

SERFF Tracking Number: LCNC-126527496 State: Arkansas  
Filing Company: Lincoln Life and Annuity Company of New York State Tracking Number: 45163  
Company Tracking Number: LFF10002 ET AL LLANY  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Application Supplements  
Project Name/Number: Application Supplements/LFF10002 et al

## Filing at a Glance

Company: Lincoln Life and Annuity Company of New York

Product Name: Application Supplements

SERFF Tr Num: LCNC-126527496 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved-  
Closed State Tr Num: 45163

Sub-TOI: L08.000 Life - Other

Co Tr Num: LFF10002 ET AL State Status: Approved-Closed  
LLANY

Filing Type: Form

Reviewer(s): Linda Bird

Authors: William Otten, Jane  
Neidermyer, Lori Saltmarsh

Disposition Date: 03/16/2010

Date Submitted: 03/10/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Application Supplements

Status of Filing in Domicile: Pending

Project Number: LFF10002 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: 03/16/2010

Explanation for Other Group Market Type:

State Status Changed: 03/16/2010

Deemer Date:

Created By: Jane Neidermyer

Submitted By: Jane Neidermyer

Corresponding Filing Tracking Number:

Filing Description:

March 8, 2010

Re: Individual Life Application Forms

LFF10002 Medical Supplement

LFF10003 Aviation Supplement

LFF10005 Avocation and Sports Supplement

LFF10008 Foreign Travel or Residence Supplement

SERFF Tracking Number: LCNC-126527496 State: Arkansas  
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Lincoln Life & Annuity Company of New York  
Group & NAIC #: 0107-62057

We are submitting the above-referenced forms for your review and approval. These are new forms and will not be replacing any other forms.

Form LFF10002 Medical Supplement, Form LFF10003 Aviation Supplement, Form LFF10005 Avocation and Sports Supplement and Form LFF10008 Foreign Travel or Residence Supplement are being filed. These supplements will be used in conjunction with the Reinstatement or Change Application when additional information is required, as applicable, and will constitute a part of the application. The Reinstatement or Change Application LFF06363 was approved on 08/11/09 under file number 43170x. These supplements may also be used with any other Applications approved in the future.

These forms are multi company forms. In the event that one of our underwriting companies referenced in the forms chooses to stop using a form, it is our intent to remove the company name from the form without re-filing the form. Upon approval, the company reserves the right to change the format of the forms without altering the approved language. As the forms are multi company, we are submitting filings similar to this one for each of the companies listed on the forms. We have bracketed the Service Address of the companies in order to provide for flexibility. We confirm the brackets will not appear on production versions of the form.

The Flesch Scores for the forms combined with the Reinstatement or Change Application LFF06363 are: Form LFF10002 has attained a Flesch score of 50.99, Form LFF10003 has a score of 50.79, Form LFF10005 has a score of 50.97 and form LFF10008 has a Flesch score of 50.97. The forms have been submitted concurrently for approval to our Home State of New York. This submission contains no unusual or possibly controversial items from the standpoint of normal company or industry standards. To the best of our knowledge and belief, these forms comply with all the applicable laws and regulations of your state. If applicable, the appropriate certifications, transmittals, checklists and filing fees are included.

We trust the information provided is satisfactory and look forward to your response. Should you require additional information, please feel free to contact me toll-free at 1-800-258-3648, ext. 5627, by fax at 1-603-226-5128 or via e-mail at the address shown below.

Jane P. Neidermyer, FLMI, AIRC  
Senior Analyst, Life Product Compliance  
Email: jane.Neidermyer@lfg.com

## **Company and Contact**

SERFF Tracking Number: LCNC-126527496 State: Arkansas  
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**Filing Contact Information**

Jane Neidermyer, Analyst, Product Compliance jane.neidermyer@lfg.com  
 One Granite Place 603-226-5627 [Phone]  
 Concord, NH 03301

**Filing Company Information**

Lincoln Life and Annuity Company of New York CoCode: 62057 State of Domicile: New York  
 350 Church Street Group Code: 107 Company Type: Life  
 Hartford, CT 06103 Group Name: State ID Number:  
 (800) 238-6252 ext. [Phone] FEIN Number: 22-0832760  
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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$200.00  
 Retaliatory? No  
 Fee Explanation: AR fee of \$50 per form is greater than IN fee of \$35 per form  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Lincoln Life and Annuity Company of New York	\$200.00	03/10/2010	34775340

