

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.

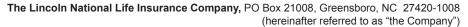
REQUEST FOR QUOTE - SECTION B. EMPLOYEE:

- 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.



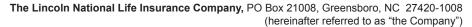


Please call 800-423-2765 for a quote or email this form to <u>ClientServices@LFG.com</u>.

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 ID				Polic	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	ance Te	ance Terminated 6. Date Employment Terminated			ed		
7. Amount o Amount \$	f Lost Coverage:		8. Date Employee Last	Worke	d:					
P. Reason for Loss □ Retirement □ Disabled □ Employment Terminated □ Policy Termination □ Age Reduction of Coverage: □ Other, please explain:										
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			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. 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)	2. Name (First, MI, Last)								
3. Date of Birth (<i>mm/dd/yy</i>)	4. Social Security Number								
5. Address (Street, City, State, ZIP)									
6. Phone Number (include area code)	Phone Number (include area code) 7.								
8. Has the Proposed Insured become eligible for any otl ☐ Yes ☐ No If "Yes," for how much?	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 ☐			roduct 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 Prin	nary or Contingent Benef	iciary, please atta	ch 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 I	nsurance and submit allocation form(s) with this Applic	cation.)
1. Have you, the Proposed Insured(s) and the Owner, if other that Prospectus for the policy applied for and have you had sufficient		\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	\square Y \square N
3. Do you understand that the cash values may increase or decrefunds held in the Separate Account?	ase depending on the investment performance of the	\square Y \square N
4. With this in mind, do you believe that the policy applied for is anticipated financial needs?	in accord with your insurance objective and your	$\square Y \square N$
CASH VALUES MAY INCREASE OR DECREASE IN ACCORDING THE DEATH BENEFIT MAY BE VARIABLE		EPARATE
SERVICE OFFICE ENDORSEMENTS (For Company Us	e Only. We will attach additional documentation as nee	ded.)
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 withholdi	no
Each of the Undersigned declares that:	Taiso certify that I am not subject to backup withholding	ng.
 This Application consists of: a) Application for Conversion of Gr thereto; and d) any supplements, all of which are required by the G. No agent, broker or medical examiner has the authority to make or mod. I HAVE READ, or have had read to me, the completed Application all statements and answers in this application are correctly rece 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 atta. I agree that with the acceptance of any policy issued on the life person are relinquished. Corrections, additions or changes to this application may be mad Office Endorsements". Acceptance of a policy issued with such be made in classification (including age at issue), plan, amount, STATE DISCLOSURE AND SIGNATURE Any person who, with intent to defraud or knowing that he/she is claim containing a false or deceptive statement is guilty of insurance. 	Company for the plan, amount and benefits applied for. lify any Company contract or to waive any of the Company's ation for Conversion of Group Life Insurance before signed, and are full, complete and true. I confirm that up on. I will notify the Company immediately if any information are incorrect or untrue, the Company may have the ched to it. of the Proposed Insured, all rights under the Group Pottle by the Company. Any such changes will be shown under changes will constitute acceptance of the changes. Not or benefits unless agreed to in writing by the Applicant facilitating fraud against an insurer, submits an applicate	requirements. Igning below. Ig
To the best of my knowledge and belief, the answers given above are		omer of which
will be attached to the policy when issued, will be a part of the policinsured, all rights under the Group Policy for such person are relincontract of insurance or bind the Company in any way. WHEN INSURANCE TAKES EFFECT. The Insurance applied from the following the termination of the group coverage if the first perposed Insured. Upon timely receipt by the Company of the conthe Owner(s) and/or any beneficiaries either under the group policy	cy; (b) by acceptance of any policy issued on the life of quished; and (c) only an officer of the Company can more or on any person to be insured will take effect on the 1 premium is paid during the conversion period and the liversion application and first premium, coverage will be	the Proposed take or alter a lst day of the ifetime of the e available to
Signed in, this	day of (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	ed Rep.
APPLICABLE TO VARIABLE LIFE ONLY: I have reviewed the and find the transaction suitable.	Application, Supplements, New Account Form and allo	ocation forms

Page 2 of 2 LFF07384 7/10

Printed Name of Registered Principal or Broker/Dealer

Signature of Registered Principal or Broker/Dealer