

SERFF Tracking Number: JEPL-125726813 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 39647
Company Tracking Number: J-5757
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Endowment Rider
Project Name/Number: Endowment Rider/J-5757

Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: Endowment Rider SERFF Tr Num: JEPL-125726813 State: ArkansasLH
TOI: L08 Life - Other SERFF Status: Closed State Tr Num: 39647
Sub-TOI: L08.000 Life - Other Co Tr Num: J-5757 State Status: Approved-Closed
Filing Type: Form Co Status: Sent to State Reviewer(s): Linda Bird
Authors: Jane Neidermyer, William Otten, Lori Saltmarsh Disposition Date: 07/18/2008
Date Submitted: 07/17/2008 Disposition Status: Approved
Implementation Date Requested: 11/01/2008 Implementation Date:

State Filing Description:

General Information

Project Name: Endowment Rider Status of Filing in Domicile: Pending
Project Number: J-5757 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 07/18/2008
State Status Changed: 07/18/2008 Deemer Date:
Corresponding Filing Tracking Number:
Filing Description:
Re: Individual Life Insurance Policy Form - Rider
J-5757 Endowment Rider
The Lincoln National Life Insurance Company
Group & NAIC #: 020-65676

We are submitting the required number of copies of the above-referenced Rider for your review and approval. It is a new form and will not replace any previously approved form. We will use previously approved applications LFF06300,

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LFF06311 and LFF06312 which were approved on 12/15/06 under file # 34427, SERFF # JEPL-125033786.

This individually underwritten Rider will be available in those situations where the company has a contractual obligation to make a product available with a guaranteed premium, guaranteed death benefit and endowment benefit. The Rider is an option for the client if the UL products in our portfolio do not meet the need by themselves. It will be available on fully underwritten, simplified issue and guaranteed issue UL policies. The issue ages for this Rider are 0-85. Upon approval, this Rider may be used with previously approved individual life insurance policy forms and any individual life insurance policies, which may be approved in the future.

We have bracketed certain items in the form as variable information because they may change for new issues in the future (but not in-force policies). These items include: officer names/signatures and the service office address. It is our understanding that changes to the bracketed items for new issues will not require a new filing of these forms. We confirm that the brackets will not actually appear on the forms at issue.

Rider form J-5757 achieves a Flesch score of 51.45. This filing is being submitted concurrently to our Home State of Indiana and is pending approval. The appropriate certification(s), transmittal and filing fee are included, as applicable. The policy form will be marketed with an illustration pursuant to the illustration regulation in your State and the corresponding certification is included. To the best of our knowledge and belief, the filing complies with all the laws and regulations of your state. This submission contains no unusual or possibly controversial items from the standpoint of normal company or industry standards.

We trust that the information provided is satisfactory and look forward to your response.

Company and Contact

Filing Contact Information

Jane Neidermyer, Compliance Analyst jane.neidermyer@lfg.com
One Granite Place (800) 258-3648 [Phone]
Concord, NH 03302-0515 (603) 226-5128[FAX]

Filing Company Information

The Lincoln National Life Insurance Company CoCode: 65676 State of Domicile: Indiana
350 Church Street Group Code: 20 Company Type: Life Insurance

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Hartford, CT 06103
(800) 258-3648 ext. [Phone]

Group Name:
FEIN Number: 35-0472300

State ID Number:

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Filing Fees

Fee Required? Yes
Fee Amount: \$35.00
Retaliatory? Yes
Fee Explanation: IN fee is \$35 per form filed
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Lincoln National Life Insurance Company	\$35.00	07/17/2008	21467512

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	07/18/2008	07/18/2008

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Disposition

Disposition Date: 07/18/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Submission Letter		Yes
Supporting Document	ASM		No
Form	Endowment Rider		Yes

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Form Schedule

Lead Form Number: J-5757

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	J-5757	Certificate	Endowment Rider	Initial		51	Final J-5757 Endowment Rider.pdf
		Amendmen	t, Insert				
		Page,	Endorseme				
		nt or Rider					

The Lincoln National Life Insurance Company,

Service Office: [100 North Greene Street, P.O. Box 21008, Greensboro, NC 27420-1008]

Endowment Rider

Rider Provisions

This Rider forms a part of the policy to which it is attached. "We", "Us" or "Our" means The Lincoln National Life Insurance Company; "You" and "Your" means the Owner of the policy as shown on the schedule page of the policy.

Effective Date The Effective Date of this Rider is the Policy Date as shown on the schedule page.

