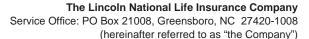


APPLICATION FOR LIFE INSURANCE

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

LFF06321-2 (CALIFORNIA)





APPLICATION FOR LIFE INSURANCE

GENERAL INSTRUCTIONS FOR COMPLETING THE APPLICATION

Please follow these instructions carefully. If you have any questions, please contact your Marketing Department for assistance before completing this application. Thank you for the opportunity to underwrite your business.

Please complete #1 of the Agreement and Acknowledgement Section to indicate which Sections of the Application you are submitting.

COMPLETING THE APPLICATION

- Answer all questions on each page, and record each answer in complete detail using black or blue ink.
- DO NOT USE correction fluid/tape or any similar item. If you need to change answers draw a line through the mistake and have the change initialed by the Owner(s). If a health question is changed, draw a line through the mistake and have the change initialed by the Proposed Insured.
- Have the Proposed Insured(s) and Owner(s) read the application to confirm that all questions are answered accurately, sign and date the application.
- The LICENSED AGENT OR BROKER must complete and date the AGENT'S REPORT.
- Include the completed Health Summary Sections (applicable to each Proposed Insured) when submitting an application if a completed Medical Supplement (Part II) will not be submitted or to initiate the underwriting process while an exam and Medical Supplement (Part II) are awaiting completion.
- While completion of the applicable Health Summary Sections is not required if a full paramedical or medical examination is necessary, answering all medical questions will enable the underwriter to promptly begin the underwriting process. (See Underwriting Guidelines for further details.)
- If a full paramedical or medical exam is over 90 days old but less than 180 days old, the applicable Health Summary Section must be completed.
- If applying for Variable Life Insurance please complete the Suitability Section on Page 4 of 5, the completed VUL/SVUL Allocations form must accompany the application.
- If applying for a term product, the billing options are: EFT; List Bill 5 or more insureds; or Direct Annual only.
- Please refer to product specifications for complete details and billing options.

AUTHORITY

No agent, broker, registered representative or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.

TEMPORARY INSURANCE AGREEMENT (TIA)

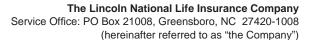
If payment is made with the application, you must give a copy of the TIA to the Owner(s). Do not accept money orders or cash. Only checks payable to the Lincoln National Life Insurance Company noted at the top of the page are acceptable. If you are submitting applications for alternate or multiple applications, only one TIA per proposed insured may be in effect at one time. Please refer to the TIA for details.

- Payment with Application May Not Be Submitted if:
 - 1. The Life insurance applied for exceeds \$3,000,000 on any one life including optional benefit riders.
 - 2. Any Proposed Insured's age is less than 15 days or in excess of 70 years.
 - 3. Any of the questions at the beginning of the TIA is answered YES or LEFT BLANK.
- If the Payment with Application Rules allow payment to be submitted, please follow these guidelines:
 - 1. Submit payment with application only in the form of a currently dated check made payable to The Lincoln National Life Insurance Company noted at the top of the page.
 - 2. The TIA must be signed and dated by the Proposed Insured(s) and Owner(s). The Licensed Agent, Broker or Registered Representative must also sign as Witness.
 - 3. Give a copy of the TIA to the Owner(s) and submit the original with the application
 - 4. Submit the payment with the application and write the amount of the payment in #2 of the Agreement and Acknowledgement Section.

SPECIAL INSTRUCTIONS

- This application is broken out in Sections (A-D) and you can either "tear-out" or not print those sections that you do not use. Please indicate in #1 of the Agreement and Acknowledgement Section (via check boxes) which Sections of the Application you are submitting.
- If there is only 1 proposed insured, then you do not need to send in Sections B and C for Proposed Insured B. These are not needed and the application will be in good order without them. Please indicate on Page 4 of 5 in the Agreement and Acknowledgement Section #1 which Sections you are including.
- Section D, Defined Age Questionnaire, needs to be completed if either Proposed Insured is age 70 or older.
- Question 31 and 37; enter Owner(s) information here, including the name of the trust and trustees.
- Questions 62 64; please complete these questions if you will not be completing a Medical Supplement. Please include the full name, address and phone number for each physician consulted, as this will assist with the underwriting process.

