

LIFE CONVERSION CHECKLIST

Use the checklist below to guide you through the Life Conversion Quote and Application process:

REQUEST FOR QUOTE - SECTION A. EMPLOYER / GROUP ADMINISTRATOR:

- Please note, the Employee must apply for Life Conversion within 31 days from the date of their loss of coverage. You must notify the Employee of their Conversion rights immediately following their loss of coverage. If their application is received after 31 days, Life Conversion coverage may be denied.
- Complete Section A, sign and date the Request for Quote form to confirm member eligibility information.
- Forward the completed form and this checklist to the Employee immediately following their loss of coverage.
- Once you've confirmed all information in Section A, The Lincoln National Life Insurance Company will work directly with the Employee / Proposed Insured regarding their Life Conversion application process.

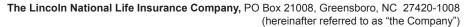
REQUEST FOR QUOTE - SECTION B. EMPLOYEE:

- Please note, you have 31 days from the date of your loss of coverage to apply for an Individual Life Conversion Policy. If your application is received in our office after 31 days, Life Conversion may be denied. No policy will be issued and no benefit will be payable until all information, including premium is received.
- Call 1-800-423-2765 or email your Request for Quote form to <u>ClientServices@LFG.com</u> to receive an Individual Life Insurance Conversion Quote - you are converting from a Group Policy to an Individual Policy and premiums are subject to change.
- If you choose to accept the Life Conversion quote for Individual Life Insurance, you will be sent a copy of the quoted illustration for your review and an application to sign and return with your initial payment of the insurance premium.
- Once you have received these items, please continue on to the following instructions to complete the application process.

APPLICATION FOR CONVERSION OF GROUP LIFE INSURANCE – SECTION A. EMPLOYEE / MEMBER:

•	complete the application process, the following items must be returned to The Lincoln National Life Insurance impany. These items must be returned within 31 days from the date of your loss of coverage. No policy will be issued do no benefit will be payable until all information, including premium is received.
	Request for Quote Form
	Application for Conversion of Group Life Insurance for each Proposed Insured (Employee, Spouse and Children)
	☐ Life Insurance Illustration – you will need to sign the Signature Page of the Illustration for each Proposed Insured (Employee, Spouse and Children)
	☐ Electronic Funds Transfer (EFT) Authorization (if electing to pay Monthly)
	Payment for the Initial Premium – based upon the quoted premium in the Life Insurance Illustration.
	Mail to:
	The Lincoln National Life Insurance Company
	P O Box 0821
	Carol Stream, IL 60132-0821

Please allow approximately 60 days to finalize issuance of your Individual Life Conversion Policy. If you should need
any assistance in the meantime, please contact our Client Services Department at 1-800-423-2765.



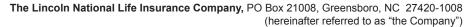


Please call 800-423-2765 for a quote or email this form to <u>ClientServices@LFG.com</u>.

Mail this completed form and premium payment to: The Lincoln National Life Insurance Company PO Box 0821, Carol Stream, IL 60132-0821

REQUEST FOR QUOTE - LINCOLN GROUP CONVERSION

			RATOR: Please note, the the date their Loss of C			omplete	the Requ	est for Quote	/Application
Group Policy Name				Group				y Number	
Covered Em	ployee / Member Infori	natio	on:	'					
2. Name (First, MI, Last)					3. Date of Birth (mm/dd/yy)				
4. Date of H	ire or Enrollment		5. Date Employee Insura	erminated	6. Date Employment Terminated				
7. Amount o Amount \$	f Lost Coverage:		8. Date Employee Last Worked:						
9. Reason for of Coverage	r Loss Retirement		isabled Employment ain:	Termin	ated \square Po	licy Term	nination	□ Age Reduc	tion
Covered Spo	ouse Information:								
10. Amount o	f Lost Coverage for Spo	use §	\$						
Covered Dep	pendent Information:								
11. Amount o	of Lost Coverage for Dep	ende	nt \$		-				
I, the Admini	strator of the Group Polic	y, de	clare that the information p	rovide	d above is co	mplete ar	d true to tl	ne best of my l	knowledge.
Administrator Name (Please Print)					Administrator Phone Number (include area co			lude area code)	
Administrato	r Email Address								
Signature of	Employer / Group Adr	ninis	strator	-		Date	:		
your Em payable this form Conversi	iployment/Membership until all information, ir n available when callin	tern iclud ig) of sent	ote, you must complete to ninated or you had a los ling premium is received r email us at <u>ClientServ</u> a proposal document an	s of co l. Pleas vices@	overage. No se call 800-4 LFG.com.	policy w 123-2765 If you an	ill be issu for a Life re interes	ed and no be Conversion ted in the pr	nefit will be quote (have oposed Life
Proposed In	sured Information:								
Employee Name				E	Employee SSN			Employee Cigarette Use ☐ Yes ☐ No	
Employee Ac	ldress								
	First Name	M.I.	Last Name		SSN		Gender	Birth Date	Cigarette Use
SPOUSE:							□М□Г		☐ Yes ☐ No
CHILDREN:							□М□Г		□ Yes □ No
							\Box M \Box F		□Yes □ No
							□М□Г		☐ Yes ☐ No





Mail to:

The Lincoln National Life Insurance Company PO Box 0821, Carol Stream, IL 60132-0821