Benefit This Rider will guarantee that prior to the Insured's Attained Age 121 the policy will not enter the Grace Period during the Endowment Rider Requirement Period if the Endowment Rider Specified Premium Requirement Test is met as defined below.

Definitions

1. "Endowment Rider Specified Premium Requirement Test" is met on the Monthly Anniversary Day if the total gross premiums paid less partial surrenders and any Debt, is greater than or equal to the Endowment Rider Specified Monthly Required Premium as shown on the schedule page times the number of completed policy months as measured from the Policy Date.
2. "Endowment Rider Requirement Period" is all policy years prior to the Insured's Attained Age 121.

Grace Period Processing Under the Policy While this Rider is in effect the policy will enter the Grace Period if, on a Monthly Anniversary Day the Cash Surrender Value is insufficient to cover the cost of a monthly deduction due on the Monthly Anniversary Day unless one of the following tests is met:

- (1) the Endowment Rider Specified Premium Requirement Test as defined herein; or
- (2) any Five Year Minimum Premium Test if applicable to the base policy to which this Rider is attached.

We will require payment of the lesser of (1), (2) or (3) where:

- (1) is an amount required to restore the Cash Surrender Value to an amount sufficient to cover the cost of a monthly deduction for the month following the end of the Grace Period;

- (2) is an amount sufficient to meet the Endowment Rider Specified Premium Requirement Test during the Endowment Rider Requirement Period for the month following the end of the Grace Period;
- (3) is an amount sufficient to meet any Five Year Minimum Premium Test, if applicable, of the base policy to which this Rider is attached.

Reinstatement If Your Policy lapses and is reinstated, this Rider may be reactivated or reinstated. We will require payment of the lesser of (1) or (2) where:

- (1) is an amount that results in a Cash Surrender Value on the date of reinstatement that is sufficient to keep the policy and this Rider in force for at least 2 months;
- (2) is an amount that is sufficient to meet the Endowment Rider Specified Premium Requirement Test.

Effect of Policy Changes A change in Death Benefit Option under the policy will terminate this Rider. Decreases in Specified Amount and changes that result in a more favorable rating class may result in a decrease in the Endowment Rider Specified Monthly Required Premium. Rider additions and Rider deletions will have no effect on the Endowment Rider Specified Monthly Required Premium. Increases in Specified Amount will result in an increase to the Endowment Rider Specified Monthly Required Premium. Such change will be effective on the Monthly Anniversary Day coincident with or next following your request for a change. We will notify You of any increase in Endowment Rider Specified Monthly Required Premium.

Continuation of Policy at Attained Age 121 When Endowment Rider is in Effect

If this Rider is in force at the Insured's Attained Age 121 and the Endowment Rider Specified Premium Requirement Test is met (and the policy is not in the Grace Period), the following changes will occur. This provision will replace the "Continuation of Policy After Age 121" provision as outlined in the policy:

- (a) Your policy will continue in force for the lifetime of the Insured unless You surrender this policy;
- (b) the Cash Value will be set equal to the Death Benefit and thereafter the Cash Surrender Value will be equal to the Death Benefit decreased by any Debt;
- (c) no further premium payments may be made;

- (d) no further monthly deductions will be taken;
- (e) no further partial surrenders may be taken (policy must be fully surrendered);
- (f) policy loans can continue to be taken. Loan rates will apply as stated on the schedule page; and
- (g) all supplemental riders and benefits will terminate.

Termination This rider will end and coverage will cease to be in force upon the earlier of:

- a. Our receipt of written request by You to terminate the Policy or this Rider;
- b. The death of the Insured;
- c. Surrender, lapse or termination of the policy;
- d. A Death Benefit Option change under the policy.

[*C. Suzanne Ulmack*]

[Secretary]

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Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 07/09/2008

Comments:

Attachments:

AR Cert. of Compl..pdf
AR_Readability.pdf

Review Status:

Satisfied -Name: Application 07/09/2008

Comments:

We will use previously approved applications LFF06300, LFF06311 and LFF06312 which were approved on 12/15/06 under file # 34427, SERFF # JEPL-125033786.

Attachments:

Generic LFF06300.pdf
LFF06311 Generic LNL only.pdf
LFF06312 Generic LNL only.pdf

Review Status:

Satisfied -Name: Submission Letter 07/10/2008

Comments:

Attachment:

AR Sublet.pdf

ARKANSAS

CERTIFICATE OF COMPLIANCE

The Lincoln National Life Insurance Company

Re: J-5757 Endowment Rider

To the best of my knowledge and belief, the rider listed above complies with the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance department.

