The Lincoln National Life Insurance Company
Group Insurance Service Office
P.O. Box 2616, Omaha, NE 68114
Phone: 800-423-2765 Fax: 877-573-6177
Email: lfgenrollments@LFG.com

EVIDENCE OF INSURABILITY INFORMATION

Instructions for Employee Applicant (Please complete the required sections as noted below.)

1. If you are providing evidence of insurability for:
   a. **Applicant (Employee) insurance only — Complete Sections A, C, D, E, F, G and H.**
   b. **Dependent (Spouse) insurance only — Complete *all* sections of this form.**
   c. **Applicant (Employee) and Dependent (Spouse) insurance — Complete *all* sections of this form.**
   NOTE: Evidence of insurability is not required for children.

2. Complete the form in ink, and sign and date after **Section H**. Retain a copy of this form for your records.

3. Complete, sign, and date the **AUTHORIZATION** for Applicant and Dependent Applicant.

4. Read the **NOTICE OF INSURANCE INFORMATION PRACTICES** and retain it for your records.

5. Return your completed form to:

The Lincoln National Life Insurance Company
Group Insurance Service Office
P.O. Box 2616
Omaha, NE 68114
Email: lfgenrollments@LFG.com

Or fax the form to:
877-573-6177

Please take the following steps to avoid delays in our evaluation of your request for insurance:
-Follow all instructions on this sheet.
-Answer all questions (yourself and your dependents) on the form.
-Provide full and complete information for any questions requiring additional details.
-Provide complete names and addresses of any doctors and hospitals.

Any incomplete or incorrect information could result in a delay.

NOTE: Insurance is not effective until the company approves in writing. We will notify you of your approval status.

If you have questions on completing this form, please contact Lincoln Financial Group Customer Service at 800-423-2765, or email us at clientservices@lfg.com.

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The Lincoln National Life Insurance Company
Group Insurance Service Office
P.O. Box 2616, Omaha, NE 68103-2616
Phone: 800-423-2765 Fax: 877-573-6177
Email: lfgenrollments@LFG.com

EVIDENCE OF INSURABILITY INFORMATION

Please submit this form to THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (the Company). Insurance that requires evidence of insurability will not be effective until the Company approves in writing.

Employer Completes this Section.	
Group Name:	Group ID/Number/Code:
Billing Division or Location:	Sort Group/Code:
Policy #(s):	

Complete and return this entire form. Print clearly in ink. Incomplete forms will delay processing.

A. Applicant (Employee) Insurance Information

First Name _____ Middle Name/MI _____ Last Name _____

Social Security Number ___-___-___ Date of Birth ___/___/___ State of Birth _____ Employee ID _____

Street Address (Include Apt. or Suite Number) _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____ Best Time To Call _____ AM/PM

Email Address _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single

Average Hours Worked Per Week: ☐ Full-Time ☐ Part-Time Employee Occupation: _____

Earnings: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly $_____ Date of Employment: ___/___/___

Is the Employee Actively at Work? ☐ Yes ☐ No Date of Rehire: ___/___/___

Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions stated in the policy and certificate.

Type of Group Insurance	Current Amount	Additional Amount	Total Amount
☐ Life (Employee)	$_____	$_____	$_____
☐ Dependent Life (Spouse)	$_____	$_____	$_____
☐ Short Term Disability (STD)	$_____	$_____	$_____
☐ Long Term Disability (LTD)	$_____	$_____	$_____
☐ Voluntary/Optional Life (Employee)	$_____	$_____	$_____
☐ Voluntary/Optional Life (Spouse)	$_____	$_____	$_____
☐ Voluntary/Optional/Buy-Up Short-Term Disability (STD)	$_____	$_____	$_____
☐ Voluntary/Optional/Buy-Up Long-Term Disability (LTD)	$_____	$_____	$_____
☐ Critical Illness (Employee)	$_____	$_____	$_____
☐ Critical Illness (Spouse)	$_____	$_____	$_____

Continue on Next Page. . .

