of the thyroid, pancreas, or other endocrine glands?	☐	☐
g. Cancer, tumor, polyp, cyst, lymphoma, leukemia, or other malignant disorder?	☐	☐
h. Asthma, emphysema, bronchitis, sleep apnea, or other disease or disorder of the lung or respiratory system?	☐	☐
i. Disease of the kidney, bladder, prostate, breast, or reproductive organs, urine abnormality or sexually transmitted disease?	☐	☐
j. Cirrhosis of the liver, ulcerative colitis, Crohns disease, hepatitis or other disease or disorder of the stomach, liver, colon, rectum or intestines?	☐	☐
k. Arthritis, osteoporosis, paralysis or disease or disorder of the muscles, bones, joints or connective tissue?	☐	☐
l. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any other immunological disorder, or tested positive for the HIV virus?	☐	☐
m. Any disease or disorder of the eyes, ears, nose, throat, skin or lymph glands?	☐	☐
3. Has the Proposed Insured within the past 5 years been consulted, examined, or treated by any physician or practitioner for reasons not stated above?	☐	☐
4. Is the Proposed Insured currently taking any medications? (If yes, please list them and prescribed doses.)	☐	☐
5. Has the Proposed Insured smoked cigarettes in the past 12 months?	☐	☐
6. Family History: Diabetes, cancer, high blood pressure, heart disease, mental illness, or suicide?	☐	☐

	Age if Living?	Cause of Death?	Age at Death?
Father			
Mother			
Brothers & Sisters			

DETAILS of "Yes" answers. **(IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS:** Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

7. a. Name and address of the Proposed Insured's physician? ______________________________

b. Date and reason last consulted? ______________________________

c. What treatment was given or medication prescribed? ______________________________

Any person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer, as determined by a court of competent jurisdiction, is guilty of a crime.

I hereby declare that the statements and answers to the above questions are complete and true to the best of my knowledge and belief. I agree that a copy of this Part III shall be attached to and form a part of any policy issued.

Dated at: ______________________________ (City, State) On: ______________________ (Month, Day, Year)

Witness: ______________________________, M.D. ______________________________
Signature of Proposed Insured or Parent or Guardian if a Juvenile

MEDICAL EXAMINER'S REPORT

8. a. Height (in shoes)	Weight (clothed)	Males Only:			Details of "Yes" Answers (Identify Item)
		Chest (full inspiration)	Chest (forced expiration)	Abdomen, at umbilicus	
ft. in.	lbs.	in.	in.	in.	

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

c. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

9. Blood Pressure (if above 140/90 please take additional readings.)

Systolic			
Diastolic { 4th phase			
Diastolic { 5th phase			

10. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

11. Heart: Is there any:

Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No

Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No

(Describe below – if more than one, describe separately)

Location	Murmur 1.	Murmur 2.
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:		
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

Indicate: MCL

Apex by X

Murmur area by O

Point of greatest intensity by O

Transmission by ➧

For comments, your impression and diagnosis?

12. Is there on examinations any abnormality of the following: (Circle applicable items and give details.)

		Yes	No
	a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
	b. Skin (incl. scars); lymph nodes; veins or peripheral arteries?	☐	☐
	c. Nervous system (include reflexes, gait, paralysis)?	☐	☐
	d. Respiratory system?	☐	☐
	e. Abdomen (include scars)?	☐	☐
	f. Genitalia (males only)?	☐	☐
	g. Endocrine system (include thyroid and breasts)?	☐	☐
	h. Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
13.	a. Are there any hernias?	☐	☐
	b. Any hemorrhoids?	☐	☐
14.	Are you aware of additional medical history: Signs, symptoms or laboratory findings? (A confidential report may be sent to the Medical Director)	☐	☐
15.	a. Are you related to Applicant?	☐	☐
	b. Are you associated with the Applicant in any business or financial venture?	☐	☐
16.	Have you any reason to believe the Proposed Insured smokes cigarettes?	☐	☐
17.	Have you any reason to believe that he uses or has used alcoholic beverages or drugs to excess?	☐	☐

18. Mail urine specimen in the provided container.

a.

