

Please check appropriate underwriting company:

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

MEDICAL SUPPLEMENT

(Part II of Application)

Proposed Insured _____ Date of Birth (mm/dd/yy) _____

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

| Name | Address | Phone |
|------|---------|-------|
| | | |
| | | |

| Name | Address | Phone |
|------|---------|-------|
| | | |

a) Date and reason of last visit: _____

b) Tests performed & treatment received: _____

(If you answer "Yes" to any of the following questions, please give details in space provided in #11.)

- | | | Yes | No |
|--|--------------------------|--------------------------|--------------------------|
| 2. Height _____ ft./_____ in. Weight _____ lbs. | | | |
| a) Has your weight changed by more than 10 pounds during the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) If "Yes", by how many pounds? _____ Gain _____ Loss _____ | | | |
| 3. Have you had or been advised to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test (excluding HIV tests) or are you now planning to seek medical advice or treatment for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised to have any hospitalization or surgery which has not been completed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had any indication of, or been treated for: | | | |
| a) Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Any tumor, cancer, cysts, melanoma or lymphoma? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Allergies, anemia, leukemia, disorder of the lymph glands, clotting disorder or any other blood disorder (excluding HIV tests and studies)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Asthma, emphysema, shortness of breath, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k) Any disorder of the eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l) Any mental or physical disorder or medically or surgically treated condition not listed above? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been diagnosed by or received treatment from a medical professional for Acquired Immunodeficiency Syndrome (AIDS)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use alcoholic beverages? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>(If "Yes" provide type, frequency & amount.)</i> Type _____ Frequency _____ Amount _____ | | | |
| 8. Have you ever been treated for drug or alcohol abuse or been advised by your doctor to limit your use of alcohol or any medication, prescribed or not? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

Type: Cigarettes Cigar Pipe Chew Tobacco Snuff Nicotine Patches/ Gum

| | | | | | |
|-------------------------------|--|--|--|--|--|
| Date First Used: (month/year) | | | | | |
| Date Last Used: (month/year) | | | | | |
| Amount and Frequency: | | | | | |

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

12. Details: (List details from "Yes" answered questions above; please include question number.)

| 13. | Age if Living & Health Status | Diabetes, Cancer, Heart Disease? (include age of onset) | Age at Death & Cause |
|---------------|-------------------------------|--|----------------------|
| a. Father | | | |
| b. Mother | | | |
| c. Sibling(s) | | | |
| | | | |
| | | | |

COMPLETE QUESTIONS 14-18 IF PROPOSED INSURED IS AGE 70 OR OLDER. IF NOT, PROCEED TO SIGNATURE SECTION ON NEXT PAGE.

14. Point to three objects and ask the Proposed Insured to tell you what they are and indicate that you are going to ask them to recall these later. Record the 3 objects (i.e., pencil, chair, clock).

15. Does the Proposed Insured:

| | Yes | No |
|---|--------------------------|--------------------------|
| a) Use any assistive devices for walking such as a wheelchair, walker, or cane, or have difficulty ambulating? (If "Yes", provide details.) | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Drive? (If "No", when and why did they stop?) | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Have a history of falls in the past year? (If "Yes", how many and provide details.) | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Exercise? (If "Yes", what type and how often?) | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Need any assistance with the following activities: (If "Yes", provide details.) | | |
| Bathing | <input type="checkbox"/> | <input type="checkbox"/> |
| Dressing | <input type="checkbox"/> | <input type="checkbox"/> |
| House Cleaning | <input type="checkbox"/> | <input type="checkbox"/> |
| Handling Finances | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking Medication | <input type="checkbox"/> | <input type="checkbox"/> |

16. Ask the Proposed Insured today's date including the year, day of week, month and day of the month. Record his/her response.

17. Ask the Proposed Insured to recall the three objects identified earlier. Record his/her response.

18. In the space below this question, ask the Proposed Insured to draw a clock face, mark the hours and draw the hands to show the time 11:10.