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. LFF06321-2





IMPORTANT NOTICE

Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of these notices to each Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

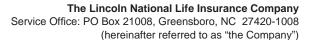
CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)





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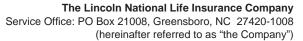
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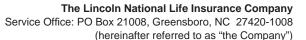


APPLICATION FOR LIFE INSURANCE - PART I

APPLICANT INFORMATION - PROPOSED	INSURED A (Required Section)	
1. Proposed Insured A (First, Middle, Last)		2. ☐ Male ☐ Female
3. Date of Birth (If over age 70, please complete Section D.) (mm/dd/yy)	4. Soc. Sec. No.	5. Are you a citizen of the United States? □ Y □ N
6. Place of Birth (State, Country)	7. Driver's License # & State	If "No," what country?
8. Home Address (Street, City, State, ZIP)		
9. Occupation/Duties	10. Employer	
11. Business Address (Street, City, State, ZIP)		
12. Annual Earned Income \$	13. Annual Unearned Income \$	14. Net Worth \$
15. In the last 5 years have you filed for bankruptcy? $\square Y \square N$ (If "Yes," please complete the Financial Supplement.)	16. Primary Phone # \square AM \square PM	17. Work Phone #
COVERAGE INFORMATION (As available pe	r product)	
18. Plan of Insurance	and Variable Universal Life Product only - not require Increase by Premium	(Specified Amount, if UL or VUL) ed for Term or Whole Life.) by Premium Less Policy Factor g the Guideline Premium Test unless ers). ege. um ly Deductions ed Premium \$
BILLING INSTRUCTIONS (As available per p	·	
23. Premium Mode: Annual Semi-Annua		Other
24. Modal Planned Premium: \$	25. Lump Sum: \$	
26. Special Billing: (check one, if applicable) New L	•	
 27. Source of Premium: (inheritance, loan, business activity) 29. Premium Notices To: (check one only.) (Please note we □ Owner in Question 31 □ Owner in Question 30. Special Instructions: 	(Co e cannot bill to your agent.)	utomatic Premium Loan: $\Box Y \Box N$ complete for Whole Life only.) t Residence \Box Other (indicate below)

	OWNER INFORMATION (1) tejt blank, Froposea Insurea(s) will be owner)									
31. 0	Owner Name									
	32. Owner Address									
	Relationship to 33. Proposed Insured(s) 34. Owner Soc. Sec. No. / TIN									
35. E	Pate of Birth/Trust Date		36. Citizen of ((Country)						
37. (Owner Name									
38 (Owner Address									
R	Relationship to Proposed Insured(s)		40 Owner Soc	. Sec. No. / TIN						
	Date of Birth/Trust Date									
43. Is	s this policy being purchased as part centificiary of the policy?		42. Citizen of (ed life insurance pro	•	nployer is the di	rect or indir	ect			
	NEFICIARY DESIGNATION (Unntingent), the proceeds are to be paid					s (Primary,				
Sel	ect Primary (P) or Contingent (C) Ber	neficiary for each lin	e completed. If Tr	ust, check here \square .						
44. □ P	a. Name/Trust name & Trustees			b. Soc. Sec. No./T	TIN					
\Box C				c. Relationship to Proposed Insure	ed					
45.	a. Name/Trust name & Trustees			b. Soc. Sec. No./TIN						
□ P □ C				c. Relationship to Proposed Insured						
46.	a. Name/Trust name & Trustees			b. Soc. Sec. No./TIN						
□ P □ C				c. Relationship to						
47.	a. Name/Trust name & Trustees			Proposed Insure						
□Р				b. Soc. Sec. No./TIN c. Relationship to						
□ C 48.	Special Instructions			Proposed Insured						
40.	Special instructions									
AP	PLICANT INFORMATION - PRO	POSED INSURED	A							
 49. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? □ Y □ N (If "Yes", please complete and sign all required replacement forms.) 50. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. (Please list in the box below.) 										
If	If none, check this box: \square Please indicate the Type of coverage: Business (B); Key Person (K); or Personal (P).									
Compa	ny	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	1035 Exchange	Туре			
		\$			\Box Y \Box N	$\Box Y \Box N$				
		\$			\Box Y \Box N	\Box Y \Box N				
		\$			\Box Y \Box N	$\Box Y \Box N$				
		\$			\Box Y \Box N	$\square Y \square N$				

51. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? (If "Yes," please provide details in the space provided.)						\Box Y \Box	N		
Company			Amount		Type (Life or D		Reason Policy Applied For		
			\$						
			\$						
	What is the tota application? \$		ew life insurance cov	erage tl	hat will be placed	inforce	with all companies including this		
			a premium financing the Premium Financing St			wed, adv	vanced or paid from another persor	ı □Y □] N
54.	In the past 5 yean increased pr	ears, have you a remium? (If "Yes	applied for life, healts", provide further inform	h or dis	sability insurance he "Details" space p	and bee	en declined, postponed or charged	l □Y □] N
G	ENERAL RIS	K INFORMA	TION - PROPOSE	D INSU	JRED A				
((If "Yes", an Aviati	ion Supplement is r	required; this includes bal	loon pilo	ts.)		lot, student pilot or crew member?] N
	gliding, sky or	scuba diving, o	r mountain, rock or	echnica	al climbing? (If ")	Yes", an A	tor vehicle or boat racing, in hang vocation Supplement is required.)	S □ Y □] N
((If "Yes", a Foreig	n Travel or Residen	ice Supplement is required	d.)			da within the next year?	□У□] N
58.	In the past 5 yea your driver's lic	ars, have you be cense suspended	en convicted of any d d, restricted or revoke	riving u ed? (If "	nder the influence Yes," please indicate v	of alcoh	nol or other drugs violations, or had and dates in the "Details" space provided.	l) □Y □] N
1	parole, in the "Det	tails" space provide	ed.)				of felony and if currently on probation or	□У□] N
	or active; list bran		duties, mobilization cates				ard? (If "Yes", please indicate if Retired of deployment has been received, to	□У□	1 N
61.	tobacco, snuff,	nicotine gum a	nd/or patches)? (If "	Yes", list	below.)	includin	ng, but not limited to, chew		
	Туре	:	Date First Used: (month/year)	D	ate Last Used: (month/year)	I	Amount and Frequency:		
			N - PROPOSED IN						
62. I	Provide full nai	me/address/pho	ne number of person	al phys	sician(s) and any o	other phy	ysicians seen within the past 5 year	ırs.	
- 8	a. Date and rea	ason of last visit	t:						
ł	o. Tests perform	med & treatmer	nt received:						
	Height Weight	_ft. /i lbs.	•	•	nanged by more than pounds?	-	oounds during the past 12 months' Gain Loss	' 🗆 Y 🗆	N
64.		Age if Living	g & Health Status		etes, Cancer, Hear (include age of ons	t Diseas		use	
	a. Father								
	b. Mother								
	c. Sibling(s)								
65.	Details: (List de	tails from question.	s answered "Yes" and ple	ase speci	fy to which question r	numbers de	etails pertain.)		