B. Applicant (Spouse) Information – Only complete if applying for Dependent insurance.

First Name | Middle Name/MI | Last Name

Social Security Number ___-___-___ | Date of Birth ___/___/___ | State of Birth | Gender: ☐ Male ☐ Female

Provide contact information if different than the Employee information above.

Street Address (Include Apt. or Suite Number) | City | State | Zip

Cell Phone | Home Phone | Work Phone | Best Time To Call ___ AM/PM

Email Address

STATEMENT OF HEALTH

C. Medical Information – Applicants complete if applying for ANY insurance.

Employee: Height: ___Ft___In. Weight: ___lbs.

Spouse: Height: ___Ft___In. Weight: ___lbs.

	Employee	Spouse
In the past 12 months, has anyone applying for insurance smoked a cigarette, cigar or pipe, chewed tobacco or used tobacco or nicotine in any form?	☐ Yes ☐ No	☐ Yes ☐ No

D. Medical Information – Applicants complete if applying for Life or Disability insurance. You must answer YES or NO for each question per Applicant to avoid a processing delay.

If you answer YES to ANY part of ANY question below, provide complete details in Section E (Additional Details), including condition, treatment, and names of medication.

		Employee	Spouse
1.	**Within the past 7 years,** has anyone applying for insurance had, or been told by a physician that they had, or been treated for a condition listed below:		
	a. Heart, blood vessel or circulatory disorder; liver or kidney disorder; sleep apnea, lung or respiratory disorder; mental or nervous disorder; diabetes, cancer (excluding basal cell carcinoma of the skin), tumor, epilepsy or seizure disorder, hepatitis (excluding hepatitis A), or stroke?	☐ Yes ☐ No	☐ Yes ☐ No
	b. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for antibodies to HIV (Human Immunodeficiency Virus)?	☐ Yes ☐ No	☐ Yes ☐ No
	c. Have you been medically treated for alcoholism, drug use or dependency?	☐ Yes ☐ No	☐ Yes ☐ No
2.	Within the past 5 years, has anyone applying for insurance been diagnosed with a physical or mental or nervous disorder not listed above?	☐ Yes ☐ No	☐ Yes ☐ No
3.	a. Has anyone applying for insurance ever been diagnosed with hypertension (high blood pressure)?	☐ Yes ☐ No	☐ Yes ☐ No
	b. If 3a is Yes, within the last year, has that person had a systolic (top number) blood pressure reading higher than 150 more than once or a diastolic (bottom number) blood pressure reading higher than 100 more than once?	☐ Yes ☐ No	☐ Yes ☐ No
	c. If 3a is Yes, is anyone applying for insurance taking three or more medications for hypertension (high blood pressure) or had their medications changed or increased within the past 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
4.	a. Is anyone **applying** for insurance currently under observation or treatment by a physician?	☐ Yes ☐ No	☐ Yes ☐ No
	b. Is anyone applying for insurance currently taking any medication(s) prescribed by a physician?	☐ Yes ☐ No	☐ Yes ☐ No
5.	**Within the past 5 years,** has anyone applying for insurance been diagnosed or treated for:		
	a. Disorder of the back, neck, or spine?	☐ Yes ☐ No	☐ Yes ☐ No
	b. Osteoarthritis, Rheumatoid Arthritis, or degenerative joint disease?	☐ Yes ☐ No	☐ Yes ☐ No
	c. Injury to or damage to the ligaments, cartilage, or meniscus of the knee?	☐ Yes ☐ No	☐ Yes ☐ No
6.	**Within the past 24 months**, other than colds, flu or normal pregnancy, has anyone applying for insurance lost time from work more than 5 consecutive days due to disability, illness, injury or mental or nervous disorder?	☐ Yes ☐ No	☐ Yes ☐ No
7.	Has anyone applying for insurance been told by a medical professional that medical, surgical, psychiatric or rehabilitative care is required in the next 24 months?	☐ Yes ☐ No	☐ Yes ☐ No
8.	Is anyone applying for **Disability** insurance currently pregnant?	☐ Yes ☐ No	☐ Yes ☐ No

E. Additional Details

Provide details for any questions answered YES in SECTION D. (Attach additional sheet, if needed).

