Lincoln Financial Group℠

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 ClientServices@LFG.com 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.

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Lincoln Life & Annuity Company of New York

Service Office: PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as "the Company")

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

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

A. EMPLOYER/GROUP ADMINISTRATOR: Please note, the Employee must complete the Request for Quote/Application for Conversion within 31 days from the date their Loss of Coverage.

1. Group Policy Name	Group ID	Policy Number

Covered Employee / Member Information:

2. Name *(First, MI, Last)*		3. Date of Birth *(mm/dd/yy)*
4. Date of Hire or Enrollment	5. Date Employee Insurance Terminated	6. Date Employment Terminated
7. Amount of Lost Coverage: Amount $_____	8. Date Employee Last Worked:	

9. Reason for Loss of Coverage: ☐ Retirement ☐ Disabled ☐ Employment Terminated ☐ Policy Termination ☐ Age Reduction ☐ Other, please explain: _____

Covered Spouse Information:

10. Amount of Lost Coverage for Spouse $_____

Covered Dependent Information:

11. Amount of Lost Coverage for Dependent $_____

I, the Administrator of the Group Policy, declare that the information provided above is complete and true to the best of my knowledge.

Administrator Name (Please Print)	Administrator Phone Number *(include area code)*
Administrator Email Address	

_____ _____

Signature of Employer / Group Administrator **Date**

B. EMPLOYEE/MEMBER: Please note, you must complete the Application for Conversion within 31 days from the date your Employment/Membership terminated or you had a loss of coverage. No policy will be issued and no benefit will be payable until all information, including premium is received. Please call 800-423-2765 for a Life Conversion quote (have this form available when calling) or email us at ClientServices@LFG.com. If you are interested in the proposed Life Conversion Quote, you will be sent a proposal document and Application for Conversion form to proceed with the Life Conversion Application Process.

Proposed Insured Information:

Employee Name	Employee SSN	Employee Cigarette Use ☐ Yes ☐ No
Employee Address		

	First Name	M.I.	Last Name	SSN	Gender	Birth Date	Cigarette Use
SPOUSE:					☐M ☐F		☐Yes ☐No
CHILDREN:					☐M ☐F		☐Yes ☐No
					☐M ☐F		☐Yes ☐No
					☐M ☐F		☐Yes ☐No

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Mail to:
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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 or reduced or within any extended conversion notice period, whichever is later. 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 Policy Number

Proposed Insured Information:

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. ☐ Male ☐ Female
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? _____	

Converted Coverage Information: *(As available per product. After calling for a quote, you will receive an illustration that will assist you with completing these questions.)*

9. Plan of Insurance _____

10. Amount of Insurance *(Specified Amount, if UL or VUL)* $ _____

11. Have you smoked any cigarettes in the past 12 months? ☐ 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 ☐ _____ (Not available with all products, see product specifications for details)

b. Death Benefit Qualification Test (DBQT) - For IRS purposes, premiums will be tested using:
☐ Guideline Premium Test ☐ Cash Value Accumulation Test
The DBQT cannot be changed after issue unless the terms of the policy require a change.

14. Additional Benefits and Riders *(If applicable)*:
☐ Accelerated Benefit Rider - An administrative charge of $300 is applicable. The requested portion of the death benefit will be subject to (check the applicable box): ☐ an interest bearing lien against the policy for flexible premium adjustable life insurance policies; or ☐ an actuarial discount reflecting early payment of amounts held under the policy for other life insurance policies.
☐ Other Benefits and Riders *(not listed above)*. (Please provide full details: e.g. coverage amounts/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 Number
c. Address	d. Phone	e. Date of Birth
16. Contingent Beneficiary Name	a. Relationship	b. Social Security Number
c. Address	d. Phone	e. Date of Birth

Proposed Owner Information: (*Complete this Section if the Proposed Insured is not the Owner.)*

17. Full Name of Owner	18. Relationship	19. Owner SSN or TIN
20. Address	21. Phone	22. Date of Birth

B. SUITABILITY *(Complete only if applying for Variable Life Insurance and submit allocation form(s) with this Application.)*

1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	☐Y ☐N
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	☐Y ☐N
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	☐Y ☐N
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objectives and your anticipated financial needs?	☐Y ☐N

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT (SUBJECT TO ANY SPECIFIED MINIMUM GUARANTEES). THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS. ILLUSTRATIONS OF BENEFITS, INCLUDING DEATH BENEFITS, POLICY VALUES AND CASH SURRENDER VALUES ARE AVAILABLE UPON REQUEST.

SERVICE OFFICE ENDORSEMENTS *(For Company Use Only. We will attach additional documentation as needed.)*

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 withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Application for Conversion of Group Life Insurance; b) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for and are attached to and made a part of the policy.
2. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
3. If you are applying for an accelerated benefit rider, please note the following: (a) Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable; and (b) No separate premium is payable for the accelerated benefit rider.
4. I HAVE READ, or have had read to me, the completed Application for Conversion of Group Life Insurance before signing below. All statements and answers in this application are correctly recorded, are representations and not warranties and are full, complete and true to the best of my knowledge and belief. I understand that any material misrepresentations may result in the loss of coverage under the policy . I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
5. I agree that with the acceptance of any policy issued on the life of the Proposed Insured, all rights under the Group Policy for such person are relinquished.
6. Any administrative changes made by the Company will be shown under "Service Office Endorsements". No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

SIGNATURE

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.

WHEN INSURANCE TAKES EFFECT. The Insurance applied for on any person will take effect on the day following termination of the group coverage if the first premium is paid during the conversion period and the lifetime of the Proposed Insured and within 31 days of the date of the application. Upon timely receipt by the Company of the conversion application and first premium, coverage will be available to the Owner(s) and/or any beneficiaries either under the group policy or the Company's new policy/certificate, but not under both.

Signed in _____, this _____ day of _____ _____
(state) (month) (year)

Signature of Proposed Insured
(Parent or Guardian if under 14 years and 6 months 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.

APPLICABLE TO VARIABLE LIFE ONLY: I have reviewed the Application, Supplements, New Account Form and allocation forms and find the transaction suitable.

Signature of Registered Principal or Broker/Dealer

Printed Name of Registered Principal or Broker/Dealer

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SUPPLEMENTARY CONTACT INFORMATION

This information is requested to assist us in identifying and contacting your beneficiary(ies) in the event of a claim/distribution and ensure benefits are paid out appropriately. State regulations may require benefits be paid to the State if the beneficiary cannot be located in a timely manner.

This information is in connection with the Application/Ticket dated _____

made on the life of: _____ .
Name(s) of Proposed Insured(s)

Owner Information

Name	Phone

Name	Phone

Insured Information

Name	Phone

Name	Phone

Beneficiary Information

Name	Phone
Address	Date of Birth

Name	Phone
Address	Date of Birth

Name	Phone
Address	Date of Birth

Name	Phone
Address	Date of Birth