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/16/2010	03/16/2010

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## Disposition

Disposition Date: 03/16/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: LCNC-126527496 State: Arkansas  
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Medical Supplement		Yes
Form	Aviation Supplement		Yes
Form	Avocation and Sports Supplement		Yes
Form	Foreign Travel or Residence Supplement		Yes

SERFF Tracking Number: LCNC-126527496 State: Arkansas  
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## Form Schedule

### Lead Form Number: LFF10002

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LFF10002	Application/Medical Supplement Enrollment Form	Initial		50.990	LFF10002 brackets.pdf
	LFF10003	Application/Aviation Supplement Enrollment Form	Initial		50.790	LFF10003 brackets.pdf
	LFF10005	Application/Avocation and Sports Supplement Enrollment Form	Initial		50.970	LFF10005 brackets.pdf
	LFF10008	Application/Foreign Travel or Residence Supplement Form	Initial		50.970	LFF10008 brackets.pdf



Please check appropriate underwriting company:

- [The Lincoln National Life Insurance Company,] [Service Office: PO Box 21008, Greensboro, NC 27420-1008]
- [Lincoln Life & Annuity Company of New York,] [Service Office: PO Box 21008, Greensboro, NC 27420-1008]
- [First Penn-Pacific Life Insurance Company,] [Service Office: PO Box 21008, Greensboro, NC 27420-1008]  
(hereinafter referred to as "the Company")

**MEDICAL SUPPLEMENT**

**(Part II of Application)**

Proposed Insured (*please print name*) \_\_\_\_\_ Date of Birth (*mm/dd/yy*) \_\_\_\_\_

1. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

Name	Address	Phone

a) Date and reason of last visit: \_\_\_\_\_

b) Tests performed & treatment received: \_\_\_\_\_

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

2. Height _____ ft./_____ in. Weight _____ lbs.	Yes	No
a) Has your weight changed by more than 10 pounds during the past 12 months?		
b) If "Yes", by how many pounds? _____ Gain _____ Loss	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	<input type="checkbox"/>	<input type="checkbox"/>
5. <b>Have you ever had any indication of, or been treated by a licensed medical professional for:</b>		
a) Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
b) Any tumor, cancer, cysts, melanoma, lymphoma, or any disorder of the lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>
c) Anemia, leukemia, clotting disorder or any other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d) Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	<input type="checkbox"/>	<input type="checkbox"/>
e) Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
f) Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	<input type="checkbox"/>	<input type="checkbox"/>
g) Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	<input type="checkbox"/>	<input type="checkbox"/>
h) Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>
i) Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	<input type="checkbox"/>	<input type="checkbox"/>
j) Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	<input type="checkbox"/>	<input type="checkbox"/>
k) Any disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
l) Any mental or physical disorder or medically or surgically treated condition not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you use alcoholic beverages? ( <i>If "Yes", provide type, frequency &amp; amount.</i> )		
Type _____ Frequency _____ Amount _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	<input type="checkbox"/>	<input type="checkbox"/>

10. 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.)  Y  N

Type	Date First Used: (month/year)	Date Last Used: (month/year)	Amount and Frequency:

11. 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.

12. **Details:** (List details from questions answered "Yes" and please specify to which question numbers details pertain.)

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

The Undersigned declares that:

I have read or have had read to me the completed Medical Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete and true. I agree that this Medical Supplement constitutes a part of the application for insurance. I understand that any false statements or material misrepresentations may result in the loss of coverage under the policy.