SECTION A - HEALTH SUMMARY

APPLICANT INFORMATION - PROPOSED INSURED A

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

See Chief witting Guidelines for further details.)							
1. Proposed Insured A (First, Middle, Last)	2. Date of Birth (mm/dd/yy)						
► If you answer "Yes" to any of the following questions, please provide further informa	ntion in the "Details" space p	rovid	ed.				
, , , , , , , , , , , , , , , , , , , ,	•	Yes					
3. Within the past 5 years, have you had or been advised by a licensed medical professional to have a check-up, EKG,							
x-ray, blood or urine test or any other diagnostic test (excluding HIV tests) or are you no	w planning to seek medical						
advice or treatment?			Ш				
4. Within the past 5 years, have you been a patient in a hospital, clinic, sanatorium or other advised by a licensed medical professional to have any hospitalization or surgery which							
5. Within the past 10 years, have you been diagnosed with and/or treated by a licensed	l medical professional for:						
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failur the heart or blood vessels?	re or other impairments of						
b. Any tumor, cancer, cysts, melanoma or lymphoma?							
c. Anemia, leukemia, impairment of the lymph glands, clotting disorder or any other blottests and studies)?	ood disorder (excluding HIV						
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular impairment?							
e. Asthma, emphysema, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or other impairment of the respiratory system?	shortness of breath or any						
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain ir	npairment?						
g. Bipolar impairment, major depressive impairment, schizophrenia; or been treated and anxiety, depression, stress or any other emotional condition?	/or received counseling for						
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other impair esophagus, liver, intestines, gallbladder, or pancreas?	ment of the stomach,						
 i. Any complications of pregnancy or impairment of the testicles, prostate, breasts, ovar or urinary bladder? 	ies, uterus, cervix, kidney						
j. Arthritis, gout, or any impairment of the back, spine, muscles, nerves, bones, joints or	r skin?						
6. Have you ever been diagnosed by or received treatment from a licensed medical professi Immunodeficiency Syndrome (AIDS)?	onal for Acquired						
7. Do you use alcoholic beverages? (If "Yes", provide Type, Frequency & Amount.)							
Type Frequency Amour	nt						
8. Within the past 10 years, have you been treated for drug or alcohol abuse or been advised							
professional to limit your use of alcohol or any medication, prescribed or not?	a of a moonson monour						
9. Within the past 5 years have you used or experimented with cocaine, non-prescribed man non-prescription stimulants, depressants, or narcotics?	ijuana, or other						
10. List all medication and dosages you are currently taking or have taken in the last 30 days over the counter drugs, aspirin and herbal supplements.	s, including prescriptions,						
11. Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.)							



The Lincoln National Life Insurance Company

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

SECTION B - ADDITIONAL INSURED

APPLICANT INFORMATION - PROPO	OSED INSURE	D B						
1. Proposed Insured B (First, Middle, Last)			2		□ Male □ Female			
3. Date of Birth (If over age 70 please complete Sec (mm/dd/yy)	etion D.) 4. Soc.	Sec. No.	4		Are you a citize United States?	\square Y \square N	1	
6. Place of Birth (State, Country)	7. Drive	er's License # & State			If "No," what c	ountry?		
8. Home Address (Street, City, State, ZIP)	,		'					
9. Occupation/Duties	10. Emp	loyer						
11. Business Address (Street, City, State, ZIP)	'							
12. Annual Earned Income \$	13. Annu	ual Unearned Income \$	1	4.]	Net Worth \$			
15. In the last 5 years have you filed for bankruptcy? ☐ Y ☐ N (If "Yes," please complete the Financial Supplement		ary Phone #	□ AM 1		Work Phone #		☐ AM ☐ PM	
18. Beneficiary for applicable Rider: a. N	lame							
b. Soc Sec. No./TIN		tionship to osed Insured B						
your existing policies or annuities to pay (If "Yes", please complete and sign all require 20. Please list amounts of all inforce life insu If none, check this box: □ Please indicate the Type of coverage: Busin	rance on your life	e, including any policies t		een	sold. (Please list i		elow.)	
	ce mount	Policy Number	Issue Date (mm/dd/yy)		Replacement or Change of Policy?	1035 Exchange	Туре	
\$					\Box Y \Box N	□Y □	N	
\$					\Box Y \Box N	□Y □1	N	
\$					\Box Y \Box N	□Y □1	N	
\$					\Box Y \Box N	□Y □ 1	N	
21. Do you have any applications currently per coverage with any other company? (If "Ye.			e or disabil	ity i	nsurance	ПΥ	□N	
Company	Amount	Type (Life or Disability)	Reason Poli	cy A	pplied For			
	\$							
\$ 22. What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? \$								
23. Is this policy being funded via a premium	23. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? (If "Yes", please complete the Premium Financing Supplement.)							
24. In the past 5 years, have you applied for lan increased premium? (If "Yes", provide fur			n declined,	pos	stponed or charg		□N	

