



The Lincoln National Life Insurance Company, PO Box 21008, Greensboro, NC 27420-1008 (hereinafter referred to as "the Company")

Mail this completed form to: The Lincoln National Life Insurance Company, PO Box 2616, Omaha, NE 68103-2616

APPLICATION FOR CONVERSION OF GROUP LIFE INSURANCE

A. EMPLOYER: Please complete all of Section A, date and sign form to help us process the application quickly. We must receive this form within 31 days of "Date Employment Terminated" as shown on this form.

- 1. Group Policy Name:
Proposed Insured Information: 2. Name:
3. Birthdate:
4. Social Security Number:
5. Date of Hire:
6. Date Group Insurance Terminated:
7. Date Employment Terminated:
8. Date Last Worked:
9. Amount of Current Insurance Available: a. Amount \$ b. Plan c. Class
10. Reason for termination of group life coverage:
Retirement Disabled Age Reduction Group Policy Terminated
Other, please explain

GENERAL. Once this information is received, a letter will be sent directly to the Proposed Insured. The Lincoln National Life Insurance Company will calculate the premium amount and effective date of the Conversion Policy and notify the Proposed Insured at that time.

Date Signed Signature of Administrator
Administrator Phone Number Administrator Fax Number

B. EMPLOYEE: Please complete all of Section B, date and sign form to help us process your application quickly. We must receive this form within 31 days of "Date Employment Terminated" as shown on this form.

- Proposed Insured Information:
1. Present Occupation:
2. Name:
3. Address (Street, City, State, Zip Code):
4. Phone Number:
5. Age:
6. Sex:
7. Insurance Amount applied for: \$
8. Premium payable (check one) a. Annual b. Semi-Annual c. Quarterly d. Bank Draft

Beneficiary Information. (If naming more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.)

- 9. Primary Beneficiary: a. Relationship:
b. Social Security Number:
10. Contingent Beneficiary: a. Relationship:
b. Social Security Number:
11. Is Proposed Insured covered by or eligible for any other Group Insurance, other than The Lincoln National Life Insurance Company? Yes No If yes, for how much?
12. Does the Proposed Insured use tobacco products now or in the past twelve months? Yes No
13. In the past 3 years, has the Proposed Insured engaged in, or in the future does the Proposed Insured plan to engage in, flying in non-commercial aircraft? Yes No If yes, give details

Complete this Section if the Proposed Insured is not the Owner/Premium Payor:

- 14. Full Name of Owner/Premium Payor:
15. Address of Owner/Premium Payor: (Street, City, State, Zip Code)
16. Relationship to Proposed Insured:

GENERAL. To the best of my knowledge and belief, the answers given above are true and complete. I agree that: (a) this application, a copy of which will be attached to the policy when issued, will be a part of the policy; (b) by acceptance of any policy issued on the life of the Proposed Insured, all rights under the Group Policy for such person are relinquished; and (c) only an officer of the Company can make or alter a contract of insurance or bind the Company in any way.

Under penalties of perjury, I, the Owner, (if other than the Proposed Insured) declare that the Social Security Number shown is correct and that the Internal Revenue Service has not notified me that I am subject to back-up withholding for failing to properly report dividend or interest income.

WHEN INSURANCE TAKES EFFECT. The Insurance applied for on any person to be insured will not take effect unless the first premium is paid during the lifetime of the Proposed Insured and during the 31 days following the date group coverage terminated. Insurance will take effect at the end of the 31 day period following the date group coverage terminated.

FRAUD NOTICE: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Date Signed Signature of Proposed Insured

State Where Signed Signature of Owner/Premium Payor

COMMENTS: