

#### 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.

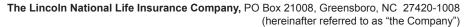
### **REQUEST FOR QUOTE - SECTION B. EMPLOYEE:**

- 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.



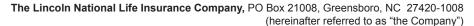


Please call 800-423-2765 for a quote or email this form to <u>ClientServices@LFG.com</u>.

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

	OYER/GROUP ADMINITION OF STREET OF S					complete	the Requ	est for Quote	/Application
1. Group Po	licy Name			Grou	p ID		Polic	y Number	
Covered Em	ployee / Member Inform	atio	n:						
2. Name (Fi						3. Date of Birth (mm/dd/yy)			
4. Date of H	ire or Enrollment		5. Date Employee Insura	ance To	erminated	6. Date Employment Terminated			ed .
7. Amount o	of Lost Coverage:		8. Date Employee Last	Worke	d:	1			
9. Reason fo of Covera	r Loss		sabled   Employment  in:	Termin	ated $\square$ Po	olicy Tern	nination	☐ Age Reduc	tion
	ouse Information:								
10. Amount o	of Lost Coverage for Spou	se \$							
	pendent Information:								
	of Lost Coverage for Depe		·		-				
I, the Admini	istrator of the Group Policy	, dec	lare that the information p	rovide	d above is co	mplete a	nd true to the	he best of my l	knowledge.
Administrator Name (Please Print)						Administrator Phone Number (include area co			lude area code)
Administrato	or Email Address								
Signature of	f Employer / Group Adm	inist	rator			Date	2		
your En payable this forr Convers	YEE/MEMBER: Pleas ployment/Membership until all information, in available when calling ion Quote, you will be s ion Application Process.	term cludi g) or	inated or you had a los ng premium is received email us at <u>ClientServ</u>	s of co l. Plea vices@	overage. No se call 800-4 LFG.com.	policy v 423-2765 If you a	vill be issu for a Life re interes	ed and no be e Conversion ted in the pr	enefit will be quote (have oposed Life
Proposed In	sured Information:								
Employee Name				F	Employee SSN			Employee Cigarette Use  ☐ Yes ☐ No	
Employee Ad	ddress								
	First Name	M.I.	Last Name		SSN	1	Gender	Birth Date	Cigarette Use
SPOUSE:							$\square$ M $\square$ F		☐ Yes ☐ No
CHILDREN:							□M □F		☐ Yes ☐ No
							□М□Г		□ Yes □ No
							□М □F		□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. APPLICANT/PROPOSED INSURED: Please ca Application for Conversion within 31 days from the			` 1					
confirmed until the completed and signed application			, C					
1. a. Group Policy Name	b. Group ID	c. Grou	p Policy Number					
Proposed Insured Information:		, , , , , , , , , , , , , , , , , , ,						
2. Name (First, MI, Last)	2. Name (First, MI, Last)							
3. Date of Birth (mm/dd/yy)	4. Social Security Number							
5. Address (Street, City, State, ZIP)								
6. Phone Number (include area code)	7. □ M	Male 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 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	2)\$							
11. Have you smoked any cigarettes in the past 12 month	ns? □ Yes □ No							
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 □			roduct 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> ). (Please provide full details: e.g. coverage amounts/percentages/etc.):								
Beneficiary Information: (If naming more than one Pri	mary or Contingent Benef	ficiary, please atta	sch 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					
<b>Proposed Owner Information:</b> (Complete this Section 1)	if the Proposed Insured is	not the Owner.)	1					
17. Full Name of Owner		· · · · · · · · · · · · · · · · · · ·	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	Insurance and submit allocation form(s) with this Apple	ication.)
Have you, the Proposed Insured(s) and the Owner, if other the Prospectus for the policy applied for and have you had sufficient to the policy applied for any have you had sufficient to the policy applied for any have you have you had sufficient to the policy applied for any have you ha		$\Box$ Y $\Box$ N
2. Do you understand that the amount and duration of the death investment performance of funds in the Separate Account?	benefit may increase or decrease depending on the	$\Box$ Y $\Box$ N
3. Do you understand that the cash values may increase or decrefunds held in the Separate Account?		$\Box$ Y $\Box$ N
4. With this in mind, do you believe that the policy applied for i anticipated financial needs?		$\Box$ Y $\Box$ N
CASH VALUES MAY INCREASE OR DECREASE IN ACC ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE		SEPARATE
SERVICE OFFICE ENDORSEMENTS (For Company U.		eded.)
AGREEMENT AND ACKNOWLEDGEMENT		
<ol> <li>I, the Owner, certify my TIN or SSN as provided by me is correct.</li> <li>Each of the Undersigned declares that:</li> <li>This Application consists of: a) Application for Conversion of G thereto; and d) any supplements, all of which are required by the</li> <li>No agent, broker or medical examiner has the authority to make or mo</li> <li>I HAVE READ, or have had read to me, the completed Applic All statements and answers in this application are correctly recobelief. I confirm that upon receipt of the contract I will review immediately if any information in the application is incorrect. Company may have the right to deny benefits or rescind covera</li> <li>I agree that with the acceptance of any policy issued on the life person are relinquished.</li> <li>Corrections, additions or changes to this application may be ma</li> </ol>	roup Life Insurance; b) any amendments to the application. Company for the plan, amount and benefits applied for. dify any Company contract or to waive any of the Company's action for Conversion of Group Life Insurance before sorded, and are full, complete and true to the best of my keep the answers recorded on the application. I will notify aution: If your answers on this application are incorrect ge under the policy and any riders attached to it. The of the Proposed Insured, all rights under the Group Police with the Company. Any such changes will be shown under the Company.	on(s) attached s requirements. igning below. nowledge and the Company or untrue, the olicy for such
Office Endorsements". Acceptance of a policy issued with such be made in classification (including age at issue), plan, amount, STATE DISCLOSURE AND SIGNATURE		
CT Only. Any person who, with intent to defraud or knowing that or files a claim containing a false or deceptive statement is guilty o KY Only. Any person who, knowingly and with intent to defraud an or statement of claim containing materially false information or comaterial thereto commits a fraudulent insurance act which is a crir To the best of my knowledge and belief, the answers given above as 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 relia contract of insurance or bind the Company in any way.  WHEN INSURANCE TAKES EFFECT. The Insurance applied month following the termination of the group coverage if the first Proposed Insured. Upon timely receipt by the Company of the contract of and/or any beneficiaries either under the group policy.	f insurance fraud, as determined by a court of competent y insurance company or other person, files an application inceals for the purpose of misleading, information conceins and subjects such person to criminal and civil penaltive true and complete. I agree that: (a) this application, a civil (b) by acceptance of any policy issued on the life of aquished; and (c) only an officer of the Company can refer on any person to be insured will take effect on the premium is paid during the conversion period and the lanversion application and first premium, coverage will be yor the Company's new policy/certificate, but not under	at jurisdiction. If for insurance rning any fact ies. Copy of which the Proposed nake or alter a lst day of the ifetime of the e available to
Signed in, this	day of	
(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 Register	red Rep.
<b>APPLICABLE TO VARIABLE LIFE ONLY:</b> I have reviewed the and find the transaction suitable.	ne Application, Supplements, New Account Form and all	ocation forms
Signature of Registered Principal or Broker/Dealer	Printed Name of Registered Principal or Broker/De	ealer

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