GENERAL RISK INFORMATION - PROPOSED INSURED B									
25.	5. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? (If "Yes", an Aviation Supplement is required; this includes balloon pilots.)								
26.	Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing? (If "Yes", an Avocation Supplement is required.)								
27.	Do you now, or of a Foreign Travel or it			ide of the United States	or Canada wi	thin the next year? (If "Yes",	\square Y \square N		
28.	In the past 5 years	s, have you be	en convicted of any dr			other drugs violations, or had es in the "Details" space provided.)			
29.		een convicted	of a felony? (If "Yes",			ny and if currently on probation			
30.	Are you a memb Retired or active; lis	er of the Mili	tary Armed Forces, N	Military Reserves or Nati					
31.	In the past 5 yea	rs, have you u		acts containing nicotine	(including, b	ut not limited to, chew			
	Type	ncotine guin a	Date First Used: (month/year)	Date Last Used: (month/year)		Amount and Frequency:	$\square Y \square N$		
	MEDICAL INF	ORMATION	- PROPOSED INS	SURED B (Answer this see	ction only when	required.)			
32.	Provide full name	e/address/pho	ne number of person	al physician(s) and any	other physici	ans seen within the past 5 year	ars.		
		1	1		1 7	1 7			
	a. Date and reason	on of last visit	••						
	b. Tests perform								
33.	Height	ft. / i1	n. a. Has your w	eight changed by more t	han 10 pound	ds during the past 12 months?			
	Weight	lbs.	b. If "Yes," by	how many pounds?		Gain □ Loss			
34.		Age if Living	g & Health Status	how many pounds? Diabetes, Cancer, Hear (include age of on.		Age at Death & Car	use		
	a. Father								
	b. Mother								
	c. Sibling(s)								
35.	Details: (List deta	ils from question.	s answered "Yes" and ple	ase specify to which question i	numbers details	pertain.)			



The Lincoln National Life Insurance Company

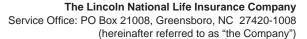
Service Office: PO Box 21008, Greensboro, NC 27420-1008 (hereinafter referred to as "the Company")

SECTION C - HEALTH SUMMARY

APPLICANT INFORMATION PROPOSED INSURED B

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

1. Proposed Insured B (First, Middle, Last):	2. Date of Birth (mm/dd/yy):						
► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space pro							
3. Within the past 5 years, have you had or been advised by a licensed medical professiona x-ray, blood or urine test or any other diagnostic test (excluding HIV tests) or are you not	-	Yes	No				
advice or treatment?							
4. Within the past 5 years, have you been a patient in a hospital, clinic, sanatorium or other advised by a licensed medical professional to have any hospitalization or surgery which	has not been completed?						
5. Within the past 10 years, have you been diagnosed with and/or treated by a licensed	_						
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failu the heart or blood vessels?	re or other impairments of						
b. Any tumor, cancer, cysts, melanoma or lymphoma?							
c. Anemia, leukemia, impairment of the lymph glands, clotting disorder or any other ble tests and studies)?	ood disorder (excluding HIV						
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular impairment?							
e. Asthma, emphysema, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or other impairment of the respiratory system?	shortness of breath or any						
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain in	_						
g. Bipolar impairment, major depressive impairment, schizophrenia; or been treated and anxiety, depression, stress or any other emotional condition?	l/or received counseling for						
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other impair esophagus, liver, intestines, gallbladder, or pancreas?	ment of the stomach,						
i. Any complications of pregnancy or impairment of the testicles, prostate, breasts, ovar or urinary bladder?	ries, uterus, cervix, kidney						
j. Arthritis, gout, or any impairment of the back, spine, muscles, nerves, bones, joints o	r skin?						
6. Have you ever been diagnosed by or received treatment from a licensed medical professi Immunodeficiency Syndrome (AIDS)?	onal for Acquired						
7. Do you use alcoholic beverages? (If "Yes", provide Type, Frequency & Amount.)							
Type Frequency Amoun	nt	_					
8. Within the past 10 years, have you been treated for drug or alcohol abuse or been advise professional to limit your use of alcohol or any medication, prescribed or not?	d by a licensed medical						
9. Within the past 5 years have you used or experimented with cocaine, non-prescribed mannon-prescription stimulants, depressants, or narcotics?	rijuana, or other						
10. List all medication and dosages you are currently taking or have taken in the last 30 day over the counter drugs, aspirin and herbal supplements.	s, including prescriptions,						
11. Details: (List details from questions answered "Yes" and please specify to which question numbers details po	ertain.)						





SECTION D - DEFINED AGE QUESTIONNAIRE (Complete if either Proposed Insured is age 70 or over.)