APPLICATION FOR CONVERSION OF GROUP LIFE INSURANCE

A ABBLICANTE PROPORTED INCLINED DI	11 000 402 2765 S	· · · · · · · · · · · · · · · · · · ·	2 / 1/ /				
A. APPLICANT/PROPOSED INSURED: Please call 800-423-2765 for a Life Conversion Quote. You must complete the Application for Conversion within 31 days from the date your group insurance terminated. Please note, eligibility will NOT be confirmed until the completed and signed application is received by the Company.							
1. a. Group Policy Name	b. Group ID	c. Group	p Policy Number				
Proposed Insured Information:		•					
2. Name (First, MI, Last)							
Date of Birth (mm/dd/yy) 4. Social Security Number							
5. Address (Street, City, State, ZIP)							
6. Phone Number (include area code)	7. □ M □ Fe	Tale emale					
8. Has the Proposed Insured become eligible for any other Group Insurance since the date the life insurance terminated? □ Yes □ No If "Yes," for how much?							
Coverage Information: (As available per product. After calling for a quote, you will receive an illustration that will assist you with completing these questions.)							
9. Plan of Insurance							
10. Amount of Insurance (Specified Amount, if UL or VUL))\$						
11. Have you smoked any cigarettes in the past 12 month							
12. Premium Mode (check one) a. □ Annual b. □ Semi-Annual c. □ Quarterly d. □ Monthly (Bank draft required for this option, please complete the attached EFT form.)							
13. a. Death Benefit Option Level (Not available with all products, see product specifications for details)							
 b. Death Benefit Qualification Test (DBQT) - For IRS purposes, premiums will be tested using: □ GPT □ CVAT The DBQT cannot be changed after issue unless the terms of the policy require a change. 							
14. Additional Benefits and Riders (<i>If applicable</i>): ☐ Accelerated Benefit Rider ☐ Other Benefits and Riders (<i>not listed above</i>). (Please provide full details: e.g. coverage amounts/percentages/etc.):							
Beneficiary Information: (If naming more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.)							
15. Primary Beneficiary Name	a. Relationship		b. Social Security Number				
16. Contingent Beneficiary Name	a. Relationship		b. Social Security Number				
Proposed Owner Information: (Complete this Section i	f the Proposed Insured is	not the Owner.)					
17. Full Name of Owner		18. Relationship	to Proposed Insured				
19. Address of Owner (Street, City, State, ZIP) 20. Owner SSN or TIN							

B. SUITABILITY (Complete only if applying for Variable Life In	
1. Have you, the Proposed Insured(s) and the Owner, if other than Prospectus for the policy applied for and have you had sufficien	nt time to review it? $\square Y \square N$
2. Do you understand that the amount and duration of the death be investment performance of funds in the Separate Account?	enefit may increase or decrease depending on the $\hfill\Box Y\hfill\Box N$
3. Do you understand that the cash values may increase or decrease funds held in the Separate Account?	se depending on the investment performance of the \Box Y \Box N
4. With this in mind, do you believe that the policy applied for is i anticipated financial needs?	in accord with your insurance objective and your $\Box \ Y \ \Box \ N$
CASH VALUES MAY INCREASE OR DECREASE IN ACCO ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE O	
SERVICE OFFICE ENDORSEMENTS (For Company Use	
AGREEMENT AND ACKNOWLEDGEMENT	
I, the Owner, certify my TIN or SSN as provided by me is correct. I	also certify that I am not subject to backup withholding.
Each of the Undersigned declares that:	
1. This Application consists of: a) Application for Conversion of Grothereto; and d) any supplements, all of which are required by the Co	
$2. \ \ No agent, broker or medical examiner has the authority to make or modition and and and are the support of the support o$	
the contract I will review the answers recorded on the application	ded, and are full, complete and true. I confirm that upon receipt of n. I will notify the Company immediately if any information in the on are incorrect or untrue, the Company may have the right to deny
4. I agree that with the acceptance of any policy issued on the life of	of the Proposed Insured, all rights under the Group Policy for such
person are relinquished.	. h., 4h., C.,
 Corrections, additions or changes to this application may be made Office Endorsements". Acceptance of a policy issued with such be made in classification (including age at issue), plan, amount, o 	changes will constitute acceptance of the changes. No change will
STATE DISCLOSURE AND SIGNATURE	
Any person who, with intent to defraud or knowing that he/she is fa claim containing a false or deceptive statement is guilty of insurance	
To the best of my knowledge and belief, the answers given above are	
will be attached to the policy when issued, will be a part of the policy	
Insured, all rights under the Group Policy for such person are relinquent	uished; and (c) only an officer of the Company can make or alter a
contract of insurance or bind the Company in any way.	
WHEN INSURANCE TAKES EFFECT. The Insurance applied for month following the termination of the group coverage if the first pr Proposed Insured. Upon timely receipt by the Company of the conv the Owner(s) and/or any beneficiaries either under the group policy of	remium is paid during the conversion period and the lifetime of the ersion application and first premium, coverage will be available to
Signed in, this	day of
(state)	(month) (year)
Signature of Proposed Insured	Signature of Owner
(Parent or Guardian if under 15 years of age)	(If other than the Proposed Insured)
Signature of Licensed Agent, Broker or Registered Rep.	Printed Name of Licensed Agent, Broker or Registered Rep.
APPLICABLE TO VARIABLE LIFE ONLY: I have reviewed the and find the transaction suitable.	Application, Supplements, New Account Form and allocation forms
Signature of Registered Principal or Broker/Dealer	Printed Name of Registered Principal or Broker/Dealer

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