Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: Application Supplements
SERFF Tr Num: LCNC-126527497
State: Arkansas

TOI: L08 Life - Other
SERFF Status: Closed-Approved-Closed
State Tr Num: 45156

Sub-TOI: L08.000 Life - Other
Co Tr Num: LFF10002 ET AL LNL
State Status: Approved-Closed

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
Project Number: LFF10002 et al
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 03/16/2010

Deemer Date:
Submitted By: Jane Neidermyer
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
The Lincoln National Life Insurance Company

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 03/16/2010
Created By: Jane Neidermyer
Corresponding Filing Tracking Number:

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 various life insurance applications and the reinstatement or change application when additional information is required, as applicable, and will constitute a part of the application for life insurance. The attached chart shows which forms will be used with which applications, and the approval information for the applications. 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 Indiana. 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

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

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:	$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 #
The Lincoln National Life Insurance Company	$200.00	03/10/2010	34775338

Correspondence Summary

Dispositions

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

Disposition

Disposition Date: 03/16/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LCNC-126527497*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	*45156*
Company Tracking Number:	*LFF10002 ET AL LNL*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application Supplements*		
Project Name/Number:	*Application Supplements/LFF10002 et al*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Chart of applications		Yes
Form	Medical Supplement		Yes
Form	Aviation Supplement		Yes
Form	Avocation and Sports Supplement		Yes
Form	Foreign Travel or Residence Supplement		Yes

Form Schedule

Lead Form Number: LFF10002

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

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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.**

		Yes	No
2.	Height _____ ft./_____ in. Weight _____ lbs.		
	a) Has your weight changed by more than 10 pounds during the past 12 months?		
	b) If "Yes", by how many pounds? _____ Gain _____ Loss	☐	☐
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?	☐	☐
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?	☐	☐
5.	**Have you ever had any indication of, or been treated by a licensed medical professional 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, 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 complications 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 or medically or surgically treated condition not listed above?	☐	☐
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?	☐	☐
7.	Do you use alcoholic beverages? *(If "Yes", provide type, frequency & amount.)*		
	Type _____ Frequency _____ Amount _____	☐	☐
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?	☐	☐
9.	In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐

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 **Printed Name of Proposed Insured**
(Parent or Guardian if under 14 years of age)

_____ _____
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:

☐ ARCA	☐ ASA	☐ Auto Crash	☐ Autocross	☐ Indy/Formula1	☐ Demolition Derby	☐ Drift Racing
☐ Drag Racing - *indicate type*				☐ IMSA - US Based Series - *indicate type*		
☐ Kart Racing - *indicate type*				☐ Midgets - *indicate type*		
☐ Modified - *indicate type*				☐ NASCAR - *indicate type*		
☐ Sand and Dune Buggy - *indicate type*				☐ Sprint Cars - *indicate type*		
☐ Sportscar Racing - *indicate type*				☐ Sportscar Vintage Racing - *indicate type*		

Choose the Boat Racing Classification from the list below:

☐ Offshore and Sportboat racing	☐ Drag Racing
☐ Hydroplanes - *indicate type*	☐ Record Attempts

Choose the Motor Cycle Racing Classification from the list below:

☐ Dirt Track Racing	☐ Enduro Racing	☐ Hill Climbs	☐ Ice Racing
☐ Marshals	☐ Sand Racing	☐ Scooter and Moped Racing	☐ Speedway
☐ Spring Events	☐ Stunt Riding	☐ Trails Riding	☐ Trials
☐ Veteran and Vintage	☐ Supercross, Arenacross (both motorcycle and ATV)		
☐ Circuit Racing - *indicate type*		☐ International Events - *indicate type*	
☐ Drag Racing - *indicate type*		☐ Motocross - *indicate type*	

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**

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
AR_Readability LNL.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: Not a policy filing
Comments:

Item Status: **Status Date:**

Satisfied - Item: Chart of applications
Comments:
Attachment:
AR LNL Application List.pdf

Arkansas

READABILITY CERTIFICATION

The Lincoln National Life Insurance Company

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

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:***
LFF10002	***50.99***
LFF10003	***50.79***
LFF10005	***50.97***
LFF10008	***50.97***

Pamela M. Telfer, Assistant Vice President
Product Compliance

Date: 03/08/2010

The Lincoln National Life Insurance Company **Applications to be used with Supplements** **ARKANSAS**

Application	Date Approved	File Number	Name of Application	Medical Supp LFF10002	Aviation Supp LFF10003	Avocation Supp LFF10005	Foreign Travel Supp LFF10008
LFF06321	6/16/2008	39195	Application for Life Insurance	X	X	X	X
LFF06312	12/15/2006	34427	Simplified Issue Application		X	X	
LFF06363	8/11/2009	LCNC-126254207	Reinstatement or Change Application	X	X	X	X
LFF06371	4/3/2009	42032	Application for Life Insurance Institutional Markets		X	X	
B59	2/26/2007	35133	BOLI/COLI Application for Life Insurance	X	X	X	X

And any applications approved in the future