1. Proposed Insured A (First, Middle, Last)		
2. Proposed Insured B (First, Middle, Last)		
	Proposed Insured A	Proposed Insured B
3. Will you, the proposed insured and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	$\square Y \square N$	\square Y \square N
4. Have you, the proposed insured, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf which will have an ownership or beneficial interest in this policy?	□Y □N	
5. Have you, the proposed insured, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the proposed insured, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	□Y□N	
6. Have you, the proposed insured, ever sold a policy to a life settlement, viatical or other secondary market provider, or are you in the process of selling a policy?	\Box Y \Box N	\Box Y \Box N
7. Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.)		
OWNER INFORMATION		

8.	Owner Name	Owner
9.	Will you, the proposed owner and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	\Box Y \Box N
10.	Have you, the proposed owner, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf?	\Box Y \Box N
11.	Have you, the owner, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the owner, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	\Box Y \Box N
12.	Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? (If "Yes", please complete the Premium Financing Application Supplement.)	\Box Y \Box N
13.	Details: (List details from questions answered "Yes" and please specify to which question numbers details pertain.)	

SUITABILITY

Complete only if applying for Variable Life Insurance and submit allocation form(s) with this Application:

1.			
	Prospectus for the policy applied for and have you had sufficient time to review it?	$\sqcup Y$	\square 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?	\Box Y	\square 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?	$\square Y$	\square N
4.	With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your		
	anticipated financial needs?	$\square Y$	\square N

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, certify that the tax identification or social security number 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) Part I (including Sections A-D if needed); b) Part II Medical Application, if required; c) 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. This Application for Life Insurance Part I shall be complete when it includes Applicant Information Proposed Insured A, and any or none of the following (please check, as applicable, included Sections A-D):
 - □ Section A- Health Summary -Proposed Insured A, □ Section B- Applicant Information -Proposed Insured B, □ Section C. Health Summary Proposed Insured B, □ Section D. Defined A as Questionnaire
 - \square Section C -Health Summary -Proposed Insured B, and \square Section D Defined Age Questionnaire.
- 2. I/We further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me/us; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured(s); and 3) the Proposed Insured(s) remain in the same state of health and eligibility for insurance as described in each part of the application at the time conditions 1) and 2) are met.

I/We have paid \$______ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I/we acknowledge that I/we fully understand and accept its terms. (Please complete Temporary Life Insurance Agreement and submit with application.)

No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's

- 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.
- 4. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true to the best of my knowledge and belief. 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, provided the false statements were made with actual intent to deceive or if they materially affected the Company's acceptance of the risk.
- 5. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
- 6. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

AR, DC, KY, ME, NM, OH and PA Only. 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 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.

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TRUST VERIFICATION

I/WE hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any licensed physician, medical professional, hospital, clinic or any other medical institution, insurance support organizations, insurance company, Medical Information Bureau (MIB, Inc.), state motor vehicle division, consumer reporting agency, Social Security Administration, or employer that has any records or knowledge of me/us or my/our physical or mental health history, diagnosis, treatment, and prognosis, information regarding alcohol or drug abuse and including but not limited to transaction records, employment records, financial records, and complete medical records (including information regarding insurance, demographics, referral documents and records from other facilities), or motor vehicle information to give all such information to The Lincoln National Life Insurance Company, their licensed representatives and/or their reinsurers, MediConnect.net Inc., GiS, or any other party acting on the Company's behalf.

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

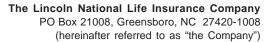
This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected. I/We or my/our authorized representative may have a copy of this authorization upon request. The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

☐ I elect to be interviewed if an Investigative Consumer Report is prepared. SIGNATORY SECTION Signed in this day of (state) (vear) Signature of Proposed Insured A Signature of Proposed Insured B (If coverage applied for) (Parent or Guardian if under 16 years of age) (Parent or Guardian if under 16 years of age) Signature of Applicant/Owner/Trustee (If other than Proposed Insured) Signature of Applicant/Owner/Trustee (If other than Proposed Insured) (Provide Officer's Title if policy is owned by a Corporation) (Provide Officer's Title if policy is owned by a Corporation) TO BE COMPLETED BY AGENT ONLY (i) Does the applicant have any existing life insurance policies or annuities? $\square Y \square N$ (ii) Do you know or have you any reason to believe that replacement of insurance is involved? $\square Y \square N$ If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant. I declare that I have accurately answered all questions contained in this section. I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice. Signature of Licensed Agent, Broker or Registered Representative Name of Licensed Agent, Broker or Registered Representative (Please Print) 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 of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