Question Number	Applicant Name	Condition & Length of Condition	Treatment/ Names of Medication	Date of Diagnosis	Current Status of Condition	Attending Physician's Name, Address, and Phone Number

Continue on Next Page. . .

F. Medical Information – Applicants complete if applying for Critical Illness insurance. You must answer YES or NO for each question per Applicant to avoid a processing delay.

	Employee	Spouse
1. **Within the past 7 years,** has anyone applying for insurance been diagnosed with or received treatment for Systemic Lupus, Type I or II Diabetes, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or sarcoidosis?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
2. **Within the past 7 years,** has anyone applying for insurance been diagnosed with or received treatment for Pacemaker, any type of fibrillation, coronary artery disease, atherectomy or any type of heart surgery, heart attack, congestive heart failure, cardiomyopathy, stroke, transient ischemic attack, congenital heart disease, chronic anticoagulation therapy?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
3. Is anyone applying for insurance currently taking three or more high blood pressure (HBP) medications or had HBP medications changed or increased within the past six months?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
4. **Within the past 7 years,** has anyone applying for insurance been diagnosed with or received treatment for internal cancer, lymphoma, leukemia or melanoma?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
5. **Within the past 7 years,** has anyone applying for insurance been diagnosed with or received treatment for Cystic fibrosis, renal hypertension or any kidney disease or disorder (not including stones), chronic obstructive pulmonary disease, emphysema, pulmonary fibrosis, Hepatitis or liver disease or disorder (not including Hepatitis A), cirrhosis of the liver, any organ transplant, or donor?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
6. **Within the past 7 years**, has anyone applying for insurance been diagnosed with or received treatment for glaucoma or retinitis pigmentosa?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

Continue on Next Page. . .

G. Fraud Warning/State Disclosure(s)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

H. Acknowledgments

1. I request the insurance for which I am (or may become) or my Spouse is (or may become) eligible under group policies issued by The Lincoln National Life Insurance Company;
2. I authorize any required deductions from my pay;
3. I represent to the best of my knowledge and belief that the above Statement of Health is true and complete, and that each item answered yes is fully disclosed;
4. I represent that if the above Statement of Health has been completed to obtain insurance for my Spouse, I have discussed and reviewed with my Spouse the responses and information supplied on behalf of my Spouse in the Statement of Health, and to the best of our knowledge and belief, the Spouse portion of the Statement of Health is true and complete, and each item answered yes is fully disclosed;
5. I acknowledge that I have read the **Fraud Warning/State Disclosure(s)**; and
6. I understand that for continued eligibility I must remain an active employee working at least the minimum hours or otherwise continue insurance as outlined in the contract and that my coverage will not be effective until the Company has approved in writing. **The attached AUTHORIZATION has been completed and signed by me (Employee Applicant). A separate authorization has been completed and signed by the (Spouse) Applicant.**

Signature of (Employee) Applicant: **X**_____ Date: ____/____/____

Signature of (Spouse) Applicant: **X**_____ Date: ____/____/____

PLEASE COMPLETE THE ATTACHED AUTHORIZATION
(EACH APPLICANT MUST COMPLETE AND SIGN HIS/HER OWN AUTHORIZATION)
Return all pages to avoid processing delays.

Continue on Next Page. . .

AUTHORIZATION FOR RELEASE OF INFORMATION

AUTHORIZATION: I (the undersigned) authorize any physician, medical professional, medical facility, pharmacy benefit manager, insurer, reinsurer, consumer reporting agency or MIB, Inc. ("MIB") to release information from the records of:

1. Applicant/Patient Name:_____
(Last) (First) (Middle)

Date of Birth: ____/____/____ Social Security Number: ____-_____-_____

This Authorization covers any periods of medical treatment during the last seven years.

