

#### 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.

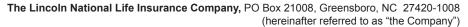
### **REQUEST FOR QUOTE - SECTION B. EMPLOYEE:**

- 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:

•	To complete the application process, the following items must be returned to The Lincoln National Life Insurance Company. These items must be returned within 31 days from the date of your loss of coverage. No policy will be issued and 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.



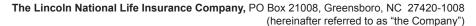


Please call 800-423-2765 for a quote or email this form to <u>ClientServices@LFG.com</u>.

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
1. Group Policy Name				Group				y Number	
Covered Em	ployee / Member Infori	natio	on:	'					
2. Name (Fin	rst, 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	D. Reason for Loss □ Retirement □ Disabled □ Employment Terminated □ Policy Termination □ Age Reduction of Coverage: □ Other, please explain:								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.
Administrato	r Name (Please Print)				Administrator Phone Number (include area of			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 Na	ame			E	Employee SS	N		Employee Ci  ☐ 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

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<b>A. APPLICANT/PROPOSED INSURED:</b> Please ca Application for Conversion within 31 days from the confirmed until the completed and signed application	date your group insurance	e terminated. Plea	~ 1			
1. a. Group Policy Name	b. Group ID	c. Group	p Policy Number			
Proposed Insured Information:		•				
2. Name (First, MI, Last)						
3. Date of Birth ( <i>mm/dd/yy</i> )	Date of Birth (mm/dd/yy)  4. Social Security Number					
5. Address (Street, City, State, ZIP)						
6. Phone Number (include area code)	<ul><li>5. Phone Number (include area code)</li><li>7. □ Male</li><li>□ Female</li></ul>					
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 completing these questions.)	calling for a quote, you w	ill receive an illus	tration that will assist you with			
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. □ d. □ Monthly (Bank	~	•	ete the attached EFT form.)			
13. a. Death Benefit Option  Level   (Not available with all products, see product specifications for details)						
<ul> <li>b. Death Benefit Qualification Test (DBQT) - For IRS purposes, premiums will be tested using:</li> <li>□ GPT □ CVAT</li> <li>The DBQT cannot be changed after issue unless the terms of the policy require a change.</li> </ul>						
14. Additional Benefits and Riders ( <i>If applicable</i> ):  ☐ Accelerated Benefit Rider  ☐ Other Benefits and Riders ( <i>not listed above</i> ). (Plea	se provide full details: e.ş	g. coverage amoui	nts/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		b. Social Security Number			
16. Contingent Beneficiary Name	a. Relationship		b. Social Security Number			
<b>Proposed Owner Information:</b> (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	surance and submit allocation form(s) with this Application.)
1. Have you, the Proposed Insured(s) and the Owner, if other than Prospectus for the policy applied for and have you had sufficient	
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 $\hfill\Box Y \Box N$
3. Do you understand that the cash values may increase or decreas funds held in the Separate Account?	se depending on the investment performance of the $\hfill\Box Y\Box N$
4. With this in mind, do you believe that the policy applied for is i anticipated financial needs?	n 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	
<ol> <li>I, the Owner, certify my TIN or SSN as provided by me is correct. I Each of the Undersigned declares that:</li> <li>This Application consists of: a) Application for Conversion of Growthereto; and d) any supplements, all of which are required by the Color thereto; and d) any supplements, all of which are required by the Color thereto; and d) any supplements, all of which are required by the Color thereto; and d) any supplements at the authority to make or modified.</li> <li>I HAVE READ, or have had read to me, the completed Application All statements and answers in this application are correctly recont the contract I will review the answers recorded on the application application is incorrect. Caution: If your answers on this application benefits or rescind coverage under the policy and any riders attacted.</li> <li>I agree that with the acceptance of any policy issued on the life of person are relinquished.</li> <li>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, or STATE DISCLOSURE AND SIGNATURE</li> <li>AR, NM and OH Only. Any person who, knowingly and with intent to for insurance or statement of claim containing materially false information any fact material thereto commits a fraudulent insurance act which is 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</li> </ol>	up Life Insurance; b) any amendments to the application(s) attached company for the plan, amount and benefits applied for. If you are conversion of Group Life Insurance before signing below ded, and are full, complete and true. I confirm that upon receipt on a will notify the Company immediately if any information in the on are incorrect or untrue, the Company may have the right to derived to it. If the Proposed Insured, all rights under the Group Policy for such the Proposed Insured, all rights under the Group Policy for such the Company. Any such changes will be shown under "Service changes will constitute acceptance of the changes. No change wire benefits unless agreed to in writing by the Applicant.  In defraud any insurance company or other person, files an application or conceals for the purpose of misleading, information concerning a crime and subjects such person to criminal and civil penalties. The true and complete. I agree that: (a) this application, a copy of which the propose of any policy issued on the life of the Propose.
Insured, all rights under the Group Policy for such person are relinque contract of insurance or bind the Company in any way.	uished; and (c) only an officer of the Company can make or alter
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 convethe Owner(s) and/or any beneficiaries either under the group policy of	emium is paid during the conversion period and the lifetime of the ersion application and first premium, coverage will be available
Signed in, this	
(state)	(month) (year)
Signature of Proposed Insured (Parent or Guardian if under 14 years of age)	Signature of Owner (If other than the Proposed Insured)
Signature of Licensed Agent, Broker or Registered Rep.	Printed Name of Licensed Agent, Broker or Registered Rep.
<b>APPLICABLE TO VARIABLE LIFE ONLY:</b> I have reviewed the and find the transaction suitable.	Application, Supplements, New Account Form and allocation forn
Signature of Registered Principal or Broker/Dealer	Printed Name of Registered Principal or Broker/Dealer
~-Branch or respected remember or proper/perior	

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