

SERFF Tracking Number: LCNC-126091339 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42032
Company Tracking Number: LFF06371 ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: IM Life Application
Project Name/Number: IM Life Application/LFF06371 et al

Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: IM Life Application

SERFF Tr Num: LCNC-126091339 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 42032

Sub-TOI: L08.000 Life - Other

Co Tr Num: LFF06371 ET AL

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Beth Scekeres, Jane
Neidermyer, Lori Saltmarsh

Disposition Date: 04/03/2009

Date Submitted: 04/02/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: IM Life Application

Status of Filing in Domicile: Pending

Project Number: LFF06371 et al

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: 04/03/2009

Explanation for Other Group Market Type:

State Status Changed: 04/03/2009

Deemer Date:

Created By: Lori Saltmarsh

Submitted By: Beth Scekeres

Corresponding Filing Tracking Number:

Filing Description:

The Lincoln National Life Insurance Company
(NAIC# 020-65676, FEIN # 35-0472300)

Re: Individual Life Application Forms

LFF06371 Application for Life Insurance (Part I)

LFF06372 Temporary Life Insurance Agreement

We are submitting the required number of copies of the above-referenced forms for your review and approval. The

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application and agreement are new forms and are not intended to replace any previously approved forms.

Upon approval, the Application for Life Insurance (Part I) and Temporary Life Insurance Agreement will be used in applying for our individual life insurance products sold by properly licensed agents/representatives.

The forms received the following Flesch scores: Application for Life Insurance (Part I) 51.12 and Temporary Life Insurance Agreement 51.56. These forms have been submitted concurrently to our Home State of Indiana and are pending approval. If applicable, the appropriate certifications, transmittals, checklists and filing fees are included. To the best of our knowledge and belief, these forms comply with all the applicable laws and regulations of your state.

We have bracketed several items within the forms as variable information to allow for flexibility in the content of the form. No change in the variable areas will be made which will be in conflict with the laws, rules and regulations of your jurisdiction. In addition, no change in the variability will be made which in any way expands the scope of the item being changed. 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. Upon approval, we reserve the right to change the format of a form without altering the approved language, though it is possible page numbers may change.

Company and Contact

Filing Contact Information

Beth Scekeres, Contract Analyst Beth.Scekeres@lfg.com
350 Church Street 860-466-1962 [Phone]
MPM1 860-466-1348 [FAX]
Hartford, CT 06103-1106

Filing Company Information

The Lincoln National Life Insurance Company CoCode: 65676 State of Domicile: Indiana
350 Church Street - MPM1 Group Code: 20 Company Type: Life
Hartford, CT 06103-1106 Group Name: State ID Number:
(860) 466-2899 ext. [Phone] FEIN Number: 35-0472300

Filing Fees

Fee Required? Yes
Fee Amount: \$70.00
Retaliatory? Yes
Fee Explanation: \$35 ea retaliatory x 2 forms = \$70

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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Lincoln National Life Insurance Company	\$70.00	04/02/2009	26895336

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/03/2009	04/03/2009

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Disposition

Disposition Date: 04/03/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Form Schedule

Lead Form Number: LFF06371

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LFF06371	Application/ Application for Life Enrollment Insurance - Part I Form	Initial		51.120	LFF06371.pdf
	LFF06372	Application/Temporary Life Enrollment Insurance Agreement Form	Initial		51.560	LFF06372.pdf

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 this notice to the 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)]

APPLICATION FOR LIFE INSURANCE - PART I

APPLICANT INFORMATION - PROPOSED INSURED (Required Section)		
1. Proposed Insured <i>(First, Middle, Last)</i>	2. <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Date of Birth <i>(mm/dd/yy)</i>	4. Soc. Sec. No. (SSN)	5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," what country?
6. Place of Birth <i>(State, Country)</i>	7. Driver's License # & State	
8. Home Address <i>(Street, City, State, ZIP)</i>		
9. Occupation/Duties	10. Employer	
11. Business Address <i>(Street, City, State, ZIP)</i>		
12. Annual Income <i>(from all sources)</i> \$	13. Net Worth \$	