To the best of my knowledge and belief we are in compliance with the requirements of Arkansas Code Ann. 23-79-138. We provide a document entitled "Important Information to Policyholders" which contains the required information.

To the best of my knowledge and belief we are in compliance with the requirements of Regulation 49 and we provide the required Guaranty Association notice.



Pamela M. Telfer, AVP
Product Compliance

Date: July 14, 2008

VUL, UL, TERM

Arkansas

READABILITY CERTIFICATION

The Lincoln National Life Insurance Company

Re: J-5757 – Endowment Rider

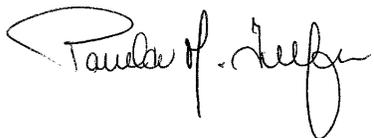
We hereby certify that the attached Form is in compliance with the Rules and Regulation requirements regarding Life, Annuities, and Accident and Sickness Insurance Language Simplification Standards and has achieved a Flesch Reading Ease score of:

Form Number:

J-5757

Flesch:

51.45



Pamela M. Telfer, Assistant Vice President
Product Compliance

Date: July 14, 2008

APPLICATION FOR LIFE INSURANCE - PART I

PROPOSED INSURED A

1. Name (First) (Middle) (Last)			2. <input type="checkbox"/> Male <input type="checkbox"/> Female		3. Date of Birth (mm/dd/yy)	
4. Place of Birth (State, Country)		5. Social Security Number (xxx-xx-xxxx)		6. Driver License # & State		
7a. Home Address (Street) (City) (State)			7b. Home Address Zip Code			
8. Employer			9. Occupation/Duties			
10a. Business Address (Street) (City) (State)			11. Phone Number (check most convenient time to contact) Primary: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Work: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Email: _____			
10b. Business Address Zip Code:						
12. Annual Earned Income: \$			13. Annual Unearned Income: \$			
14. Total Assets: \$			15. Total Liabilities: \$			
16. Net Worth: \$			17. In the last 5 years have you filed for bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", complete the Financial Supplement.			

18. 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? Yes No
 (If "Yes", please complete and sign all required replacement forms and complete Question 19.)

19. What is the total amount of all inforce insurance on your life? (Please list in the box below.) **If none, check this box:**

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	Check here if 1035Exchange
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

20. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? (If "Yes", provide details in Question 26.) Yes No

21. 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" to Question 21, complete with details below.) Yes No

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	\$		
	\$		
	\$		

22. Will you, the proposed insured and/or beneficiary, and/or any entity on your behalf, receive any compensation, whether via the form of cash, property, an agreement to pay money in the future, a percentage of the death benefit, or otherwise, if this policy is issued? (If "Yes", provide details in Question 26.) Yes No

23. Have you, the proposed insured, been involved in any discussion about the possible sale or assignment of this policy or a beneficial interest in a trust, LLC or other entity created or to be created on your behalf? (If "Yes", provide details in Question 26.) Yes No

24. 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? (If "Yes", provide details in Question 26.) Yes No

25. 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.) Yes No

26. **Details:** (List details from questions above; please include question number details pertain to.)

APPLICATION FOR LIFE INSURANCE - PART I

PROPOSED INSURED B

1. Name (First) (Middle) (Last)	2. <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Date of Birth (mm/dd/yy)
4. Place of Birth (State, Country)	5. Social Security Number (xxx-xx-xxxx)	6. Driver License # & State

7a. Home Address (Street) (City) (State)	7b. Home Address Zip Code
--	---------------------------

8. Employer	9. Occupation/Duties
-------------	----------------------

10a. Business Address (Street) (City) (State)	11. Phone Number (check most convenient time to contact) Primary: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Work: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Email: _____
10b. Business Address Zip Code:	

12. Annual Earned Income: \$	13. Annual Unearned Income: \$
------------------------------	--------------------------------

14. Total Assets: \$	15. Total Liabilities: \$
----------------------	---------------------------

16. Net Worth: \$	17. In the last 5 years have you filed for bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "Yes", complete the Financial Supplement.</i>
-------------------	--

18. 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? Yes No
(If "Yes", please complete and sign all required replacement forms and complete Question 19.)