I certify that I made this examination at _____ o'clock AM. P.M. on the _____ day of _____, _____

Signature of Examiner

Designation

Each of the Undersigned declares that:

I have read or have had read to me the completed Medical Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete and true. I agree that this Medical Supplement constitutes a part of the application for insurance. I understand that any false statements or material misrepresentations may result in the loss of coverage under the policy.

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

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

Signature of Examiner

Printed Name of Examiner

MEDICAL EXAMINER'S REPORT

| | | | | | | |
|--|---|---|---|---|--------------------------|--------------------------|
| 19a. Height <i>(In Shoes)</i> _____ ft. / _____ in. | b. Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No | c. Weight <i>(Clothed)</i> _____ lbs. | d. Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| d. Any change in weight in the past year? <i>(If "Yes", provide amount, if gain or loss.)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No Amount _____ <input type="checkbox"/> Gain <input type="checkbox"/> Loss | | | | | | |
| 20. BLOOD PRESSURE <i>(If above 140/90, report additional readings below):</i> | | 21. PULSE | At Rest | After Exercise | 3 Min. Later | |
| Systolic | | Rate | | | | |
| Diastolic | | Irregularities per minute | | | | |
| 22. HEART Is there any: Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No Edema <input type="checkbox"/> Yes <input type="checkbox"/> No Dyspnea <input type="checkbox"/> Yes <input type="checkbox"/> No Murmur(s) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If more than one murmur describe each separately.)</i> | | | | | | |
| <input type="checkbox"/> Constant | | <input type="checkbox"/> Intermittent | | <input type="checkbox"/> Transmitted | | |
| <input type="checkbox"/> Localized | | <input type="checkbox"/> Systolic | | <input type="checkbox"/> Presystolic | | |
| <input type="checkbox"/> Diastolic | | <input type="checkbox"/> Soft (Gr. 1-2) | | <input type="checkbox"/> Mod. (Gr. 3-4) | | |
| <input type="checkbox"/> Loud (Gr. 5-6) | | Location: | | | | |
| Transmission: | | | | | | |
| 23. Is there any abnormality of the following: <i>(Circle Applicable items and give details. If more room is needed, provide details in Examiner's Confidential Opinion.)</i> | | | | | | |
| a. Eyes, ears, nose, mouth or pharynx? <i>(If vision or hearing is markedly impaired, indicate degree and correction.)</i> | | | | | Yes | No |
| b. Skin; lymph nodes; veins or peripheral arteries? <i>(include scars)</i> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Peripheral arteries or pulses? | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Nervous system? <i>(include reflexes, gait, paralysis)</i> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Respiratory system? | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Abdomen? <i>(include scars)</i> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Endocrine system? <i>(include thyroid)</i> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Musculoskeletal system? <i>(include spine, joints, amputations, muscle strength)</i> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Mental status? | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Is there any use of adaptive devices? <i>(cane, walker, wheelchair)</i> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Is appearance unhealthy or older than stated age? | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are you aware of additional medical history; signs, symptoms or laboratory findings? <i>(A confidential report may be sent to the Medical Director.)</i> | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Are you related to the Applicant? | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Are you associated with the Applicant in any business or financial ventures? | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you any reason to believe that the Applicant uses or has used alcoholic beverages or drugs to excess? | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. If you do any of the following, please indicate: | | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| Sent to Lab: <input type="checkbox"/> Blood Profile <input type="checkbox"/> Urine Specimen | | To Field Office: <input type="checkbox"/> Chest X-Ray <input type="checkbox"/> EKG | | <input type="checkbox"/> Other _____ | | |
| 29. EXAMINER'S CONFIDENTIAL OPINION: | | | | | | |
| URINALYSIS: ALWAYS SEND A URINE SPECIMEN AND BLOOD SAMPLE (IF APPLICABLE) TO APPROPRIATE LAB. | | | | | | |
| Medical Examiner <i>(Please Print)</i> | | | Examination Company P.O. Address | | Examiner # | |
| Name of Agent <i>(Please Print)</i> | | | Dated at <i>(City and State)</i> | | Date | |

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.

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continued on back

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.

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 _____

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.

**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