Specific Gravity	Albumin	Sugar

b. I am satisfied that the specimen voided at _____ A.M. or _____ P.M. is authentic.

c. MAIL SPECIMEN IF:

(1) There are any abnormalities in specimen examined.

(2) There is a family history of diabetes or a personal history of G.U. disease or urinary abnormalities.

(3) The blood pressure exceeds 140/90.

(4) The AMOUNT APPLIED for exceeds $100,000.

d. Are you forwarding a specimen?

☐ Yes ☐ No

PLEASE PRINT

Dated at ______________________ (City) ______________ (State) on ______________, 20_____ Medical Examiner ______________________

Name of Agent ______________________ Examiner's P.O. Address ______________________

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SUPPLEMENTAL APPLICATION FOR INSURANCE

Proposed Insured #1 ______________________ Date of Birth __________ Proposed Insured #2 (Second-to-Die only) ______________________ Date of Birth __________

Application Questions (provide details to yes answers below)	Proposed Insured #1		Proposed Insured #2	
	Yes	No	Yes	No
1. Does any Proposed Insured have any impairment, whether mental or physical, for which any Proposed Insured needs or receives assistance or supervision in performing every day living activities such as bathing, dressing, eating, transferring or locomotion, toileting, or bowel and bladder control?	☐	☐	☐	☐
2. Does any Proposed Insured use a wheelchair, walker or cane, oxygen, catheter, dialysis machine, or other mechanical device?	☐	☐	☐	☐
3. Has any Proposed Insured received a medical diagnosis within the past 5 years under which any Proposed Insured was advised to have any medical treatment or surgical operation which has not yet been performed?	☐	☐	☐	☐
4. During the past 5 years, has any Proposed Insured been confined to a hospital, a nursing home or an assisted living facility or has such confinement or residence been recommended?	☐	☐	☐	☐
5. Is any Proposed Insured currently confined to a hospital or nursing home or residing in an assisted living facility?	☐	☐	☐	☐
6. Is any Proposed Insured currently receiving adult day care or home health care or has such care been recommended or received by any Proposed Insured during the past 5 years?	☐	☐	☐	☐
7. Has any Proposed Insured ever been rejected or rated for nursing care or home health care coverage?	☐	☐	☐	☐

Proposed Insured	Question No.	Date	Details

Notice

The long-term care rider being applied for with this application is an approved long-term care insurance rider under California law and regulations. However, the benefits payable under this rider will not qualify for Medi-Cal asset protection under the California Partnership for Long-Term Care.

For information about policies and certificates qualifying under the California Partnership for Long-Term Care, call the Health Insurance Counseling and Advocacy Program at the Toll-Free Number: 1-800-434-0222.

I understand that any person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer, as determined by a court of competent jurisdiction, is guilty of a crime.

Caution: If your answers on this Supplemental Application are incorrect or untrue, the Company may have the right to deny benefits or rescind your policy.

I hereby declare that the statement and answers to the above questions are complete and true to the best of my knowledge and belief. I agree that a copy of this Supplemental Application shall be attached to and form a part of any policy issued.

Dated at: ______________________ (City) ______________________ (State) On: __________ (Month) __________ (Day), __________ (Year)

Witness: ______________________ ______________________ Signature of Proposed Insured #1

Witness: ______________________ ______________________ Signature of Proposed Insured #2, if applicable

Lincoln
Financial Group®

Notice and Consent Form for AIDS Virus (HIV) Antibody/Antigen Testing

Also administrative agent for:
CIGNA Life Insurance Company
Connecticut General Life Insurance Company
Aetna Life Insurance Company
ING Life Insurance and Annuity Company

So that we may evaluate your eligibility for insurance, it is requested that you consent to be tested to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV). By dating and signing this form, you agree that these tests may be performed and that the test results will be used in making our underwriting decision. This form also provides information about the test and other important information which we urge you to read.