19. What is the total amount of all inforce insurance on your life? *(Please list in the box below.)* **If none, check this box:**

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	Check here if 1035Exchange
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

20. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide details in Question 26.)* Yes No

21. 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" to Question 21, complete with details below.)* Yes No

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	\$		
	\$		
	\$		

22. Will you, the proposed insured and/or beneficiary, and/or any entity on your behalf, receive any compensation, whether via the form of cash, property, an agreement to pay money in the future, a percentage of the death benefit, or otherwise, if this policy is issued? *(If "Yes", provide details in Question 26.)* Yes No

23. Have you, the proposed insured, been involved in any discussion about the possible sale or assignment of this policy or a beneficial interest in a trust, LLC or other entity created or to be created on your behalf? *(If "Yes", provide details in Question 26.)* Yes No

24. 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? *(If "Yes", provide details in Question 26.)* Yes No

25. 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.)* Yes No

26. **Details:** *(List details from questions above; please include question number details pertain to.)*

OWNER INFORMATION (If left blank, Proposed Insured(s) will be owner)

► If a Trust, provide Trustee Name(s), Trust Name.

27. Owner Name (First, Middle, Last)		28. Citizen of (Country)
29. Owner Address		30. Date of Birth (if applicable) (mm/dd/yy)
31. Owner Social Security or Tax ID #	32. Relationship to Proposed Insured(s)	33. Trust Date (only if Trust is Owner)

34. Is this policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? Yes No
35. Will you, the proposed owner and/or beneficiary, and/or any entity on your behalf, receive any compensation, whether via the form of cash, property, an agreement to pay money in the future, a percentage of the death benefit, or otherwise, if this policy is issued? (If "Yes", provide details in Question 38.) Yes No
36. Have you, the proposed owner, been involved in any discussion about the possible sale or assignment of this policy or a beneficial interest in a trust, LLC or other entity created or to be created on your behalf? (If "Yes", provide details in Question 38.) Yes No
37. 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.) Yes No
38. **Details:** (List details from questions above; please include question number details pertain to.)

COVERAGE INFORMATION

39. Plan of Insurance _____ (If you are applying for MoneyGuard Long Term Care, please complete the MoneyGuard LTC Supplement to Application. If you are applying for variable life insurance, please complete Premium Allocation and Disclosure form.)

40. Amount of Insurance (Specified Amount, if UL or VUL) _____

41. (i) Death Benefit Option (Complete for Universal Life and Variable Universal Life Product only - not required for Term or Whole Life.)
 Level Increase by Cash Value Increase by Premium Increase by Premium Less Policy Factor

(ii) Death Benefit Qualification Test - For IRS purposes, premiums will be tested using the Guideline Premium Test unless
 Cash Value Accumulation Test is checked (not available on all products). **Cannot be changed after issue.**

42. Additional Benefits and Riders: Waiver of Premium Accelerated Benefit Rider Disability Income Rider (Complete DI Supplement)

Waiver Monthly Deductions Waiver Specified Premium \$ _____

Term on Spouse/Other Insured Rider \$ _____ Children's Term Insurance Rider (Complete Child's Supplement)

Supplemental Coverage \$ _____

Other Benefits and Riders (not listed above). Please provide full details: e.g. coverage amounts/percentages/etc.):

43. Save Age (Not applicable to MoneyGuard) Yes No (If not saving age, policy will be current dated.)

44. Complete only if applying for Variable Life Insurance with the Company. Submit Premium Allocation and Disclosure Form for Variable Universal Life with Application:

Suitability

- | | Yes | No |
|--|--------------------------|--------------------------|
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |

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.

BILLING INSTRUCTIONS AS AVAILABLE PER PRODUCT

45. Planned Premium: \$ _____ 46. Lump Sum: \$ _____ 1035 Exchange
47. Premium Frequency: Annually Semi-Annually Quarterly Monthly (EFT) Other _____
48. Special Billing: *(check one, if applicable)* New List Bill Existing List Bill *(provide #)* _____
49. Automatic Premium Loan *(Complete for Whole Life only.)* Yes No
50. Premium Notices To: *(check all that apply.) (Please note we cannot bill to your agent.)*
- Insured at Residence Insured at Business Owner Other _____

51. Special Instructions:

BENEFICIARY DESIGNATION *Beneficiaries share equally unless otherwise indicated.*

► **If a Trust, provide Trustee Name(s), Trust Name and date of Trust.**

52. Primary Beneficiary(ies):	53. Social Security or Tax ID #:	54. Relationship to Proposed Insured:
55. Contingent Beneficiary(ies):	56. Social Security or Tax ID #:	57. Relationship to Proposed Insured:
58. Beneficiary for Spouse/Other Insured Term Rider:	59. Social Security or Tax ID #:	60. Relationship to Spouse/Other Insured:

MEDICAL INFORMATION - PROPOSED INSURED A (Answer this section only when required.)

► If you answer “Yes” to any of the following questions, please give details in the space provided on the next page.