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AGENT'S REPORT (Completed Form Must Accompany Application for Life Insurance)

	GENERAL INFORMATION				
1.	(a) Name of Proposed Insured(s)			(b) How long h Insured(s)?	nave you known the Proposed
2.	Are you related to the Proposed Insured(s	s)?	If "Yes", Give deta	ils:	
3.	•	☐ Buy/Sell ☐ Outright Gift ☐	•	Charitable Gift	☐ Deferred Compensation
4.	(a) Is this policy being paid for with a premof the financing plan being used, name	nium financing loan?	☐ Yes ☐ No If "	Yes", provide com	plete details to include the name
	(b) Is this policy being paid for with functions based on the provision of funding for	• •		-	
	Details:				
 5.	Do the Proposed Insured(s) and Owner(s)	read and understanc	l the English Langua	ge? □ Yes □ N	No If "No", how was
	the application completed?				
6.	If LifeComp program was used, have you				
7.	Answer only if Proposed Insured is a Hor (a) Spouse's Life Insurance:	nemaker	Amo	ount Inforce	Amount Applied For \$
8.	Answer only if Proposed Insured is under	r age 18.	-		
	(a) Father's Life Insurance:		\$		\$
	(b) Mother's Life Insurance:		\$		\$
	(c) Are siblings also being insured?	Yes □ No	\$		\$
	If "No", please explain:		I		
9.	I have verified that this policy will not resecondary market provider. If otherwise,		as already been sold	to a life settlem	ent, viatical or other
	BUSINESS FINANCES (Complete only i	f this is business insu	rance)		
10.		☐ Partnership	☐ Sole Proprietors	hip \square Othe	er:
11.		☐ Owner of	% of business	r —	
12.		Total Business Liabi		Total Busine	ess Net Worth:
		\$		\$	
13.	Net Income (Profit) for the past 2 years:	Last year \$		Previous yea	nr \$

14.	What insurance does the business business insurance on each?	s maintain on the lives of each	corporate officer/key	y person/partner and t	he amoun	t of
	Name	Title	% of Ownership	Amount Inforce	Amount	Applied For
				\$	\$	
				\$	\$	
				\$	\$	
	ACENIE INTEGRALATION (E.		1 011	<u> </u>		T 1.
F	AGENT INFORMATION (To ensor inc	sure proper payment of commit correct information may delay			sections.	incomplete
15.	Name of Managing General Ager	<u> </u>			ng Organiz	zation (IMO):
16.	Have you recently submitted pap If "Yes" please describe the cha		ng hierarchy or com	mission set-up? \[\sum Y	es □ N	No .
17.	Agents who participated in this a	pplication: (please print)				
	Full Name of Agent(s) entitled to commission:		SSN (xxx-xx-xxxx)	Agent Numb Sa/Pc Code S		% Comm.
	Writing					%
	Second					%
	Third					%
18.	Primary Agent's: (a) E-mail Addr	ess:	(t) Phone Number:		
20.	mplete this section if you are affili MGA/RD/RLS Name: Broker Dealer Client/Owner Acco	,	Broker Dealer Afi	filiation:		
	AGENT CERTIFICATION					
 I a I c I c 	have reviewed all the questions of affecting the insurability of the Production of all sales materials were left with declare I have not been involved settlement, viatical or other second	posed Insured(s) which is not lved, I certify that only compa the applicant. in any recommendation regard	fully recorded in this any approved sales mandling the possible sale	s application. aterials were used in t	his sale and spolicy to	nd that copies
h	declare that I have verified that all has been disclosed on this applica ettlement, viatical or other second	ation, including any coverage				
f	declare, to the best of my knowled for with funds from any person or funding for the policy. If otherwise	entity whose only interest in t	he policy is the poter	ntial for earnings base	d on the p	provision of
► I	declare that I have accurately ans	wered all questions contained	in the Agent's Repo	rt in connection with	this appli	cation.
Sig	gnature of Licensed Agent, Broker or I	Registered Representative	 Date			

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