Signed in \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_ (state) (month) (year)

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

\_\_\_\_\_  
**Printed Name of Proposed Insured**

\_\_\_\_\_  
**Signature of Witness** (Examiner/Licensed Representative/Agent)

\_\_\_\_\_  
**Printed Name of Witness** (Examiner/Licensed Representative/Agent)



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**AVIATION SUPPLEMENT**

1. Proposed Insured (*please print name*) \_\_\_\_\_ Date of Birth (*mm/dd/yy*) \_\_\_\_\_
2. What type of pilot license do you now have?  Student, date obtained \_\_\_\_\_  Commercial  Private  
 IFR  Flight Instructor  ATR  Other \_\_\_\_\_
3. Date of last FAA medical examination \_\_\_\_\_
4. Do you have any operational limitations on your medical certificate?  Yes  No If "Yes", please provide details.  
\_\_\_\_\_

5. Total number of solo hours flown as a pilot \_\_\_\_\_ Date of last flight \_\_\_\_\_

6. What type(s) of aircraft do you fly? Give make and model \_\_\_\_\_  
Description:  Fixed Wing  Rotorcraft  Jet  Piston  Turboprop  Single-Engine  Multi-Engine Seating Capacity \_\_\_\_\_

7. Have you flown or do you intend to fly a balloon, sailplane, prototype, experimental, ultra light or personally built or assembled aircraft?  Yes  No If "Yes", please describe \_\_\_\_\_

8. Have you ever had an aircraft accident, or been grounded, fined, reprimanded, or had your license revoked for violation of air regulations?  Yes  No If "Yes", please describe \_\_\_\_\_

9. Hours as a pilot, co-pilot, or other crew member:		Total to Date	Next 12 Months	Last 12 Months	1-2 Years Ago
Not Flying For Pay	Pleasure				
	Personal business transportation				
	Instruction as a student				
	Other (describe below)				
Flying For Pay	Scheduled passenger airline				
	Non-scheduled airline, charter				
	Freight transportation				
	Employer owned aircraft for employee travel				
	Instructor				
	Crop dusting, seeding, or aerial spraying				
	Active duty (military)				
	National Guard or Reserve				
Other (describe below)					

10. Additional Details: \_\_\_\_\_  
\_\_\_\_\_

I have read or have had read to me the completed Aviation Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete and true. I agree that this Aviation Supplement constitutes a part of my application for insurance. I understand that any false statements or material misrepresentations may result in the loss of coverage under the policy.

Signed in \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_ (state) (month) (year)

\_\_\_\_\_  
**Signature of Proposed Insured** (Parent or Guardian if under 14 years of age) **Witness**



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**AVOCATION AND SPORTS SUPPLEMENT (Do Not Use for Aviation)**

Answer questions with as much detail as possible. Use a SEPARATE questionnaire for EACH SPORT participated in.

Proposed Insured (*please print name*) \_\_\_\_\_ Date of Birth (*mm/dd/yy*) \_\_\_\_\_

**SECTION I - DIVING**

1. Are you a certified diver?  Yes  No
2. Are you a member of an organized club?  Yes  No
3. Are you classified as a  Professional  Instructor  Amateur
4. How many years have you participated in underwater diving? \_\_\_\_\_
5. What are the locations of diving activities? (i.e., lakes, rivers, oceans, deep sea, caves, ice diving)? \_\_\_\_\_
6. Do you dive alone?  Yes  No
7. If "Yes", please provide details as to frequency, depth and average time \_\_\_\_\_
8. Indicate what countries you dive in \_\_\_\_\_

9. Complete the following table

Frequency and depth	Last 12 Months		Expected Next 12 Months	
	Number	Average Duration Per Dive	Number	Average Duration Per Dive
0 to 100 Feet				
101 to 130 Feet				
131 to 150 Feet				
Over 150 Feet				

**SECTION II - MOTOR SPORT RACING**

10. Under what sanctioning body do you normally compete? (AMA, NHRA, USAC, etc.) \_\_\_\_\_
11. Indicate make and model of each vehicle including horsepower and displacement and any special equipment \_\_\_\_\_
12. Indicate locations where vehicle is raced including track type \_\_\_\_\_

Choose the Motor Racing Classification from the list below:

<input type="checkbox"/> ARCA	<input type="checkbox"/> ASA	<input type="checkbox"/> Auto Crash	<input type="checkbox"/> Autocross	<input type="checkbox"/> Indy/Formula1	<input type="checkbox"/> Demolition Derby	<input type="checkbox"/> Drift Racing
<input type="checkbox"/> Drag Racing - <i>indicate type</i>			<input type="checkbox"/> IMSA - US Based Series - <i>indicate type</i>			
<input type="checkbox"/> Kart Racing - <i>indicate type</i>			<input type="checkbox"/> Midgets - <i>indicate type</i>			
<input type="checkbox"/> Modified - <i>indicate type</i>			<input type="checkbox"/> NASCAR - <i>indicate type</i>			
<input type="checkbox"/> Sand and Dune Buggy - <i>indicate type</i>			<input type="checkbox"/> Sprint Cars - <i>indicate type</i>			
<input type="checkbox"/> Sportscar Racing - <i>indicate type</i>			<input type="checkbox"/> Sportscar Vintage Racing - <i>indicate type</i>			