71. Provide full name/address/phone number of personal physician(s) and any other physicians seen:

a. Date and reason of last visit: _____

b. Tests performed & treatment received: _____

72. Height _____ ft. / _____ in. Weight _____ lbs.

a. Has your weight changed by more than 10 pounds during the past 12 months? Yes No

b. If “Yes”, by how many pounds? _____ Gain Loss

73. Have you had or been advised to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason? **Yes** **No**

74. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised to have any hospitalization or surgery which has not been completed?

75. **Have you ever had any indication of, or been treated for:**

- a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?
- b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?
- c. Anemia, leukemia, clotting disorder or any other blood disorder?
- d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?
- e. Asthma, emphysema, shortness of breath, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?
- f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?
- g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?
- h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?
- i. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?
- j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?
- k. Any disorder of the eyes, ears, nose or throat?
- l. Any mental or physical disorder medically or surgically treated condition not listed above?

76. Have you ever been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome or an AIDS related condition?

77. Do you use alcoholic beverages?
(If “Yes”, provide Type, Frequency & Amount.) Type _____ Frequency _____ Amount _____

78. Have you ever been treated for drug or alcohol abuse or been advised by your doctor to limit your use of alcohol or any medication, prescribed or not?

79. Have you ever used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?

80. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.

MEDICAL INFORMATION - PROPOSED INSURED A CONTINUED (Answer this section only when required.)

81. **Details** (List details from "Yes" answered Medical Information questions; please include question number.)

82.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? <i>(include age of onset)</i>	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

SERVICE OFFICE ENDORSEMENTS (Attach an additional sheet of paper, if necessary.)

MEDICAL INFORMATION - PROPOSED INSURED B (Answer this section only when required.)

► If you answer "Yes" to any of the following questions, please give details in the space provided on the next page.

71. Provide full name/address/phone number of personal physician(s) and any other physicians seen:

a. Date and reason of last visit: _____

b. Tests performed & treatment received: _____

72. Height _____ ft. / _____ in. Weight _____ lbs.

a. Has your weight changed by more than 10 pounds during the past 12 months? Yes No

b. If "Yes", by how many pounds? _____ Gain Loss

73. Have you had or been advised to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason? **Yes** **No**

74. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised to have any hospitalization or surgery which has not been completed?

75. **Have you ever had any indication of, or been treated for:**

- a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?
- b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?
- c. Anemia, leukemia, clotting disorder or any other blood disorder?
- d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?
- e. Asthma, emphysema, shortness of breath, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?
- f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?
- g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?
- h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?
- i. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?
- j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?
- k. Any disorder of the eyes, ears, nose or throat?
- l. Any mental or physical disorder medically or surgically treated condition not listed above?

76. Have you ever been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome or an AIDS related condition?

77. Do you use alcoholic beverages?
(If "Yes", provide Type, Frequency & Amount.) Type _____ Frequency _____ Amount _____

78. Have you ever been treated for drug or alcohol abuse or been advised by your doctor to limit your use of alcohol or any medication, prescribed or not?

79. Have you ever used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?

80. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.

MEDICAL INFORMATION - PROPOSED INSURED B CONTINUED (Answer this section only when required.)

81. **Details** (List details from "Yes" answered Medical Information questions; please include question number.)

82.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? <i>(include age of onset)</i>	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

SERVICE OFFICE ENDORSEMENTS (Attach an additional sheet of paper, if necessary.)

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, declare that my tax identification or social security number as shown 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 Application; 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. If the application includes no secondary insured (insured B), the application shall be complete without pages 1b, 4b, 5b, and 6b.
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 insurability 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.

3. 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.
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.

Oklahoma Only. *Warning:* Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of insurance fraud.

Washington Only. Any person who knowingly presents a false or fraudulent claim for the payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

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.

Connecticut and Texas Only. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, as determined by a court of competent jurisdiction.

Louisiana Only. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me/us or my/our physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I/We authorize the Company to disclose medical information to MIB, Inc., and to other insurers to whom I/we may apply for coverage.

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

The 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.