COVERAGE INFORMATION (As available per product)	
14. Plan of Insurance _____	15. Amount of Insurance \$ _____ <i>(Specified Amount, if UL or VUL)</i>
16. (i) Death Benefit Option <input type="checkbox"/> Level <input type="checkbox"/> _____ (Not available with all products, see product specifications for details.) (ii) Death Benefit Qualification Test (DBQT) - For IRS purposes, premiums will be tested using the Guideline Premium Test unless <input type="checkbox"/> Cash Value Accumulation Test is checked (not available on all products or with all riders). The DBQT cannot be changed after issue unless the terms of the policy require a change.	
17. Save Age? <input type="checkbox"/> Y <input type="checkbox"/> N <i>(If not saving age, policy will be current dated.)</i>	
18. Additional Benefits and Riders: <i>(If applicable)</i> <input type="checkbox"/> [Accelerated Benefit Rider] <input type="checkbox"/> Other Benefits and Riders <i>(not listed above)</i> . (Please provide full details: e.g. coverage amounts/percentages/etc.):	

BILLING INSTRUCTIONS (As available per product)	
19. Premium Mode: <input type="checkbox"/> Single Premium <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (EFT) <input type="checkbox"/> Other _____	
20. Modal Planned Premium: \$ _____	21. Lump Sum: \$ _____ <input type="checkbox"/> 1035 Exchange
22. Source of Premium: _____ <i>(inheritance, loan, business activity)</i>	
23. Premium Notices To: <i>(check one only.) (Please note we cannot bill to your agent.)</i> <input type="checkbox"/> Owner <input type="checkbox"/> Insured at Business <input type="checkbox"/> Insured at Residence <input type="checkbox"/> Other <i>(indicate below)</i>	
24. Special Instructions <i>(Please specify to which question number Special Instructions pertain.)</i>	

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

25. Owner Name	26. Date of Birth	27. SSN
28. Relationship	29. Citizen of (Country)	
30. Owner Address		
31. 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? <input type="checkbox"/> Y <input type="checkbox"/> N		

BENEFICIARY DESIGNATION (Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.)

32. Indicate Primary (P) or Contingent (C) Beneficiary for each line completed in the first column.

P/C	Beneficiary Name (with Trustees)	Relationship	DOB or Trust Date	SSN/TIN

APPLICANT INFORMATION - PROPOSED INSURED

33. 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.)

34. 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 none, check this box:
 Please indicate the Type of coverage: Business **(B)**; Key Person **(K)**; or Personal **(P)**.

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Replacement or Change of Policy?	1035 Exchange	Type
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
	\$			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

35. 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.)* Y N

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

36. What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? \$ _____

► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.

37. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? Y N

38. 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? Y N

39. 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? Y N

40. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? Y N

GENERAL RISK INFORMATION - PROPOSED INSURED			
41. Have you been declined for life insurance within the past 5 years, or had a trial or formal application submitted to the Company within the past 12 months?			<input type="checkbox"/> Y <input type="checkbox"/> N
42. 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.)			<input type="checkbox"/> Y <input type="checkbox"/> N
43. 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; or in similar sports? (If "Yes", an Avocation Supplement is required.)			<input type="checkbox"/> Y <input type="checkbox"/> N
44. Within the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? (If "Yes", please indicate what type and dates in the "Details" space provided.)			<input type="checkbox"/> Y <input type="checkbox"/> N
45. Have you ever been convicted of or are you awaiting trial for a felony? (If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in the "Details" space provided.)			<input type="checkbox"/> Y <input type="checkbox"/> N
46. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? (If "Yes", list below.)			<input type="checkbox"/> Y <input type="checkbox"/> N
Type:	Date First Used: (month/year)	Date Last Used: (month/year)	Amount and Frequency:

MEDICAL INFORMATION - PROPOSED INSURED	
47. Have you seen a licensed medical professional for any reason within the past 12 months? <input type="checkbox"/> Y <input type="checkbox"/> N	
a. Date(s) and reason(s) of last visit:	
b. Test(s) performed, results, diagnosis, any recommended treatment or follow up?	
48. Height _____ ft. / _____ in.	a. Has your weight changed by more than 10 pounds during the past 12 months? <input type="checkbox"/> Y <input type="checkbox"/> N
Weight _____ lbs.	b. If "Yes," by how many pounds? _____ <input type="checkbox"/> Gain <input type="checkbox"/> Loss
49. Have you been hospitalized for any reason within the past 5 years? <input type="checkbox"/> Y <input type="checkbox"/> N	
50. Have you been advised by a licensed medical professional to have any medical tests, hospitalization or surgery which have not been completed? <input type="checkbox"/> Y <input type="checkbox"/> N	
51. Have you ever had any indication of, been diagnosed with and/or been treated by a licensed medical professional for:	
a. Heart disease, heart attack, heart surgery, angioplasty, valve replacement or repair?	<input type="checkbox"/> Y <input type="checkbox"/> N
b. Congenital heart disease, cardiomyopathy, congestive heart failure or heart rhythm abnormality?	<input type="checkbox"/> Y <input type="checkbox"/> N
c. Stroke or transient ischemic attack (TIA) or been diagnosed with peripheral vascular disease including carotid artery disease/surgery or any type of aneurysm?	<input type="checkbox"/> Y <input type="checkbox"/> N
d. Chronic obstructive pulmonary disease (COPD), emphysema, chronic lung disease or sleep apnea?	<input type="checkbox"/> Y <input type="checkbox"/> N
e. Diabetes?	<input type="checkbox"/> Y <input type="checkbox"/> N
f. Seizures/epilepsy, paralysis, Parkinson's disease, dementia or memory disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N
g. Bipolar disorder or schizophrenia or been hospitalized or treated for major depression or attempted suicide within the past 5 years?	<input type="checkbox"/> Y <input type="checkbox"/> N
h. Chronic liver disease, chronic hepatitis B or C, or cirrhosis?	<input type="checkbox"/> Y <input type="checkbox"/> N
i. Ulcerative colitis or Crohn's disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
j. Impaired kidney function, chronic kidney disease, or had a kidney transplant?	<input type="checkbox"/> Y <input type="checkbox"/> N
k. Any of the following neuromuscular disorders: amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), muscular dystrophy, Huntington's disease or any other movement disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N
l. Any of the following immune disorders: rheumatoid arthritis, lupus, polymyositis, dermatomyositis, systemic sclerosis, scleroderma, sarcoidosis, or vasculitis?	<input type="checkbox"/> Y <input type="checkbox"/> N
m. Any blood disorder or clotting disorder other than anemia, within the past 5 years?	<input type="checkbox"/> Y <input type="checkbox"/> N
n. Any mental or physical disorder, or medically or surgically treated condition not listed above?	<input type="checkbox"/> Y <input type="checkbox"/> N
52. Have you ever been diagnosed by a licensed medical professional as having human immune deficiency virus (HIV) infection, Acquired Immunodeficiency Syndrome (AIDS), or have you received treatment from a licensed medical professional for AIDS? <input type="checkbox"/> Y <input type="checkbox"/> N	
53. Within the past 10 years, have you had any type of cancer, other than non-melanoma skin cancer? <input type="checkbox"/> Y <input type="checkbox"/> N	
54. Within the past 10 years, have you been treated for alcohol or drug use, or been told by a licensed medical professional to limit your alcohol intake? <input type="checkbox"/> Y <input type="checkbox"/> N	
55. Within the past 5 years, have you used or experimented with cocaine, marijuana or other non-prescription stimulants, depressants, or narcotics? (If "Yes", a Drug Usage Supplement is required.) <input type="checkbox"/> Y <input type="checkbox"/> N	
56. List all prescription medications you are currently taking or have taken within the past 30 days.	
57. Details: (List details from questions answered "Yes" and please specify to which question number details pertain.)	

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

SUITABILITY

Complete only if applying for Variable Life Insurance

1. Have you, the Proposed Insured and the Owner, if other than the Proposed Insured, received a current Prospectus for the policy applied for and have you had sufficient time to review it?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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 Application; b) any amendments to the application(s) attached thereto; and c) 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; and 3) the Proposed Insured 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. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
5. 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, CO, CT, DC, FL, KS, LA, MA, MD, MN, MO, NC, NE, NJ, NM, OH, OK, OR, PR, TX, VA, VT 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, 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.

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

The undersigned declares that:

I 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 or my 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 authorize the Company to disclose information related to my insurability to MIB, Inc., and to other insurers to whom I may apply for coverage.

I 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 understand that I 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
(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? Y N

(ii) Do you know or have you any reason to believe that replacement of insurance is involved? Y 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 know of nothing affecting the insurability of the Proposed Insured which is not fully recorded in this application.
- ▶ I declare that I have provided the Proposed Insured and Owner with the Important Notice as well as a copy of the Privacy Practices Notice.
- ▶ I declare I have not been involved in any recommendation regarding the possible sale or assignment of this policy to a life settlement, viatical or other secondary market provider. If otherwise, please explain: _____

▶ I declare that I have verified that all life insurance coverage in force, or in the process of being applied for, on the Proposed Insured has been disclosed on this application, including any coverage that has been sold or is in the process of being sold to a life settlement, viatical or other secondary market provider.