2. Information to be released: My complete medical records including:
   - information about the diagnosis, treatment or prognosis of my medical condition (including referral documents from other facilities); and
   - prescription drug records and related information maintained by physicians, pharmacy benefit managers, and other sources.

3. Information is to be released to: EMSI (Examination Management Services Incorporated), The Lincoln National Life Insurance Company or its reinsurers.

4. I understand that the purpose of disclosing this information is to evaluate my application for insurance. The Company will use the information obtained with this Authorization to determine eligibility for insurance; and will only release such information:
   - to reinsurance companies, the MIB or providers of a business or legal service concerned with my application; and
   - as otherwise may be required by law or may be further authorized by me.

5. I authorize The Lincoln National Life Insurance Company, or its reinsurers, to disclose Protected Health Information or personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

   I further understand that refusal to sign this Authorization may result in denial of eligibility for this insurance.

6. I understand the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law, however, the Company contractually requires the recipient to protect the information.

7. I understand that I may revoke this Authorization 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 insurance with the Company. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signing. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.

8. A photocopy of this Authorization is to be considered as valid as the original.

9. I acknowledge that I have received the attached Notice of Information Practices.

10. I understand that I am entitled to receive a copy of this Authorization.

Signature of Applicant: X_____ **Date:** ____/____/____

NOTICE OF INSURANCE INFORMATION PRACTICES

COLLECTION OF INFORMATION
This NOTICE is provided in compliance with your state's Insurance Information and Privacy Protection Act.

In order to provide insurance on a fair and equitable basis, we must collect information about you and others for whom insurance may be provided. This information may include age, occupation, physical condition, health history, prescription drug records, general reputation, mode of living and other personal characteristics.

You will provide much of the information. We may collect or verify information by personal interviews and by otherwise contacting Medical professionals and institutions, pharmacy benefit managers, employers, business associates, friends, neighbors and other insurance companies. We may ask insurance support organizations to collect information and submit an investigative consumer report. That organization may disclose the contents of the report to others for which it performs such services. You may request a copy of the report or a personal interview in connection with it.

DISCLOSURE OF INFORMATION
The law allows disclosure of certain information without your authorization in response to a valid administration or judicial order, as permitted or required by law, or to:

1. Persons or organizations performing professional, business or insurance functions for us;
2. Our agents, insurance support organizations or consumer reporting agencies;
3. Medical professionals and medical-care institutions;
4. Persons or organizations conducting bonafide actuarial or scientific research studies, audits or evaluations;
5. Insurance regulatory, law enforcement or other governmental authorities;
6. Persons or organizations involved in any sale, transfer, merger or consolidation of our business; and
7. Group Policyholders, certificate holders, professional peer review organizations, or persons having legal or beneficial interest in a policy of insurance.

We do NOT disclose to our affiliates any information we receive about you from a consumer reporting agency. We do NOT disclose your nonpublic personal information to third parties except as necessary to provide you our products and services.

We, or our reinsurers, may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

MIB, Inc.
Information regarding your insurability will be treated as confidential. The Lincoln National Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901. If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Information for consumers about MIB may be obtained on its website at www.mib.com.

PERSONAL DISCLOSURE
Also, you have a right to access personal information about you in our files. You may request that we correct, amend or delete information you believe is inaccurate or irrelevant. A description of the appropriate procedures will be sent to you upon written request.

TELEPHONE PERSONAL HISTORY REVIEW
After your application has been received in the Group Insurance Service Office, you may receive a telephone call from a specially trained Group Insurance Service Office Interviewer who will ask you some questions to obtain verification or additional information.

If you have questions about the terms discussed in the NOTICE, please write to:
The Lincoln National Life Insurance Company
Group Insurance Service Office
P. O. Box 2616
Omaha, Nebraska 68103-2616

DETACH THIS COPY AND KEEP FOR YOUR RECORDS