Choose the Boat Racing Classification from the list below:

<input type="checkbox"/> Offshore and Sportboat racing	<input type="checkbox"/> Drag Racing
<input type="checkbox"/> Hydroplanes - <i>indicate type</i>	<input type="checkbox"/> Record Attempts

Choose the Motor Cycle Racing Classification from the list below:

<input type="checkbox"/> Dirt Track Racing	<input type="checkbox"/> Enduro Racing	<input type="checkbox"/> Hill Climbs	<input type="checkbox"/> Ice Racing
<input type="checkbox"/> Marshals	<input type="checkbox"/> Sand Racing	<input type="checkbox"/> Scooter and Moped Racing	<input type="checkbox"/> Speedway
<input type="checkbox"/> Spring Events	<input type="checkbox"/> Stunt Riding	<input type="checkbox"/> Trails Riding	<input type="checkbox"/> Trials
<input type="checkbox"/> Veteran and Vintage	<input type="checkbox"/> Supercross, Arenacross (both motorcycle and ATV)		
<input type="checkbox"/> Circuit Racing - <i>indicate type</i>		<input type="checkbox"/> International Events - <i>indicate type</i>	
<input type="checkbox"/> Drag Racing - <i>indicate type</i>		<input type="checkbox"/> Motocross - <i>indicate type</i>	

13. Complete the following table for all forms of racing

Frequency	1-2 Years Ago		Last 12 Months				Contemplated Next 12 Months	
	Number of Races	Total Miles	Number of Races	Total Miles	Average Distance of Each Race	Fastest Speed Attained	Number of Races	Total Miles
Automobile								
Motorcycle								
Boat								
Other _____								

**SECTION III - MOUNTAIN CLIMBING**

14. Indicate type of climbing (i.e. rock, trail, ice, artificial climbing wall, scrambling, bouldering) \_\_\_\_\_
15. Indicate all locations where climbed (i.e., state, country, mountain) \_\_\_\_\_
16. Indicate Maximum height climbed \_\_\_\_\_
17. Indicate equipment used \_\_\_\_\_
18. Indicate degree of difficulty (easy, moderate, difficult, severe). Indicate maximum technical grade (4a, 4b, . . . 7b, 7c) \_\_\_\_\_

19. Complete the following table

Number of Climbs	12 to 24 Months Ago	Last 12 Months	Est. Next 12 Months	Average Days Per Trip

**SECTION IV - AERIAL SPORTS**

Choose the avocation from the list below

Parasailing and parascending       Hang-gliding / Parachuting (excluding BASE jumping), skydiving and sky surfing

Choose one of the following:     Stunt person     Instructor     Amateur     Other professional

If hang-gliding, complete the following questions

- Is it a powered or paramotor hang-glider?     Yes     No
- Record attempts?     Yes     No

20. Are you a member of a club associated with your sport?     Yes     No    If "Yes", please specify \_\_\_\_\_

21. Choose usual location     Over land     Over cliffs and ridges     Over water

22. Have you ever or do you plan to do any experimental jumping or delayed chute openings?     Yes     No    If "Yes", please provide details \_\_\_\_\_

23. Complete the following table regarding the number of flights or jumps

12 to 24 Months Ago	Last 12 Months	Est. Next 12 Months	Total Number to Date

**SECTION V - ADDITIONAL DETAILS OR OTHER AVOCATIONS NOT COVERED IN THE SUPPLEMENT**

24. Provide details regarding any other hazardous avocations including rodeo sports, boxing, equine sports, extreme sports, etc. Also use this space for any additional details for avocations listed in any of the sections of this supplement.