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) (month) (year)

Signature of Proposed Insured A
(Parent or Guardian if under 14 years of age)

Signature of Proposed Insured B (If coverage applied for)
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

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, New Account Form and Premium Allocation and Disclosure Form and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

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

GUARANTEED ISSUE APPLICATION FOR LIFE INSURANCE

PROPOSED INSURED					
1. Name (First) (Middle) (Last)			2. <input type="checkbox"/> Male <input type="checkbox"/> Female		
3. Place of Birth (State, Country)		4. Social Security Number (xxx-xx-xxxx)		5. Date of Birth (mm/dd/yy)	
6a. Home Address (Street) (City) (State)			6b. Home Address Zip Code		
7. Employer			8. Citizen of (Country)		
9a. Business Address (Street) (City) (State)			9b. Business Address Zip Code		

COVERAGE INFORMATION

10. Plan of Insurance (If VUL also complete Question 16, Premium Allocation and Disclosure Form)

11. Additional Benefits If Available (Please List):

12. Amount of Insurance (Specified Amount, if UL or VUL) \$

13. (i) Death Benefit Option (Complete for Universal Life and Variable Universal Life Product only - not required for Term and Whole Life.)
 Level Increase by Cash Value Increase by Premium Increase by Premium Less Policy Factor

(ii) Death Benefit Qualification Test - For IRS purposes, premiums will be tested using the Guideline Premium Test unless
 Cash Value Accumulation Test is checked (not available on all products). **Cannot be changed after issue.**

14. 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? Yes No
 (If "Yes", please complete and sign all required replacement forms and complete Question 15.)

15. What is the total amount of all inforce insurance on your life? (Please list in the box below.) **If none, check this box:**

Company	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	Check here if 1035Exchange
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

16. Complete only if applying for Variable Life Insurance with the Company. Submit Premium Allocation and Disclosure Form for Variable Universal Life with Application:

Suitability

- | | Yes | No |
|--|--------------------------|--------------------------|
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |

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.

OWNER INFORMATION (If left blank, Proposed Insured(s) will be owner)

► If a Trust, provide Trustee Name(s), Trust Name.

17. Owner Name (First, Middle, Last) _____ 18. Citizen of (Country) _____

19. Owner Address _____

20. Owner Social Security or Tax ID # _____ 21. Relationship to Proposed Insured(s) _____ 22. Trust Date (only if Trust is Owner) _____

23. Is the policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? Yes No

BENEFICIARY DESIGNATION Beneficiaries share equally unless otherwise indicated.

► If a Trust, provide Trustee Name(s), Trust Name and date of Trust.

24. Primary Beneficiary(ies): _____ 25. Social Security or Tax ID #: _____ 26. Relationship to Proposed Insured: _____
27. Contingent Beneficiary(ies): _____ 28. Social Security or Tax ID #: _____ 29. Relationship to Proposed Insured: _____

BILLING INSTRUCTIONS AS AVAILABLE PER PRODUCT

30. Planned Premium: \$ _____ 31. Lump Sum: \$ _____ 1035 Exchange
32. Premium Frequency: Annually Semi-Annually Quarterly Monthly (EFT)
 New List Bill Existing List Bill (provide #) _____
 PDF (Complete Transmittal) Other _____

33. Premium Notices To: (check all that apply.) (Please note we cannot bill to your agent.)
 Insured at Residence Insured at Business Owner Other _____

GENERAL RISK INFORMATION

34. What is your regular occupation? _____ Indicate length of time in your regular occupation _____

35. Have you ever used tobacco or products containing nicotine? (If "Yes", check all that apply.) Yes No

Type: Cigarettes Cigar Pipe Chew Tobacco Snuff Nicotine Patches/ Gum

Date First Used: (month/year) _____

Date Last Used: (month/year) _____

Amount and Frequency: _____

36. Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment or business for at least 30 hours per week? Yes No

36a If you answered "No" to question 35, please give details here:

37. Special Instructions:

SERVICE OFFICE ENDORSEMENTS (Attach an additional sheet of paper, if necessary)

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, declare that my tax identification or social security number as shown is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of any amendments to the application(s) attached thereto and any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. No agent or broker has the authority to make or modify any Company contract or to waive any of the Company's requirements.
3. I HAVE READ, or have had read to me, the completed Guaranteed Issue Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true.
4. I understand that, in order to informally fund benefit obligations, the Company may need to increase the amount of insurance under existing Policies on my life from time to time. I hereby authorize the Company to effect such an increase or increases without providing any further notice to me.
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.

Oklahoma Only. *Warning:* Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of insurance fraud.

Washington Only. Any person who knowingly presents a false or fraudulent claim for the payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

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.

Connecticut and Texas Only. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, as determined by a court of competent jurisdiction.