Information About AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system caused by the Human Immunodeficiency Virus (HIV). In some individuals, the virus reduces the body's normal defense mechanisms against certain diseases or infections. As a result, such individuals often develop unusual conditions such as severe pneumonia or a rare skin cancer. The symptoms of AIDS may include the following, although other causes of these symptoms are more likely: unexplained weight loss; persistent night sweats, cough, shortness of breath, diarrhea and white spots evidencing fungal infection; fever and swollen lymph nodes lasting more than one month; and raised purple spots on or under the skin or on the mucous membranes.

HIV Antibody Test

The HIV antibody test is actually a series of* tests performed by a medically accepted procedure. It is not a test for AIDS. The purpose of the tests is to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. These tests have a high degree of accuracy. Test results are not 100% accurate, however. It is possible to have a false positive or a false negative.

False positives: The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behaviors.

False negatives: The test gives a negative result, even though you are infected with HIV. This is most likely to happen in recently infected individuals. It takes at least 4 to 12 weeks for a positive test result to develop after an individual is infected, and could take as long as 6 to 12 months.

Meaning of Test Results

Positive test results: While positive test results do not necessarily mean you have AIDS, they do mean that you are at increased risk of developing AIDS or AIDS related conditions. It is generally agreed by the medical community that an individual infected with the HIV virus is infected for life.

A positive test result will adversely affect your application for life insurance. This means your application will be declined.

Negative test results: A negative test result means that the presence of antibodies or antigens to the HIV virus was not detected.

Voluntary and Anonymous Testing

Taking an HIV antibody test is voluntary. You have the right to decide not to be tested. If you decide not to be tested, you do not have to sign this form. However, if you elect not to be tested, we will be unable to further process your application for insurance. You also have the right to anonymous testing in which your name is not known to those performing the test. Anonymous testing is available at several locations. These locations can be obtained from your local health department.

Disclosure of Test Results

All test results will be treated confidentially. The results of the test will be reported to the insurer identified on this form. The results may also be reported to its affiliates, reinsurers, medical personnel, laboratories, and insurance support organizations in connection with insurance for which you have applied. In addition, if your HIV antibody test is positive or indeterminate, a code for non-specific test abnormality may be submitted to the Medical Information Bureau. No other disclosure will be made, except as may be required by law or as authorized by you.

If you own a Connecticut General Life Insurance Company (CG) or CIGNA Life Insurance Company (CLIC) contract, CG or CLIC remains the insurer and is responsible for payment of all benefits. The address and phone number for CG and CLIC are: 900 Cottage Grove Road, Routing S153, Hartford, CT 06152-2153, 860-726-6000.

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.
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If your HIV test results are known, it may help your doctor determine the medical care you need. Please indicate below the name and address of the physician to whom we may send test results if they prove to be abnormal:

Name ____________________

Address ____________________

City, State, ZIP ____________________

Behavioral Patterns that Place a Person at Risk for HIV

The AIDS virus is spread by sexual contact with an infected person, by exposure to infected blood such as through needle sharing during intravenous drug use, or as a result of a transfusion of blood or its components (but this is rare), or from an infected mother to her newborn infant.

Prevention

Individuals who have a history of high risk behavior should seriously consider changing their behavioral patterns to prevent getting or transmitting AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices and not sharing needles. If you test positive, you may also want to consider other changes in your life, such as whether to have children.

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure of the test results as described above.

Date ____________________

Proposed insured or signature of
proposed insured or parent/guardian ____________________

Lincoln Financial Group®
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Authorization for Release of Health-Related Information
to The Lincoln National Life Insurance Company
This authorization complies with the HIPAA Privacy Rule

______________________________________ ______________
Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The Lincoln National Life Insurance Company ("the Company") and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this Authorization so that the Company may: 1) underwrite my application for coverage by making eligibility, risk rating, policy/certificate issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at 350 Church Street – MIN-2, Hartford, CT 06102-5048, Attention: Privacy Official. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy/certificate or to contest the policy/certificate itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

____
Signature of Proposed Insured/Patient or Personal Representative Date

____
Description of Personal Representative's Authority or Relationship to Proposed Insured/Patient