I have read or have had read to me the completed Avocation and Sports supplement before signing below. All statements and answers in this supplement are correctly recorded and are full, complete and true. I agree that this Avocation and Sports Supplement constitutes a part of my application for insurance. I understand that any false statements or material misrepresentations may result in the loss of coverage under the policy.

Signed in \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_ (state) (month) (year)

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

Witness



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### FOREIGN TRAVEL OR RESIDENCE SUPPLEMENT

Proposed Insured (please print name) \_\_\_\_\_

Date of Birth (mm/dd/yy) \_\_\_\_\_ Citizen of (Country) \_\_\_\_\_

Proposed Owner (please print name) \_\_\_\_\_ Citizen of (Country) \_\_\_\_\_

#### Complete the following section for travel outside the U.S.

1. List cities and countries outside the U.S. to which you will travel within the next 12 months \_\_\_\_\_  
\_\_\_\_\_
2. Purpose of trip(s) \_\_\_\_\_
3. Provide length of stay in each country \_\_\_\_\_  
\_\_\_\_\_
4. Provide date departing U.S. and date returning \_\_\_\_\_

#### Complete the following section for U.S. citizens living outside the U.S. or for citizens of other countries living in or outside the U.S.

1. Where will the proposed insured be residing (if outside the U.S. or Canada) and for how long? \_\_\_\_\_  
\_\_\_\_\_
2. Does the proposed insured have either a U. S. residence, own U.S. property, U.S. business interest or other legal interest in the U.S.?  
(If answer is yes, please list U.S. assets including real estate, funds in banks, brokerage accounts, and business and how long assets held.)  
\_\_\_\_\_
3. How long will the Proposed Insured reside outside the U.S.? \_\_\_\_\_
4. Reason for residence outside the U.S. \_\_\_\_\_
5. If Proposed Insured is a citizen of another country without a permanent visa, indicate the visa type and expiration date.  
\_\_\_\_\_
6. List occupation of Proposed Insured \_\_\_\_\_
7. Did solicitation and communication concerning the sale of this product including all telephone, fax, or e-mail correspondence occur in the U.S.? \_\_\_\_\_
8. Was the application signed by the Proposed Insured and Owner in the U.S.? \_\_\_\_\_

I have read or have had read to me the completed Foreign Travel or Residence Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete and true. I agree that this Foreign Travel or Residence Supplement constitutes a part of my application for insurance. I understand that any false statements or material misrepresentations may result in the loss of coverage under the policy.

Signed in \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_ (state) (month) (year)

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

#### Agent Acknowledgment

I have completed all solicitation and application(s) for insurance in the U.S. and believe the Proposed Insured and Owner understand fully the information in this Supplement, application and any other forms completed with this application for insurance.

\_\_\_\_\_  
**Signature of Agent**

\_\_\_\_\_  
**Date**

SERFF Tracking Number: LCNC-126527496 State: Arkansas  
Filing Company: Lincoln Life and Annuity Company of New York State Tracking Number: 45163  
Company Tracking Number: LFF10002 ET AL LLANY  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Application Supplements  
Project Name/Number: Application Supplements/LFF10002 et al

## Supporting Document Schedules

**Item Status:**

**Status**

**Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachment:**

AR\_Readability LLANY.pdf

**Item Status:**

**Status**

**Date:**

**Bypassed - Item:** Application

**Bypass Reason:** Not a policy filing

**Comments:**

**Arkansas**

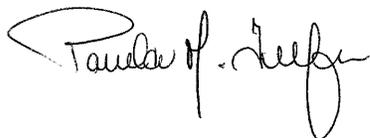
**READABILITY CERTIFICATION**

*Lincoln Life & Annuity Company of New York*

Re: *LFF10002*                      *Medical Supplement*  
*LFF10003*                      *Aviation Supplement*  
*LFF10005*                      *Avocation and Sports Supplement*  
*LFF10008*                      *Foreign Travel or Residence Supplement*

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

<u><i>Form Number:</i></u>	<u><i>Flesch:</i></u>
<i>LFF10002</i>	<i>50.99</i>
<i>LFF10003</i>	<i>50.79</i>
<i>LFF10005</i>	<i>50.97</i>
<i>LFF10008</i>	<i>50.97</i>



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Pamela M. Telfer, Assistant Vice President  
Product Compliance

Date: 3/8/2010