Louisiana Only. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

SIGNATORY SECTION

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

Signature of Proposed Insured
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(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? Yes No
- (ii) Do you know or have you any reason to believe that replacement of insurance is involved? Yes No
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.
- (iii) I declare that I asked the Proposed Insured each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of the Proposed Insured which is not fully recorded in this application.
- (iv) Identify any special compensation instructions or commission schedule or Check here if there is no special commission program:

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, New Account Form and Premium Allocation and Disclosure Form and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

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

SIMPLIFIED ISSUE APPLICATION FOR LIFE INSURANCE

PROPOSED INSURED					
1. Name (First) (Middle) (Last)	2. <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Date of Birth (mm/dd/yy)			
4. Place of Birth (State, Country)	5. Social Security Number (xxx-xx-xxxx)	6. Driver License # & State			
7a. Home Address (Street) (City) (State)	7b. Home Address Zip Code				
8. Employer			9. Citizen of (Country)		
10a. Business Address (Street) (City) (State)	10b. Business Address Zip Code				

COVERAGE INFORMATION

11. Plan of Insurance (If VUL also complete Question 17, Premium Allocation and Disclosure Form)

12. Additional Benefits If Available (Please List):

13. Amount of Insurance (Specified Amount, if UL or VUL) \$

14. (i) Death Benefit Option (Complete for Universal Life and Variable Universal Life Product only - not required for Term or Whole Life.)
 Level Increase by Cash Value Increase by Premium Increase by Premium Less Policy Factor

(ii) Death Benefit Qualification Test - For IRS purposes, premiums will be tested using the Guideline Premium Test unless
 Cash Value Accumulation Test is checked (not available on all products). **Cannot be changed after issue.**

15. 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? Yes No
(If "Yes", please complete and sign all required replacement forms and complete Question 16.)

16. What is the total amount of all inforce insurance on your life? (Please list in the box below.) **If none, check this box:**

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	Check here if 1035Exchange
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>

17. Complete only if applying for Variable Life Insurance with the Company. Submit Premium Allocation and Disclosure Form for Variable Universal Life with Application:

Suitability	Yes	No
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>

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.

OWNER INFORMATION (If left blank, Proposed Insured(s) will be owner)

► If a Trust, provide Trustee Name(s), Trust Name.

18. Owner Name (First, Middle, Last) _____ 19. Citizen of (Country) _____

20. Owner Address _____

21. Owner Social Security or Tax ID # _____ 22. Relationship to Proposed Insured(s) _____ 23. Trust Date (only if Trust is Owner) _____

24. Is the policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? Yes No

BENEFICIARY DESIGNATION Beneficiaries share equally unless otherwise indicated.

► If a Trust, provide Trustee Name(s), Trust Name and date of Trust.

25. Primary Beneficiary(ies): _____ 26. Social Security or Tax ID #: _____ 27. Relationship to Proposed Insured: _____

28. Contingent Beneficiary(ies): _____ 29. Social Security or Tax ID #: _____ 30. Relationship to Proposed Insured: _____

BILLING INSTRUCTIONS AS AVAILABLE PER PRODUCT

31. Planned Premium: \$ _____ 32. Lump Sum: \$ _____ 1035 Exchange

33. Premium Frequency: Annually Semi-Annually Quarterly Monthly (EFT)
 New List Bill Existing List Bill (provide #) _____
 PDF (Complete Transmittal) Other _____

34. Premium Notices To: (check all that apply.) (Please note we cannot bill to your agent.)
 Insured at Residence Insured at Business Owner Other _____

GENERAL RISK INFORMATION

35. Have you ever used tobacco or products containing nicotine? (If "Yes", check all that apply.) Yes No

Type: Cigarettes Cigar Pipe Chew Tobacco Snuff Nicotine Patches/ Gum

Date First Used: (month/year) _____

Date Last Used: (month/year) _____

Amount and Frequency: _____

36. Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment or business for at least 30 hours per week? Yes No

36a If you answered "No" to question 36, please give details here: _____

37. Height _____ft. _____in. Weight _____lbs **Yes No**

38. What is your regular occupation? _____

39. In the past 10 years have you applied for life, health or disability insurance and been declined, postponed or charged an increased premium?

40. Within the past two years, have you flown as a pilot, student pilot or crew member, or engaged in skin or scuba diving, racing of any kind, parachuting, sky diving or hang gliding, mountain, rock or technical climbing?

If "Yes", please complete an Aviation - Avocation Supplement.

41. In the past 10 years have you been treated for high blood pressure, heart disease, chest pain, diabetes, digestive disorder, lung disorder, cancer, kidney disease, liver disorder or nervous disorder?