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)

TEMPORARY LIFE INSURANCE AGREEMENT

[Lincoln Q&E PlusSM]

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE INSURANCE COMPANY - DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

▶ If any of the questions below are answered "Yes" or left blank with respect to a Proposed Insured, no representative of the Company is authorized to accept money, and **NO COVERAGE** will take effect under this Agreement with respect to such Proposed Insured.

1. Within the past 90 days, has the Proposed Insured been admitted to a hospital or other medical facility, been advised to be admitted or had surgery performed or recommended? Yes No
2. Within the past 2 years has the Proposed Insured been treated for heart trouble, stroke, or cancer, or had such treatment recommended by a physician or other medical practitioner? Yes No

This Agreement provides a **Limited Amount** of Life Insurance protection for a **Limited Period** of time, subject to the terms of this Agreement, in consideration of advance payment in the amount of \$ _____ in connection with the *[Lincoln Q&E PlusSM]*

Ticket dated _____ made on the life of: _____
Name of Proposed Insured

TERMS AND CONDITIONS

ELIGIBILITY - [AGE 30-70]

AMOUNT OF COVERAGE - \$500,000 MAXIMUM FOR ALL APPLICATIONS OR AGREEMENTS

If money has been accepted by the Company as advance payment for an application for Life Insurance and death of the Proposed Insured occurs while this Agreement is in effect, the Company will pay to the beneficiary designated or to the estate of the Proposed Insured if no beneficiary has been designated, the lesser of a) the amount of all death benefits applied for in the *[Lincoln Q&E PlusSM]* Ticket with respect to said Proposed Insured, including any accidental or supplemental death benefits, if applicable, or b) \$500,000. This total benefit limit applies to all insurance applied for under this or any current Tickets or Applications to the Company and any other Temporary Life Insurance Agreements.

DATE COVERAGE BEGINS

Coverage under this Agreement will begin on the date of this Agreement but only if the *[Lincoln Q&E PlusSM]* Ticket has been completed on the same date or not more than 7 days prior to the date of this Agreement.

DATE COVERAGE TERMINATES - 90 DAY MAXIMUM

Coverage under this Agreement will terminate automatically on the earliest of: a) 90 days from date of this Agreement if a required telephone interview is not completed and received by the Company, or b) 90 days from the date of this Agreement, or c) the date the insurance takes effect under the policy applied for, or d) the date the Company mails notice of termination of coverage to the premium notice address designated in the *[Lincoln Q&E PlusSM]* Ticket. The Company may terminate coverage at any time.

SPECIAL LIMITATIONS

- This Agreement does not guarantee the Company will issue a life insurance policy or any special riders or endorsement thereto.
- Fraud or material misrepresentations in the *[Lincoln Q&E PlusSM]* Ticket or in the answers to the Health Questions of this Agreement invalidates this Agreement and the Company's only liability is for refund of any payment made.
- If the Proposed Insured dies by suicide, the Company's liability under this Agreement is limited to a refund of the payment made.
- There is no coverage under this Agreement if the check or draft submitted as payment is not honored by the bank.
- No one is authorized to waive or modify any of the provisions of this Agreement.

I/WE HAVE RECEIVED A COPY OF AND HAVE READ THIS AGREEMENT AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE UNDERSTAND AND AGREE TO ALL ITS TERMS.

Agent is to leave a copy with the applicant.

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

 Date

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

 Date

 Signature of Licensed Agent, Broker or Registered Representative

 Name of Licensed Agent, Broker or Registered Representative (Please Print)

This form is to be used with the *[Lincoln Q&E PlusSM]* Program ONLY. Not eligible for use with the full underwriting.

SERFF Tracking Number: LCNC-126091339 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 42032
Company Tracking Number: LFF06371 ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: IM Life Application
Project Name/Number: IM Life Application/LFF06371 et al

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: AR_Readability.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: The Application for Life Insurance - Part I along with the Temporary Life Insurance Agreement is attached under the Form Schedule tab for review and approval.		

Arkansas

READABILITY CERTIFICATION

The Lincoln National Life Insurance Company

Re: LFF06371 – Institutional Markets Application for Life Insurance (Part I)
LFF06372 – Temporary Life Insurance Agreement

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

Form Number:

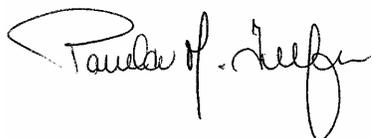
Flesch:

LFF06371

51.12

LFF06372

51.56



Pamela M. Telfer, Assistant Vice President
Product Compliance

Date: March 23, 2009