42. In the past 5 years have you received treatment for alcohol or drug use?

- | | Yes | No |
|---|--------------------------|--------------------------|
| 43. In the past 5 years have you been convicted of (i) two or more moving violations, (ii) driving under the influence of alcohol or other drugs (unless prescribed by a doctor), or (iii) had your driver's license suspended or revoked? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. In the past 10 years have you been diagnosed by a medical professional as having human immune deficiency virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), or have you received treatment from a medical professional for AIDS? | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. In the past 5 years have you been examined or treated by a physician or medical practitioner or been examined or treated in a hospital? If "Yes" provide name and address of personal physician and/or health care facility. | <input type="checkbox"/> | <input type="checkbox"/> |
- If you answered "Yes" to question 37-45, please give complete details here including date of last treatment and name/address/phone number of the attending physician (attach an additional sheet of paper if necessary):

46. Special Instructions:

SERVICE OFFICE ENDORSEMENTS (Attach an additional sheet of paper, if necessary)

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, declare that my tax identification or social security number as shown is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of any amendments to the application(s) attached thereto and any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
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 insurability 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.
3. 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 Simplified Issue Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true.
5. I understand that, in order to informally fund benefit obligations, the Company may need to increase the amount of insurance under existing Policies on my life from time to time. I hereby authorize the Company to effect such an increase or increases without providing any further notice to me.
6. 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.
7. 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.

Oklahoma Only. Warning: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of insurance fraud.

Washington Only. Any person who knowingly presents a false or fraudulent claim for the payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

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.

Connecticut and Texas Only. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, as determined by a court of competent jurisdiction.

Louisiana Only. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me/us or my/our physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I/We authorize the Company to disclose medical information to MIB, Inc., and to other insurers to whom I/we may apply for coverage.

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

The 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.

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 _____ (year)
(state) (month)

Signature of Proposed Insured
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(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? Yes No
- (ii) Do you know or have you any reason to believe that replacement of insurance is involved? Yes No
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.
- (iii) I declare that I asked the Proposed Insured each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of the Proposed Insured which is not fully recorded in this application.
- (iv) Identify any special compensation instructions or commission schedule or Check here if there is no special commission program:

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, New Account Form and Premium Allocation and Disclosure Form and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

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

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.

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 incontestability 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: Box 105 Essex Station, Boston, MA 02112. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)



July 14, 2008

Hon. Julie Benafield Bowman
Commissioner of Insurance
Compliance-Life & Health
Attn: Joe Musgrove
1200 West Third Street
Little Rock, AR 72201-1904

Lincoln Financial Group
One Granite Place
P.O. Box 515
Concord, NH 03302
phone 603 226-5000

Re: Individual Life Insurance Policy Form - Rider
J-5757 Endowment Rider
The Lincoln National Life Insurance Company
Group & NAIC #: 020-65676

Dear Mr. Musgrove:

We are submitting the required number of copies of the above-referenced Rider for your review and approval. It is a new form and will not replace any previously approved form. We will use previously approved applications LFF06300, LFF06311 and LFF06312 which were approved on 12/15/06 under file # 34427, SERFF # JEPL-125033786.

This individually underwritten Rider will be available in those situations where the company has a contractual obligation to make a product available with a guaranteed premium, guaranteed death benefit and endowment benefit. The Rider is an option for the client if the UL products in our portfolio do not meet the need by themselves. It will be available on fully underwritten, simplified issue and guaranteed issue UL policies. The issue ages for this Rider are 0-85. Upon approval, this Rider may be used with previously approved individual life insurance policy forms and any individual life insurance policies, which may be approved in the future.

We have bracketed certain items in the form as variable information because they may change for new issues in the future (but not in-force policies). These items include: officer names/signatures and the service office address. It is our understanding that changes to the bracketed items for new issues will not require a new filing of these forms. We confirm that the brackets will not actually appear on the forms at issue.

Rider form J-5757 achieves a Flesch score of 51.45. This filing is being submitted concurrently to our Home State of Indiana and is pending approval. The appropriate certification(s), transmittal and filing fee are included, as applicable. The policy form will be marketed with an illustration pursuant to the illustration regulation in your State and the corresponding certification is included. To the best of our knowledge and belief, the filing complies with all the laws and regulations of your state. This submission contains no unusual or possibly controversial items from the standpoint of normal company or industry standards.

We trust that the information provided is satisfactory and look forward to your response. Unless submitted electronically, a postage-paid envelope has been enclosed for your convenience in corresponding with us. Should you require any additional information, please feel free to contact me toll-free at 1-800-258-3648, ext. 5627, or via the email address shown below.

Sincerely,

A handwritten signature in cursive script that reads 'Jane P. Neidermyer'.

Jane P. Neidermyer, FLMI, ACS
Senior Compliance Analyst
E-mail: jane.Neidermyer@lfg.com

www.lfg.com

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates