

SERFF Tracking Number: LCNC-127401060 State: Arkansas  
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 49695  
Company Tracking Number: B61, B62, B63, B64, B65, B66, B67, B10493, B10494  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Applications - COLI, BOLI, 162 Bonus Plans/Corp. Spons.  
Project Name/Number: Applications - COLI, BOLI, 162 Bonus Plans/Corp. Spons./B61, B62, B63, B64, B65, B66, B67, B10493, B10494

## Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: Applications - COLI, BOLI, 162 SERFF Tr Num: LCNC-127401060 State: Arkansas

Bonus Plans/Corp. Spons.

TOI: L08 Life - Other

SERFF Status: Closed-Approved- State Tr Num: 49695  
Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num: B61, B62, B63, B64, State Status: Approved-Closed  
B65, B66, B67, B10493, B10494

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Raymond Fortier, Anabela Disposition Date: 10/06/2011

Tavares, Lori Saltmarsh, Renee

Gardner, Randi Johnson

Date Submitted: 09/01/2011

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Applications - COLI, BOLI, 162 Bonus Plans/Corp.  
Spons.

Status of Filing in Domicile: Pending

Project Number: B61, B62, B63, B64, B65, B66, B67, B10493, B10494

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 10/06/2011

State Status Changed: 09/07/2011

Deemer Date:

Created By: Renee Gardner

Submitted By: Renee Gardner

Corresponding Filing Tracking Number:

Filing Description:

Hon. Jay Bradford, Commissioner of Insurance

Compliance-Life & Health

1200 West Third Street

Little Rock, AR 72201-1904

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Attention: Joe Musgrove

The Lincoln National Life Insurance Company  
NAIC #65676  
FEIN #35-0472300  
Company Code #

Re:  
B61 – Executive Benefits Individual Owner Guaranteed Issue Part I Application for Life Insurance  
B62 – Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance  
B63 – Executive Benefits Individual Owner Part I and Part II Application for Life Insurance  
B64 – Medical Supplement  
B65 – Executive Benefits Corporate Owner Application for Life Insurance  
B66 – Executive Benefits Corporate Owner Application for Life Insurance Part II Application  
B67 – Temporary Life Insurance Agreement  
B10493 – Consent to be Insured Form  
B10494 – Modified Simplified Underwriting and Consent Form

Dear Mr. Musgrove:

We are submitting the required number of copies of the above-referenced forms for your review and approval. The applications, supplements and consent forms are new forms and are not intended to replace any previously approved forms.

Upon approval, the below applications and supplements will be used in applying for our Corporate Owned Life Insurance (COLI)/Bank Owned Life Insurance (BOLI) products that are currently approved and any future approved COLI/BOLI policy forms in your State. We do follow COLI Best Practices as required by the PPA. Some of these forms will be used by individuals when applying for Corporate Sponsored/162 Bonus Plans. The supplements and consent forms will be used in conjunction with the applications when additional information is required, as applicable, and will constitute a part of the application for life insurance. The above forms become part of the policy.

#### COLI/BOLI Applications for Life Insurance

B61 – Executive Benefits Individual Owner Guaranteed Issue Part I Application for Life Insurance. The application form will be used to gather information on the Owner, Insured and the Sponsoring Corporation. This form is completed when applying for Corporate Sponsored/162 Bonus Plans and will be completed by the individual Owner/Insured.

B62 – Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance. The application form will be used to gather information on the Owner, Insured and the Sponsoring Corporation. This form is

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completed when applying for Corporate Sponsored/162 Bonus Plans and will be completed by the individual Owner/Insured.

B63 – Executive Benefits Individual Owner Part I and Part II Application for Life Insurance. The application form will be used to gather information on the Owner, Insured and the Sponsoring Corporation and for gathering the Insured's medical history information. This application will be used for Simplified issue or Fully Underwritten and will be completed when applying for Corporate Sponsored/162 Bonus Plans and will be completed by the individual Owner/Insured.

B64 – Medical Supplement. This form is the medical exam form completed by a medical professional. This form would be used in conjunction with the application(s) used for fully underwritten COLI/BOLI policies, including Corporate Sponsored/162 Bonus Plans.

B65 – Executive Benefits Corporate Owner Application for Life Insurance. To be completed by the Corporate/Bank Owner for all products/Underwriting, if applicable. The application form will be used to gather information on the Owner, Insured and Plan information. This form is required to be completed by each Corporate/Business/Bank Owner.

B66 – Executive Benefits Corporate Owner Application for Life Insurance Part II Application – This application will be used for Simplified issue or Fully Underwritten policies with a Corporate/Bank Owner. The form will be used for gathering the Insured's medical history information when applying for COLI/BOLI policies. This form will be completed by the Insured in conjunction with B65, if applicable.

B67 – Temporary Life Insurance Agreement - The Temporary Life Insurance Agreement is intended to be used as Temporary Insurance under the conditions stated on the agreement, until the policy is issued. This form will be used on Non-GI coverage and only with the approval of the underwriter on a case-by-case basis.

B10493 – Consent to be Insured - This form is required for Guaranteed Issue. This form will be completed by the Insured in conjunction with B65, if applicable.

B10494 – Modified-Simplified Underwriting and Consent For - This form is required for Modified-Simplified Underwriting. This form will be completed by the Insured in conjunction with B65, if applicable.

The forms received the following Flesch scores:

Form Number	Flesch
B61 – Executive Benefits Individual Owner Guaranteed Issue Part I Application for Life Insurance	52
B62 – Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance	50
B63 – Executive Benefits Individual Owner Part I and Part II Application for Life Insurance	50
B64 – Medical Supplement	56

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B65 – Executive Benefits Corporate Owner Application for Life Insurance	51
B66 – Executive Benefits Corporate Owner Application for Life Insurance Part II Application	51
B67 – Temporary Life Insurance Agreement	51
B10493 – Consent to be Insured Form	51
B10494 – Modified Simplified Underwriting and Consent Form	53

We have bracketed several items within the forms as variable information to allow for flexibility in the content of the form. These items include Service Office addresses and phone numbers, MIB office address and phone numbers, available rider information, form page numbers and the Beneficiary Designation section on some forms, which will only appear if a Corporation/Business/Bank will allow the insured to name his/her own beneficiary. It is our understanding that changes to the bracketed items for new issues will not require a new filing of these forms. No change in the variable areas will be made which will be in conflict with the laws, rules and regulations of your state. In addition, no change in variability will be made which in any way expands the scope of the item being changed. We confirm that the brackets will not actually appear on the forms at issue.

These forms appear in final printed format as issued from a laser printer. 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.

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. 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.

We trust the information provided will be satisfactory and we look forward to your response. Should you require any additional information, please feel free to contact me toll-free at 1-800-238-6252 (ext. 62067) or email address shown below. Thank you for your time and consideration.

Sincerely,

Renee Gardner  
 Product Compliance Analyst  
 Phone: 860.466.2067  
 Toll Free: 800-238-6252 Ext. 62067  
 Email: Renee.Gardner@lfg.com  
 Enclosures

## Company and Contact

SERFF Tracking Number: LCNC-127401060 State: Arkansas  
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**Filing Contact Information**

Renee Gardner, Contract Analyst renee.gardner@lfg.com  
 350 Church street 860-466-2067 [Phone] 2067 [Ext]  
 hartford, CT 06103 860-466-1348 [FAX]

**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

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$450.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Lincoln National Life Insurance Company	\$450.00	09/01/2011	51166725

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/06/2011	10/06/2011
Approved-Closed	Linda Bird	09/07/2011	09/07/2011

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Executive Benefits Individual Owner Part I and Part II Application for Life Insurance	Renee Gardner	10/05/2011	10/05/2011
Form	Executive Benefits Corporate Owner Application for Life Insurance	Renee Gardner	10/05/2011	10/05/2011
Form	Executive Benefits Corporate Owner Application for Life Insurance Part II Application	Renee Gardner	10/05/2011	10/05/2011
Supporting Document	Amendment Letter	Renee Gardner	10/05/2011	10/05/2011

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to Reopen	Note To Filer	Linda Bird	10/05/2011	10/05/2011
Request to Reopen	Note To Reviewer	Renee Gardner	10/04/2011	10/04/2011

SERFF Tracking Number: LCNC-127401060 State: Arkansas  
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## Disposition

Disposition Date: 10/06/2011

Implementation Date:

Status: Approved-Closed

Comment: Company has corrected typographical errors in application numbers B63, B65, and B66.

Rate data does NOT apply to filing.

SERFF Tracking Number: LCNC-127401060 State: Arkansas  
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 Project Name/Number: Applications - COLI, BOLI, 162 Bonus Plans/Corp. Spons./B61, B62, B63, B64, B65, B66, B67, B10493, B10494

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Amendment Letter		Yes
Form	Executive Benefits Individual Owner Guaranteed Issue Part I Application for Life Insurance		Yes
Form	Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance		Yes
Form (revised)	Executive Benefits Individual Owner Part I and Part II Application for Life Insurance		Yes
Form	Executive Benefits Individual Owner Part I and Part II Application for Life Insurance	Replaced	Yes
Form	Medical Supplement		Yes
Form (revised)	Executive Benefits Corporate Owner Application for Life Insurance		Yes
Form	Executive Benefits Corporate Owner Application for Life Insurance	Replaced	Yes
Form (revised)	Executive Benefits Corporate Owner Application for Life Insurance Part II Application		Yes
Form	Executive Benefits Corporate Owner Application for Life Insurance Part II Application	Replaced	Yes
Form	Temporary Life Insurance Agreement		Yes
Form	Consent to be Insured Form		Yes
Form	Modified Simplified Underwriting and Consent Form		Yes

SERFF Tracking Number: LCNC-127401060 State: Arkansas  
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## Disposition

Disposition Date: 09/07/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Amendment Letter		Yes
Form	Executive Benefits Individual Owner Guaranteed Issue Part I Application for Life Insurance		Yes
Form	Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance		Yes
Form (revised)	Executive Benefits Individual Owner Part I and Part II Application for Life Insurance		Yes
Form	Executive Benefits Individual Owner Part I Replaced and Part II Application for Life Insurance		Yes
Form	Medical Supplement		Yes
Form (revised)	Executive Benefits Corporate Owner Application for Life Insurance		Yes
Form	Executive Benefits Corporate Owner Application for Life Insurance	Replaced	Yes
Form (revised)	Executive Benefits Corporate Owner Application for Life Insurance Part II Application		Yes
Form	Executive Benefits Corporate Owner Application for Life Insurance Part II Application	Replaced	Yes
Form	Temporary Life Insurance Agreement		Yes
Form	Consent to be Insured Form		Yes
Form	Modified Simplified Underwriting and Consent Form		Yes

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**Amendment Letter**

Submitted Date: 10/05/2011

**Comments:**

Thank you for reopening the filing. Please be advised, the purpose of this amendment is to correct a typographical error found in the Authorization Section of B63, B65, & B66. Please see the attached letter which itemizes the corrections and revised applications. Thank you!

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
B63	Advertising	Executive Benefits Individual Owner Part I and Part II Application for Life Insurance	Initial				50.000	B63 - Bracketed.pdf
B65	Application/Enrollment Form	Executive Benefits Corporate Owner Application for Life Insurance	Initial				51.000	B65 - Bracketed.pdf
B66	Application/Enrollment Form	Executive Benefits Corporate Owner Application for Life Insurance Part II	Initial				51.000	B66_B - Bracketed.pdf

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Application

**Supporting Document Schedule Item Changes:**

**User Added -Name: Amendment Letter**

Comment:

AR Application Correction B63, B65, B66.pdf

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**Note To Filer**

**Created By:**

Linda Bird on 10/05/2011 08:39 AM

**Last Edited By:**

Linda Bird

**Submitted On:**

10/05/2011 08:39 AM

**Subject:**

Request to Reopen

**Comments:**

Filing has been re-opened in order for correction to be made.

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**Note To Reviewer**

**Created By:**

Renee Gardner on 10/04/2011 11:47 AM

**Last Edited By:**

Renee Gardner

**Submitted On:**

10/04/2011 11:47 AM

**Subject:**

Request to Reopen

**Comments:**

Dear Ms. Bird:

In a post filing compliance review we found a typographical error in a couple of our applications that we would like to correct. We have not yet implemented these applications for use. Can you please reopen the filing so I can create an amendment? I will provide a cover letter detailing the changes. Thank you for your assistance in this matter.

Sincerely,

Renee Gardner

Product Compliance Analyst.

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## Form Schedule

### Lead Form Number: B61

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	B61	Application/ Enrollment Form	Executive Benefits Individual Owner Guaranteed Issue Part I Application for Life Insurance	Initial		52.000	B61 - Bracketed.pdf
	B62	Application/ Enrollment Form	Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance	Initial		50.000	B62 - Bracketed.pdf
	B63	Advertising	Executive Benefits Individual Owner Part I and Part II Application for Life Insurance	Initial		50.000	B63 - Bracketed.pdf
	B64	Application/ Enrollment Form	Medical Supplement	Initial		56.000	B64 - Bracketed.pdf
	B65	Application/ Enrollment Form	Executive Benefits Corporate Owner Application for Life Insurance	Initial		51.000	B65 - Bracketed.pdf
	B66	Application/ Enrollment Form	Executive Benefits Corporate Owner Application for Life Insurance Part II Application	Initial		51.000	B66_B - Bracketed.pdf
	B67	Application/ Enrollment Form	Temporary Life Insurance Agreement	Initial		51.000	B67 - Bracketed.pdf

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B10493	Application/Consent to be Enrollment Insured Form Form	Initial	51.000	B10493_B - Bracketed.pdf
B10494	Application/Modified Simplified Enrollment Underwriting and Form Consent Form	Initial	53.000	B10494_B - Bracketed.pdf

Executive Benefits Individual Owner  
Guaranteed Issue Part I  
Application for Life Insurance



**B61**  
**(Standard Version)**

**CORPORATION INFORMATION**

1. Corporation Name	2. Taxpayer Identification Number
3. Address ( <i>Street, City, State, ZIP</i> )	

**PLAN ADMINISTRATION CONTACT (*Send all correspondence to named contact in Brokers Office of Servicing Agent*)**

4. Name	5. Telephone Number ( <i>include area code</i> )
6. Address ( <i>Street, City, State, ZIP</i> )	

**PROPOSED INSURED INFORMATION**

7. Proposed Insured ( <i>First, Middle Initial, Last</i> )	8. Place of Birth		
9. Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please provide country, type of visa, expiration date and green card information): _____			
10. Date of Birth ( <i>mm/dd/yy</i> )	11. Social Security Number	12. <input type="checkbox"/> Male <input type="checkbox"/> Female	13. Driver's License # & State
14. Occupation	15. Salary \$	16. Date of Hire ( <i>mm/dd/yy</i> )	
17. Home Address ( <i>No., Street, PO Box, City, State, ZIP</i> )			

**ELIGIBILITY INFORMATION FOR PROPOSED INSURED**

18. Have you been actively at work on a full time basis (at least 30 hours/week) performing all duties of your regular occupation, at your customary place of employment for the past 3 months? (Disregard vacation days, normal non-working days and absences that total less than 4 consecutive days.) If "No", specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		
19. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? ( <i>If "Yes", list below.</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Type	Date First Used: ( <i>month/year</i> )	Date Last Used: ( <i>month/year</i> )	Amount and Frequency:

**OWNER DESIGNATION (*Select One - Please complete this section if the Insured is not the Owner*)**

20. <input type="checkbox"/> Insured <input type="checkbox"/> Trust (Name of Trust, Trustee and Date of Trust) <input type="checkbox"/> Other: _____	
21. Owner Name	22. Taxpayer Identification/Social Security Number
23. Address ( <i>Street, City, State, ZIP</i> )	
24. Name of Trustee	25. Date of Trust

**PAYOR DESIGNATION (Please complete if the Payor is other than the Owner)**

26. Payor Name \_\_\_\_\_

27. Address (Street, City, State, ZIP) \_\_\_\_\_

**BENEFICIARY DESIGNATION (Select One)**

28.  Individual (Provide Full Name, Social Security Number and Relationship)

Primary \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Address (Street, City, State, ZIP) \_\_\_\_\_

Primary \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Address (Street, City, State, ZIP) \_\_\_\_\_

29. Contingent \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Contingent \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

30.  Trust (Name of Trust, Trustee and Date of Trust)  Primary  Contingent TIN: \_\_\_\_\_

31.  Split Dollar (Enclose a copy of split dollar agreement)  Primary  Contingent

32.  Other:  Primary  Contingent

**POLICY INFORMATION**

33. Requested Policy Effective Date _____		34. Billing Frequency <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Single Premium	
35. Basic Plan <input type="checkbox"/> Corporate Universal Life _____ <input type="checkbox"/> Corporate Variable Universal Life _____		36. Death Benefit Option <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
38. <input type="checkbox"/> Guideline Premium Test <input type="checkbox"/> Cash Value Accumulation Test		39. Planned Premium Funding Schedule <input type="checkbox"/> Number of Years _____ <input type="checkbox"/> Pay to Age _____	
41. Coverage Information: (Select one) Specified Amount \$ _____ <input type="checkbox"/> See attached Census		[40. Other Rider(s) Selected Term % _____ _____ _____ Loan Spread Rider, if Selected <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3]	
[37. A.B.E. Allocations, if Selected Year 1 _____ Year 2 _____ Year 3 _____ Year 4 _____ Year 5 _____ Year 6 _____ Year 7+ _____ See attached schedule if more than 7 years.]			

**OTHER INSURANCE ON PROPOSED INSURED PENDING LEGAL/COMPLIANCE APPROVAL**

42. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefit 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 replacement forms.)

43. Amount of all life insurance presently in force or applied for. **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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please attach a list of any other additional insurance on a separate sheet. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? \$ \_\_\_\_\_

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

**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.

**SUITABILITY - COMPLETE THIS SECTION IF VUL ONLY**

1. Have you, the Proposed Insured and the Owner, received a current Prospectus, or equivalent document for the policy applied for and have you had sufficient time to review?  Yes  No
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?  Yes  No
3. Do you understand that the cash value may increase or decrease depending on the investment performance of the funds held in the Separate Account?  Yes  No
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?  Yes  No

**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.**

**STATE DISCLOSURE**

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.

**AGREEMENT AND ACKNOWLEDGEMENT**

Under penalties of perjury I, the undersigned, certify that: (a) the tax identification or social security numbers as provided by me is correct; and (b) the holders of said numbers are not subject to any backup withholding of U.S. Federal income tax.

Each of the Undersigned declares that:

1. This Application consists of: a) this Executive Benefits Individual Owner Guaranteed Issue Part I Application; b) any amendments to the application attached thereto; and c) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. The Executive Benefits Individual Owner Guaranteed Issue Part I Application is fully completed.
2. I/We further agree that coverage will take effect under the Policy only when: 1) initial premium payment has been received; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured; and 3) the Proposed Insured remains 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.
3. If this is a request to exercise an option in an existing policy, the request will become effective in accordance with the terms of that option. If this is a request for change, any and all values may be used to pay for the change and to repay any loan indebtedness. The changed policy will be subject to any loan indebtedness not repaid. Any assignment in effect at the time of this request will apply to any new insurance issued.
4. No agent, broker or medical examiner has the authority to make changes or modify any Company contract or to waive any of the Company's requirements.
5. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing. 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.
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.

**SIGNATORY SECTION**

\_\_\_\_\_  
**Signature of Proposed Insured**

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

\_\_\_\_\_  
**Signature of Applicant/Owner/Trustee**

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

\_\_\_\_\_  
**Signed at (City and State)**

- 1) Based on information obtained from the Owner, I believe the investment is suitable for the Owner's objectives.
- 2) To the best of my knowledge, the source of funding for this policy does not include: (1) a non-recourse premium financing loan; or (2) any arrangement, other than a premium financing loan, which involves any person or entity with an interest in the potential for earnings based on the provision of funding for the policy.
- 3) Does the applicant have any existing life insurance policies or annuities?  Yes  No
- 4) 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.

I declare that I have accurately answered all questions contained in this section.

\_\_\_\_\_  
**Signature of Broker, Agent or Licensed Representative**

\_\_\_\_\_  
**Name of Broker, Agent or Licensed Representative (Please Print)**

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

# Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance



**B62**  
**(Standard Version)**

**IMPORTANT NOTICE**

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

**(Please give a copy of these notices to 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 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: [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)]

CORPORATION INFORMATION	
1. Corporation Name	2. Taxpayer Identification Number
3. Address (Street, City, State, ZIP)	

PLAN ADMINISTRATION CONTACT (Send all correspondence to named contact in Brokers Office of Servicing Agent)	
4. Name	5. Telephone Number (include area code)
6. Address (Street, City, State, ZIP)	

PROPOSED INSURED INFORMATION			
7. Proposed Insured (First, Middle Initial, Last)		8. Place of Birth	
9. Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please provide country, type of visa, expiration date and green card information): _____			
10. Date of Birth (mm/dd/yy)	11. Social Security Number	12. <input type="checkbox"/> Male <input type="checkbox"/> Female	13. Driver's License # & State
14. Occupation	15. Salary \$		16. Date of Hire (mm/dd/yy)
17. Home Address (No., Street, PO Box, City, State, ZIP)			

ELIGIBILITY INFORMATION FOR PROPOSED INSURED			
18. Have you been actively at work on a full time basis (at least 30 hours/week) performing all duties of your regular occupation, at your customary place of employment for the past 3 months? (Disregard vacation days, normal non-working days and absences that total less than 4 consecutive days). If "No", specify: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No
19. 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"/> Yes <input type="checkbox"/> No
Type	Date First Used: (month/year)	Date Last Used: (month/year)	Amount and Frequency:
20. Have you, in the past 10 years been treated by a licensed medical professional for any disorder of the heart or blood vessels, tumors or cancer, diabetes, stroke or any disorder of the blood, lungs, kidneys, drug or alcohol use, depression or been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency (AIDS) or AIDS related condition? If "Yes", explain: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No

**OWNER DESIGNATION (Select One - Please complete this section if the Insured is not the Owner)**

21.  Insured     Trust (Name of Trust, Trustee and Date of Trust)     Other: \_\_\_\_\_

22. Owner Name \_\_\_\_\_ 23. Taxpayer Identification/Social Security Number \_\_\_\_\_

24. Address (Street, City, State, ZIP) \_\_\_\_\_

25. Name of Trustee \_\_\_\_\_ 26. Date of Trust \_\_\_\_\_

**PAYOR DESIGNATION (Please complete if the Payor is other than the Owner)**

27. Payor Name \_\_\_\_\_

28. Address (Street, City, State, ZIP) \_\_\_\_\_

**BENEFICIARY DESIGNATION (Select One)**

29.  Individual (Provide Full Name, Social Security Number and Relationship)

Primary \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
 Address (Street, City, State, ZIP) \_\_\_\_\_

Primary \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
 Address (Street, City, State, ZIP) \_\_\_\_\_

30. Contingent \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
 Contingent \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

31.  Trust (Name of Trust, Trustee and Date of Trust)     Primary     Contingent    TIN: \_\_\_\_\_

32.  Split Dollar (Enclose a copy of split dollar agreement)     Primary     Contingent

33.  Other:     Primary     Contingent

**POLICY INFORMATION**

34. Requested Policy Effective Date _____		35. Billing Frequency <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Single Premium	
36. Basic Plan <input type="checkbox"/> Corporate Universal Life _____ <input type="checkbox"/> Corporate Variable Universal Life _____		37. Death Benefit Option <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
39. <input type="checkbox"/> Guideline Premium Test <input type="checkbox"/> Cash Value Accumulation Test		[41. Other Rider(s) Selected Term % _____ _____ _____ Loan Spread Rider, if elected <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3]	
40. Planned Premium Funding Schedule <input type="checkbox"/> Number of Years _____ <input type="checkbox"/> Pay to Age _____		[38.A.B.E. Allocations, if elected Year 1 _____ Year 2 _____ Year 3 _____ Year 4 _____ Year 5 _____ Year 6 _____ Year 7+ _____ See attached schedule if more than 7 years.]	
42. Coverage Information: (Select one) Specified Amount \$ _____ <input type="checkbox"/> See attached Census			

**OTHER INSURANCE ON PROPOSED INSURED**

43. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefit 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 replacement forms.)

44. Amount all life insurance presently in force or applied for. **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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please attach a list of any other additional insurance on a separate sheet. What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? \$ \_\_\_\_\_

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

**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.

**SUITABILITY - COMPLETE THIS SECTION IF VUL ONLY**

- Have you, the Proposed Insured and the Owner, received a current Prospectus, or equivalent document for the policy applied for and have you had sufficient time to review?  Yes  No
- 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?  Yes  No
- Do you understand that the cash value may increase or decrease depending on the investment performance of the funds held in the Separate Account?  Yes  No
- With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?  Yes  No

**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.**

**STATE DISCLOSURE**

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.

**AGREEMENT AND ACKNOWLEDGEMENT**

Under penalties of perjury I, the undersigned, certify that: (a) the tax identification or social security numbers as provided by me is correct; and (b) the holders of said numbers are not subject to any backup withholding of U.S. Federal income tax.

Each of the Undersigned declares that:

1. This Application consists of: a) this Executive Benefits Individual Owner Modified Simplified Part I Application; b) any amendments to the application attached thereto; and c) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. The Executive Benefits Individual Owner Modified Simplified Part I Application is fully completed.
2. I/We further agree that coverage will take effect under the Policy only when: 1) initial premium payment has been received; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured; and 3) the Proposed Insured remains 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.
3. If this is a request to exercise an option in an existing policy, the request will become effective in accordance with the terms of that option. If this is a request for change, any and all values may be used to pay for the change and to repay any loan indebtedness. The changed policy will be subject to any loan indebtedness not repaid. Any assignment in effect at the time of this request will apply to any new insurance issued.
4. No agent, broker or medical examiner has the authority to make changes or modify any Company contract or to waive any of the Company's requirements.
5. I HAVE READ, or have had read to me, the completed Application before signing. 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.
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.

**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 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/We authorize the Company to disclose information related to my insurability 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.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

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**

\_\_\_\_\_  
**Signature of Proposed Insured**

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

\_\_\_\_\_  
**Signature of Applicant/Owner/Trustee**

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

\_\_\_\_\_  
**Signed at (City and State)**

- 1) Based on information obtained from the Owner, I believe the investment is suitable for the Owner's objectives.
- 2) To the best of my knowledge, the source of funding for this policy does not include: (1) a non-recourse premium financing loan; or (2) any arrangement, other than a premium financing loan, which involves any person or entity with an interest in the potential for earnings based on the provision of funding for the policy.
- 3) Does the applicant have any existing life insurance policies or annuities?  Yes  No
- 4) 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.

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

\_\_\_\_\_  
**Signature of Broker, Agent or Licensed Representative**

\_\_\_\_\_  
**Name of Broker, Agent or Licensed Representative (Please Print)**

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

Executive Benefits Individual Owner  
Part I and Part II  
Application for Life Insurance



**B63**  
**(Standard Version)**

**IMPORTANT NOTICE**

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

**(Please give a copy of these notices to 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.

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**INVESTIGATIVE CONSUMER REPORT**

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**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.

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<b>CORPORATION INFORMATION</b>	
1. Corporation Name	2. Taxpayer Identification Number
3. Address ( <i>Street, City, State, ZIP</i> )	

<b>PLAN ADMINISTRATION CONTACT</b> ( <i>Send all correspondence to named contact in Brokers Office of Servicing Agent</i> )	
4. Name	5. Telephone Number ( <i>include area code</i> )
6. Address ( <i>Street, City, State, ZIP</i> )	

<b>PROPOSED INSURED INFORMATION</b>			
7. Proposed Insured ( <i>First, Middle Initial, Last</i> )			8. Place of Birth
9. Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please provide country, type of visa, expiration date and green card information) _____			
10. Date of Birth ( <i>mm/dd/yy</i> )	11. Social Security Number	12. <input type="checkbox"/> Male <input type="checkbox"/> Female	13. Driver's License # & State
14. Occupation	15. Salary \$	16. Date of Hire ( <i>mm/dd/yy</i> )	
17. Home Address ( <i>No., Street, PO Box, City, State, ZIP</i> )			

<b>GENERAL RISK INFORMATION For Proposed Insured</b>
--

*If you answer "No" to question 18, or "Yes" to questions 21-24, explain in the space provided on Page 2.*

18. Have you been actively at work on a full time basis (at least 30 hours/week) performing all duties of your regular occupation, at your customary place of employment for the past 3 months? (Disregard vacation days, normal non-working days and absences that total less than 4 consecutive days). If "No", specify: _____	<b>Yes</b>	<b>No</b>																
	<input type="checkbox"/>	<input type="checkbox"/>																
19. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? ( <i>If "Yes", list below.</i> )	<input type="checkbox"/>	<input type="checkbox"/>																
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Type</th> <th style="width: 20%;">Date First Used: (<i>month/year</i>)</th> <th style="width: 20%;">Date Last Used: (<i>month/year</i>)</th> <th style="width: 35%;">Amount and Frequency:</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Type	Date First Used: ( <i>month/year</i> )	Date Last Used: ( <i>month/year</i> )	Amount and Frequency:														
Type	Date First Used: ( <i>month/year</i> )	Date Last Used: ( <i>month/year</i> )	Amount and Frequency:															
20 a. 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? ( <i>If "Yes", an Aviation Supplement is required; this includes balloon pilots.</i> )	<input type="checkbox"/>	<input type="checkbox"/>																
b. 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? ( <i>If "Yes", an Avocation Supplement is required.</i> )	<input type="checkbox"/>	<input type="checkbox"/>																
c. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? ( <i>If "Yes", a Foreign Travel or Residence Supplement is required.</i> )	<input type="checkbox"/>	<input type="checkbox"/>																

**GENERAL RISK INFORMATION For Proposed Insured (Continued)**

21. In 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, revoked or restricted? (If "Yes," please provide what type and dates in the "Details" space provided.)	Yes	No
22. Have you ever applied for any life, health or disability insurance which was denied, postponed, required an extra premium or was issued for a reduced amount? (If "Yes", please provide what type and dates in the "Details" space provided.)	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you ever been convicted or are you waiting 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"/>	<input type="checkbox"/>
24. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? (If "Yes", please indicate if Retired or Active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.)	<input type="checkbox"/>	<input type="checkbox"/>
25. <b>Details:</b> (If you answered "No" to question 18 or "Yes" to question 21-24 list details in this section; please include question number details pertain to and attach an additional sheet of paper, if necessary. )		

**MEDICAL RISK INFORMATION For Proposed Insured**

*If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided on page 3.*

26. <b>Have you ever had an indication of, or been treated by a licensed medical professional for:</b>	Yes	No
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 complication 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 or 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 medically or surgically treated condition not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
27. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immuno Deficiency Syndrome or an AIDS related condition?	<input type="checkbox"/>	<input type="checkbox"/>
28. Do you use alcoholic beverages? (If "Yes", Provide type, Frequency & Amount)		
Type _____ Frequency _____ Amount _____	<input type="checkbox"/>	<input type="checkbox"/>
29. 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"/>
30. In the past 5 years have you ever used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	<input type="checkbox"/>	<input type="checkbox"/>
31. 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"/>
32. 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"/>
33. 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: (Attach an additional sheet of paper, if necessary.)		

**DETAILS TO MEDICAL RISK INFORMATION QUESTIONS 26-32, if answered "Yes", please specify below.**

34. Number, nature and severity of condition, frequency of attacks, treatments received medication, dates, name, address & phone number of medical attendants and hospitals. (List details from "Yes" answered Medical Information; please include question number. *Attach an additional sheet of paper, if necessary.*)

Ques.	Details

**MEDICAL INFORMATION For Proposed Insured**

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

b. Date and reason of last visit:

c. Tests performed & treatment received:

36. Height \_\_\_\_\_ ft. / \_\_\_\_\_ in.      a. Has your weight changed by more than 10 pounds during the past 12 months?    Y    N  
 Weight \_\_\_\_\_ lbs.                      b. If "Yes," by how many pounds? \_\_\_\_\_    Gain    Loss

37.	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)			

**OWNER DESIGNATION (Select One - Please complete this section if the Insured is not the Owner)**

38.  Insured       Trust (Name of Trust, Trustee and Date of Trust)       Other: \_\_\_\_\_

39. Owner Name	40. Taxpayer Identification/Social Security Number
----------------	--

41. Address (*Street, City, State, ZIP*)

42. Name of Trustee	43. Date of Trust
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**PAYOR DESIGNATION (Please complete if the Payor is other than the Owner)**

44. Payor Name

45. Address (*Street, City, State, ZIP*)

**BENEFICIARY DESIGNATION (Select One)**

46.  Individual (Provide Full Name, Social Security Number and Relationship)  
 Primary \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
 Address (Street, City, State, ZIP) \_\_\_\_\_  
 Primary \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
 Address (Street, City, State, ZIP) \_\_\_\_\_

47. Contingent \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
 Contingent \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

48.  Trust (Name of Trust, Trustee and Date of Trust)  Primary  Contingent TIN: \_\_\_\_\_

49.  Split Dollar (Enclose a copy of split dollar agreement)  Primary  Contingent

50.  Other:  Primary  Contingent

**POLICY INFORMATION**

51. Requested Policy Effective Date \_\_\_\_\_ 52. Billing Frequency  
 Annual  Semi-Annual  Quarterly  Monthly  Single Premium

53. Basic Plan  Corporate Universal Life \_\_\_\_\_  
 Corporate Variable Universal Life \_\_\_\_\_

54. Death Benefit Option  
 1  2  3

55. A.B.E. Allocations, if Selected  
 Year 1 \_\_\_\_\_  
 Year 2 \_\_\_\_\_  
 Year 3 \_\_\_\_\_  
 Year 4 \_\_\_\_\_  
 Year 5 \_\_\_\_\_  
 Year 6 \_\_\_\_\_  
 Year 7+ \_\_\_\_\_  
 See attached schedule if more than 7 years.]

56.  Guideline Premium Test  
 Cash Value Accumulation Test

57. Planned Premium Funding Schedule  
 Number of Years \_\_\_\_\_  
 Pay to Age \_\_\_\_\_

58. Other Rider(s) Selected  
 Term % \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Loan Spread Rider, if Selected  
 Option 1  Option 2  Option 3]

59. Coverage Information: (Select one)  
 Specified Amount \$ \_\_\_\_\_  See attached Census

**OTHER INSURANCE ON PROPOSED INSURED**

60. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefit 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 replacement forms.)

61. Amount of all life insurance presently in force or applied for. **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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please attach a list of any other additional insurance on a separate sheet. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? \$ \_\_\_\_\_

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

**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.

**SUITABILITY - COMPLETE THIS SECTION IF VUL ONLY**

- |   |  |
|---|--|
| 1. Have you, the Proposed Insured and the Owner, received a current Prospectus, or equivalent document for the policy applied for and have you had sufficient time to review? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 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"/> Yes <input type="checkbox"/> No |
| 3. Do you understand that the cash value may increase or decrease depending on the investment performance of the funds held in the Separate Account?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 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"/> Yes <input type="checkbox"/> No |

**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.**

**STATE DISCLOSURE**

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.

**AGREEMENT AND ACKNOWLEDGEMENT**

Under penalties of perjury I, the undersigned, certify that: (a) the tax identification or social security numbers as provided by me is correct; and (b) the holders of said numbers are not subject to any backup withholding of U.S. Federal income tax.

Each of the Undersigned declares that:

1. This Application consists of: a) this Executive Benefits Individual Owner Part I and Part II Application; b) Part III Medical Application, if required; c) any amendments to the application attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. This Executive Benefits Individual Owner Part I and Part II Application is fully completed.
2. I/We further agree that coverage will take effect under the Policy only when: 1) initial premium payment has been received; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured; and 3) the Proposed Insured remains 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.
3. If this is a request to exercise an option in an existing policy, the request will become effective in accordance with the terms of that option. If this is a request for change, any and all values may be used to pay for the change and to repay any loan indebtedness. The changed policy will be subject to any loan indebtedness not repaid. Any assignment in effect at the time of this request will apply to any new insurance issued.
4. No agent, broker or medical examiner has the authority to make changes or modify any Company contract or to waive any of the Company's requirements.
5. I HAVE READ, or have had read to me, the completed Application before signing. 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.
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.

**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 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/We authorize the Company to disclose information related to my insurability 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.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

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**

\_\_\_\_\_  
**Signature of Proposed Insured**

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

\_\_\_\_\_  
**Signature of Applicant/Owner/Trustee**

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

\_\_\_\_\_  
**Signed at (City and State)**

- 1) Based on information obtained from the Owner, I believe the investment is suitable for the Owner's objectives.
- 2) To the best of my knowledge, the source of funding for this policy does not include: (1) a non-recourse premium financing loan; or (2) any arrangement, other than a premium financing loan, which involves any person or entity with an interest in the potential for earnings based on the provision of funding for the policy.
- 3) Does the applicant have any existing life insurance policies or annuities?  Yes  No
- 4) 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.

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

\_\_\_\_\_  
**Signature of Broker, Agent or Licensed Representative**

\_\_\_\_\_  
**Name of Broker, Agent or Licensed Representative (Please Print)**

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

**MEDICAL SUPPLEMENT**  
**(Part III 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)

# Executive Benefits Corporate Owner Application for Life Insurance



**B65**  
**(Standard Version)**

**IMPORTANT NOTICE**

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

**(Please give a copy of these notices to 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 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: [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)]

**CORPORATION INFORMATION**

1. Corporation Name	2. Taxpayer Identification Number
3. Address ( <i>Street, City, State, ZIP</i> )	

**PLAN ADMINISTRATION CONTACT (*Send all correspondence to named contact in Brokers Office of Servicing Agent*)**

4. Name	5. Telephone Number ( <i>include area code</i> )
6. Address ( <i>Street, City, State, ZIP</i> )	

**OWNER DESIGNATION (*Select One*)**

7. <input type="checkbox"/> Corporation <input type="checkbox"/> Trust (Name of Trust, Trustee and Date of Trust) <input type="checkbox"/> Other: _____	
8. Owner Name	9. Taxpayer Identification/Social Security Number
10. Address ( <i>Street, City, State, ZIP</i> )	
11. Name of Trustee	12. Date of Trust

**PAYOR DESIGNATION (*Please complete if the Payor is other than the Owner*)**

13. Payor Name
14. Address ( <i>Street, City, State, ZIP</i> )

**BENEFICIARY DESIGNATION (*Select One*)**

15. <input type="checkbox"/> Corporation
16. <input type="checkbox"/> Trust Name of Trust _____ Trustee _____ Date of Trust _____ TIN _____
17. <input type="checkbox"/> Split Dollar ( <i>Enclose a copy of split dollar agreement</i> )
18. <input type="checkbox"/> Other:

**POLICY INFORMATION**

19. Requested Policy Effective Date _____	20. Billing Frequency <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Single Premium		
21. Basic Plan <input type="checkbox"/> Corporate Universal Life _____ <input type="checkbox"/> Corporate Variable Universal Life _____		22. Death Benefit Option <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	[23.A.B.E. Allocations, if Selected Year 1 _____ Year 2 _____ Year 3 _____ Year 4 _____ Year 5 _____ Year 6 _____ Year 7+ _____ See attached schedule if more than 7 years.]
24. <input type="checkbox"/> Guideline Premium Test <input type="checkbox"/> Cash Value Accumulation Test	25. Planned Premium Funding Schedule <input type="checkbox"/> Number of Years _____ <input type="checkbox"/> Pay to Age _____	[26. Other Rider(s) Selected Term % _____ _____ _____ Loan Spread Rider, if Selected <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3]	
27. Coverage Information: <i>(Select one)</i> Specified Amount \$ _____ <input type="checkbox"/> See attached Census			

**OTHER CORPORATE OWNED/SPONSORED INSURANCE**

28. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefit 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 replacement forms.)*

29. Amount of all life insurance presently in force or applied for. **If none, check this box:**      
Please indicate the Type of coverage: Business **(B)**; Key Person **(K)**.

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

Please attach a list of any other additional insurance on a separate sheet. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? \$ \_\_\_\_\_

**SUITABILITY - COMPLETE THIS SECTION IF VUL ONLY**

30. Type of Business: \_\_\_\_\_

31. Approximate net annual income  
 Under \$1,000,000     \$1,000,001 to \$10,000,000     10,000,001 to \$50,000,000     Over \$50,000,000

32. Total Assets  
 Under \$1,000,000     \$1,000,001 to \$10,000,000     10,000,001 to \$50,000,000     Over \$50,000,000

33. Investment Objectives *(check all applicable objectives)*  
 Capital Preservation     Current Income     Growth     Tax Advantage/Deferral     Growth and Income  
 Other (please specify): \_\_\_\_\_

34. Please provide a brief description of your insurance objective in obtaining this coverage:  
\_\_\_\_\_

35. Source of Premium Dollars: *(check one)*     Corporate     Individual     Trust

36. Does the Policy Owner have any affiliation with, or work for, a member of a Stock Exchange or the National Association of Securities Dealers, Inc., or other entity in dealing as agent or principal in securities? (If "Yes", provide the name and address of the company below.)     Yes     No  
Company Name and Address: \_\_\_\_\_

**SUITABILITY - COMPLETE THIS SECTION IF VUL ONLY (Continued)**

37. Have the proper corporate resolutions been adopted authorizing the acquisition of this coverage and exercise of rights there under? Lincoln Life reserves the right to require you to provide a copy of such resolutions.  Yes  No
38. Have you, the Owner, received a current Prospectus, or equivalent document for the policy applied for and have you had sufficient time to review?  Yes  No
39. 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?  Yes  No
40. Do you understand that the cash value may increase or decrease depending on the investment performance of the funds held in the Separate Account?  Yes  No
41. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?  Yes  No

**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.**

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

**STATE DISCLOSURE**

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.

**AGREEMENT AND ACKNOWLEDGEMENT**

The Signatures below represent the following:

Under penalties of perjury, I/We certify that (a) the tax identification or social security numbers as provided by me are correct; and (b) the holders of said numbers are not subject to any backup withholding or U.S. Federal income tax.

Each of the Undersigned declares that:

1. This Application consists of a) this Executive Benefits Corporate Owner Part I Application; b) the individual Consent to be Insured form (Guaranteed Issue), or Modified Simplified Consent form (Modified SI), or Part II (Simplified or Fully Underwritten) Applications; c) Part III Medical Application, if required; any amendments to the Application attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. This Application for Life Insurance – Part I, Part II, Modified Simplified Consent or Consent to be Insured form are fully completed.
2. I/We further agree that coverage will take effect under the Policy only when: 1) initial premium has been received; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured; and 3) the Proposed Insured remains in the same state of health and insurability as described in each consent or application form that was completed to determine eligibility at the time conditions 1) and 2) are met.
3. If this is a request to exercise an option in an existing policy, the request will become effective in accordance with the terms of that option. If this is a request for change, any and all values may be used to pay for the change and to repay any loan indebtedness. The changed policy will be subject to any loan indebtedness not repaid. Any assignment in effect at the time of this request will apply to any new insurance issued.
4. 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.
5. No agent, broker or medical examiner has the authority to make changes or modify any Company contract or to waive any of the Company's requirements.

**AGREEMENT AND ACKNOWLEDGEMENT (Continued)**

- 6. I/WE HAVE READ, or have had read to me, the completed Application before signing. 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.
- 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.

**List Individuals authorized to sign for the Owner:**

<b>Printed Name</b>	<b>Title</b>	<b>Signature</b>

<b>Printed Name</b>	<b>Title</b>	<b>Signature</b>

**If there are additional individuals who should be authorized to sign on behalf of the Owner please send/attach a separate listing.**

**SIGNATORY SECTION**

<b>Signature of Applicant/Owner/Trustee</b>	<b>Date</b>

**Officer's Title if policy is owned by a Corporation**

**Signed at (City and State)**

- 1) Based on information obtained from the Owner, I believe the investment is suitable for the Owner's objectives.
- 2) To the best of my knowledge, the source of funding for this policy does not include: (1) a non-recourse premium financing loan; or (2) any arrangement, other than a premium financing loan, which involves any person or entity with an interest in the potential for earnings based on the provision of funding for the policy.
- 3) Does the applicant have any existing life insurance policies or annuities?  Yes  No
- 4) 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.

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

<b>Signature of Broker, Agent or Licensed Representative</b>	<b>Name of Broker, Agent or Licensed Representative (Please Print)</b>	<b>Date</b>

Executive Benefits  
Corporate Owner Application  
for Life Insurance  
Part II Application



**B66**  
**(Standard Version)**

**[B]**

**IMPORTANT NOTICE**

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

**(Please give a copy of these notices to 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 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: [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)]

**PROPOSED INSURED INFORMATION**

1. Proposed Insured ( <i>First, Middle Initial, Last</i> )		2. Place of Birth	
3. Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please provide country, type of visa, expiration date and green card information): _____			
4. Date of Birth ( <i>mm/dd/yy</i> )	5. Social Security Number	6. <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Driver's License # & State
8. Occupation	9. Salary \$	10. Date of Hire ( <i>mm/dd/yy</i> )	
11. Home Address ( <i>No., Street, PO Box, City, State, ZIP</i> )			
12. I have been notified by my employer that the maximum amount of insurance coverage that will be issued is: \$ _____ I understand that this form, or a copy of this form, will be given to the Owner and included as part of the policy/contract.			

**GENERAL RISK INFORMATION For Proposed Insured**

*If you answer "No" to question 13, or "Yes" to questions 15-19, explain in the space provided on Page 2.*

13. Have you been actively at work daily on a full-time basis (30 hours/week) performing all duties of your regular occupation, at your customary place of employment for the past 3 months? (Disregard vacation days, normal non-working days and absences that total less than 4 consecutive days.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? ( <i>If "Yes", list below.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No
Type	Date First Used: ( <i>month/year</i> )	Date Last Used: ( <i>month/year</i> )	Amount and Frequency:
15a. 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? ( <i>If "Yes", an Aviation Supplement is required; this includes balloon pilots.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No
b. 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? ( <i>If "Yes", an Avocation Questionnaire is required.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? ( <i>If "Yes", a Foreign Travel or Residence Questionnaire is required.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No
16. In 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 license suspended, revoked or restricted? ( <i>If "Yes", please provide what type and dates in the "Details" space provided.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Have you ever applied for any life, health or disability insurance which was denied, postponed, required an extra premium or was issued for a reduced amount? ( <i>If, "Yes", please provide what type and dates in the "Details" space provided.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Have you ever been convicted or are you waiting trial for a felony? ( <i>If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? ( <i>If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No

**GENERAL RISK INFORMATION For Proposed Insured (Continued)**

20. **Details:** (If you answered "No" to question 13, or "Yes" to questions 15-19 list details in this section; please include question number details pertain to and attach an additional sheet of paper, if necessary.)

**MEDICAL RISK INFORMATION For Proposed Insured**

If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided on page 3.

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| <b>21. Have you ever had an 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 complication 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 or 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 medically or surgically treated condition not listed above?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. 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"/> |
| 23. Do you use alcoholic beverages? (If "Yes", Provide type, Frequency & Amount)  |                          |                          |
| Type _____ Frequency _____ Amount _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. 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"/> |
| 25. In the past 5 years have you ever used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. 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"/> |
| 27. 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"/> |
| 28. 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: (Attach an additional sheet of paper, if necessary.) |                          |                          |



**OTHER INSURANCE**

33. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefit 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 replacement forms.)

34. Amount of other Corporate Sponsored life insurance presently in force or applied for: **If none, check this box:**   
 Please indicate the Type of coverage: Business (B); Key Person (K)

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	
	\$			<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	
	\$			<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	
	\$			<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	

Please attach a list of any other additional insurance on a separate sheet. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? \$ \_\_\_\_\_

**[BENEFICIARY DESIGNATION**

35. Individual (Provide Full Name, Social Security Number and Relationship)

Primary \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
 Address (Street, City, State, ZIP) \_\_\_\_\_

Primary \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
 Address (Street, City, State, ZIP) \_\_\_\_\_

36. Contingent \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
 Contingent \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

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

**AGREEMENT AND ACKNOWLEDGEMENT**

Each of the Undersigned declares that:

1. This Application consists of: a) this Executive Benefits Individual Owner Application - Part I and Part II; b) Part III Medical Application, if required; c) any amendments to the application attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. This Application for Life Insurance - Part I and Part II is fully completed.
2. I/We further agree that coverage will take effect under the Policy only when: 1) initial premium payment has been received; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured; and 3) the Proposed Insured remains 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.
3. If this is a request to exercise an option in an existing policy, the request will become effective in accordance with the terms of that option. If this is a request for change, any and all values may be used to pay for the change and to repay any loan indebtedness. The changed policy will be subject to any loan indebtedness not repaid. Any assignment in effect at the time of this request will apply to any new insurance issued.
4. No agent, broker or medical examiner has the authority to make changes or modify any Company contract or to waive any of the Company's requirements.
5. I HAVE READ, or have had read to me, the completed Application before signing. 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.
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 DISCLOSURE**

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.

**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 disclosure 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 \_\_\_\_\_  
(city) (state) (month) (year)

\_\_\_\_\_  
**Signature of Proposed Insured**

\_\_\_\_\_  
**Witness**

**TEMPORARY LIFE INSURANCE AGREEMENT**

**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 the 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. ONE FORM SHOULD BE COMPLETED FOR EACH PROPOSED INSURED.**

Questions apply to the Proposed Insured shown on the application.

1. Does Amount applied for exceed \$3,000,000?       Yes     No
2. is over age 70 (age nearest birthday),               Yes     No
3. has been, within the past 90 days, been admitted to a hospital or other medical facility, been advised to be admitted or has surgery performed or recommended, or,                               Yes     No
4. has been, within the past 2 years, 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 Application dated \_\_\_\_\_ and the Part II completed on the life of \_\_\_\_\_ listed on the \_\_\_\_\_ case census document dated \_\_\_\_\_.

**TERMS AND CONDITIONS**

**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 on any Proposed Insured(s) who are listed on the formal census document and who have fully completed a Part II application, and such Proposed Insured(s) dies while this Agreement is in effect, the Company will pay to the beneficiary designated in the Application the lesser of a) the amount of all death benefits applied for in the Application(s) with respect to said Proposed Insured(s), or b) \$500,000. This total benefit limit applies to all insurance applied for under this and any current 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 a Part I, formal census and Part II Application(s) have 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) 45 days from date of this Agreement if a required Exam or Non medical information is not 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 Part II of the Application(s). 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 Application(s) 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 a Proposed Insured(s) 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.

By: \_\_\_\_\_  
 Corporation/Owner

\_\_\_\_\_  
 Title

By: \_\_\_\_\_  
 The Lincoln National Life Insurance Company

\_\_\_\_\_  
 Title

By: \_\_\_\_\_  
 Producer

\_\_\_\_\_  
 Title

**CONSENT TO BE INSURED**

**Yes** - I, \_\_\_\_\_ (please print), consent  
 my employer \_\_\_\_\_

or any LLC or grantor trust it may establish, (the "Owner") obtaining life insurance policies (the "Policies") on my life.

I acknowledge that the Owner has an insurable interest in my life and I further acknowledge that the Policies will be used to informally fund benefit obligations. I understand and agree that the Owner named above will be the sole owner and beneficiary of the Policies and that neither I, my estate, nor any beneficiary I may designate shall have any interest in the Policies or a right to the proceeds thereof. I understand that the Policies are being acquired by the Owner for its own benefit in connection with informally funding Company benefit liabilities.

I understand that, in order to informally fund benefit obligations, the Owner may need to increase the amount of insurance under existing Policies on my life from time to time. I hereby authorize the Owner to affect such an increase or increases without providing any further notice to me. I also consent to and authorize the Owner to continue to be the owner and beneficiary of the Policies indefinitely, including after my employment with the Company terminates, whenever and for whatever reason this may occur.

I have been notified by my employer that the maximum amount of insurance issued on my life may vary but the maximum amount will not exceed \$ \_\_\_\_\_.

I understand that this form, or a copy of this form, will be given to the Owner and included as part of the policy/contract.

**No** - I do not consent to have life insurance purchased on my life.

**Work Status: (Please complete)**

1. Have you been actively at work daily on a full-time basis (at least 30 hours/week) performing all duties of your regular occupation, at your customary place of employment for the past 3 months? (Disregard vacation days, normal non-working days and absences that total less than 4 consecutive days.) If "No", specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No																
2. 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 date first used, date last used, amount and frequency):	<input type="checkbox"/> Yes <input type="checkbox"/> No																
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Type	Date First Used: <i>(month/year)</i>	Date Last Used: <i>(month/year)</i>	Amount and Frequency:														
3. Proposed Insured ( <i>First, Middle Initial, Last</i> )	4. <input type="checkbox"/> Male <input type="checkbox"/> Female																
5. Social Security Number	6. Date of Birth ( <i>mm/dd/yy</i> )	7. Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please provide country, type of visa, expiration date and green card information): _____															
8. Date of Hire ( <i>mm/dd/yy</i> )	9. Salary \$ _____																
10. Work Address ( <i>Street, City, State/Country, ZIP</i> )																	

**[Beneficiary Designation:**

11. Primary _____ % SSN: _____ Address ( <i>Street, City, State, ZIP</i> ) _____	Relationship to Insured: _____
Contingent _____ % SSN: _____	Relationship to Insured: _____

**State Disclosure**

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.

\_\_\_\_\_  
**Signature of Proposed Insured**

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

**IMPORTANT NOTICE**

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

**(Please give a copy of these notices to 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 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: [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)]

**MODIFIED SIMPLIFIED UNDERWRITING AND CONSENT FORM**

**Yes** - I, \_\_\_\_\_ (please print), consent  
my employer \_\_\_\_\_

LLC or any grantor trust it may establish, (the "Owner") obtaining life insurance policies (the "Policies") on my life.

I acknowledge that the Owner has an insurable interest in my life and I further acknowledge that the Policies will be used to informally fund benefit obligations. I understand and agree that the Owner named above will be the sole owner and beneficiary of the Policies and that neither I, myself nor any beneficiary I may designate shall have any interest in the Policies or a right to the proceeds thereof. I understand that the Policies are being acquired by the Owner for its own benefit in connection with informally funding Company benefit liabilities.

I understand that, in order to informally fund benefit obligations, the Owner may need to increase the amount of insurance under existing Policies on my life from time to time. I hereby authorize the Owner to affect such an increase or increases without providing any further notice to me. I also consent to an authorize the Owner to continue to be the owner and beneficiary of the Policies indefinitely, including after my employment with the Company terminates, whenever and for whatever reason this may occur.

I have been notified by my employer that the maximum amount of insurance issued on my life may vary but the maximum amount will not exceed \$ \_\_\_\_\_.

I understand that this form, or a copy of this form, will be given to the Owner and included as part of the policy/contract.

**No** - I do not consent to have life insurance purchased on my life.

**Work Status: (Please complete)**

1. Have you been actively at work daily on a full-time basis (at least 30 hours/week) performing all duties of your regular occupation, at customary place of employment for the past 3 months? (Disregard vacation days, normal non-working days and absences that total less than 4 consecutive days.) If "No", specify:			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. 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"/> Yes <input type="checkbox"/> No
Type	Date First Used: (month/year)	Date Last Used: (month/year)	Amount and Frequency:
3. Have you, in the past 10 years been treated for any disorder of the heart or blood vessels, tumors or cancer, diabetes, stroke or any disorder of the blood, lungs, kidneys, drug or alcohol use, depression or been diagnosed or treated by a doctor or other medical practitioner for Acquired Immune Deficiency (AIDS) or AIDS related condition? If "Yes", specify:			<input type="checkbox"/> Yes <input type="checkbox"/> No

**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

**STATE DISCLOSURES**

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.

**INSURED INFORMATION**

1. Proposed Insured ( <i>First, Middle Initial, Last</i> )		2. <input type="checkbox"/> Male <input type="checkbox"/> Female
3. Social Security Number	4. Date of Birth ( <i>mm/dd/yy</i> )	5. Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (If “No”, please provide country, type of visa, expiration date and green card information): _____
6. Date of Hire ( <i>mm/dd/yy</i> )	7. Salary \$ _____	
8. Work Address ( <i>Street, City, State/Country, ZIP</i> )		

**BENEFICIARY DESIGNATION**

9.	Primary _____ % SSN: _____	Relationship to Insured: _____
	Address ( <i>Street, City, State, ZIP</i> ) _____	
	Primary _____ % SSN: _____	Relationship to Insured: _____
	Address ( <i>Street, City, State, ZIP</i> ) _____	
10.	Contingent _____ % SSN: _____	Relationship to Insured: _____
	Contingent _____ % SSN: _____	Relationship to Insured: _____ ]

\_\_\_\_\_  
**Signature of Proposed Insured**

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

SERFF Tracking Number: LCNC-127401060 State: Arkansas  
Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 49695  
Company Tracking Number: B61, B62, B63, B64, B65, B66, B67, B10493, B10494  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Applications - COLI, BOLI, 162 Bonus Plans/Corp. Spons.  
Project Name/Number: Applications - COLI, BOLI, 162 Bonus Plans/Corp. Spons./B61, B62, B63, B64, B65, B66, B67, B10493, B10494

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> AR_LNL_Readability.pdf		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> This is an application filing, all documents are on the Form Schedule tab. <b>Comments:</b>		

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Amendment Letter <b>Comments:</b> <b>Attachment:</b> AR Application Correction B63, B65, B66.pdf		

## Arkansas

### READABILITY CERTIFICATION

#### *The Lincoln National Life Insurance Company*

**Re:** B61 – Executive Benefits Individual Owner Guaranteed Issue Part I Application for Life Insurance  
B62 – Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance  
B63 – Executive Benefits Individual Owner Part I and Part II Application for Life Insurance  
B65 – Executive Benefits Corporate Owner Application for Life Insurance  
B66 – Executive Benefits Corporate Owner Application for Life Insurance Part II Application  
B10493 – Consent to be Insured Form  
B10494 – Modified Simplified Underwriting and Consent Form  
B64 – Medical Supplement  
B67 – 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:

<u>Form Number</u>	<u>Flesch</u>
B61 – Executive Benefits Individual Owner Guaranteed Issue Part I Application for Life Insurance	52
B62 – Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance	50
B63 – Executive Benefits Individual Owner Part I and Part II Application for Life Insurance	50
B64 – Medical Supplement	56
B65 – Executive Benefits Corporate Owner Application for Life Insurance	51
B66 – Executive Benefits Corporate Owner Application for Life Insurance Part II Application	51
B67 – Temporary Life Insurance Agreement	51
B10493 – Consent to be Insured Form	53
B10494 – Modified Simplified Underwriting and Consent Form	51



Pamela M. Telfer, Vice President  
Product Compliance

Date: August 30, 2011



Financial Group®

The Lincoln National Life Insurance Company  
350 Church Street, MPM-10  
Hartford, CT 06103-1103

October 5, 2011

Hon. Jay Bradford, Commissioner of Insurance  
Compliance-Life & Health  
1200 West Third Street  
Little Rock, AR 72201-1904

Attention: Linda Bird

**The Lincoln National Life Insurance Company**  
**NAIC #65676**  
**FEIN #35-0472300**

**Re:** B61 – Executive Benefits Individual Owner Guaranteed Issue Part I Application for Life Insurance  
B62 – Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance  
B63 – Executive Benefits Individual Owner Part I and Part II Application for Life Insurance  
B64 – Medical Supplement  
B65 – Executive Benefits Corporate Owner Application for Life Insurance  
B66 – Executive Benefits Corporate Owner Application for Life Insurance Part II Application  
B67 – Temporary Life Insurance Agreement  
B10493 – Consent to be Insured Form  
B10494 – Modified Simplified Underwriting and Consent Form

Dear Ms. Bird:

In a post filing compliance review we found a typographical error in the Authorization section on three applications: B63, B65 & B66. Therefore, that we would like to correct these forms and have thus amended this filing by providing the revised applications to the Form Schedule Tab and their annotated versions to the Supporting Documentation Tab reflecting the changes below. We certify no other changes have been made to the applications.

The revisions to each application are provided in red text below. They are as follows:

**B63:**

Page 5, Authorization Section, Question 5:

5. I HAVE READ, or have had read to me, the completed Application before signing. 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.

**B65:**

Page 4, Authorization Section, Question 6:

6. I/WE HAVE READ, or have had read to me, the completed Application before signing. 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.

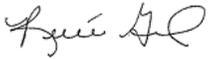
B66:

Page 5, Authorization Section, Question 5:

5. I HAVE READ, or have had read to me, the completed Application before signing. 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.

We apologize for the inconvenience due to this error. Please let us know if you have any questions regarding the above. Thank you for your assistance in this matter.

Sincerely,



Renee Gardner  
Product Compliance Analyst  
Phone: 860.466.2067  
Email: Renee.Gardner@lfg.com  
Enclosures

SERFF Tracking Number: LCNC-127401060 State: Arkansas  
 Filing Company: The Lincoln National Life Insurance Company State Tracking Number: 49695  
 Company Tracking Number: B61, B62, B63, B64, B65, B66, B67, B10493, B10494  
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
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 Project Name/Number: Applications - COLI, BOLI, 162 Bonus Plans/Corp. Spons./B61, B62, B63, B64, B65, B66, B67, B10493, B10494

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/31/2011	Form	Executive Benefits Individual Owner Part I and Part II Application for Life Insurance	10/05/2011	B63 - Bracketed.pdf (Superseded)
08/31/2011	Form	Executive Benefits Corporate Owner Application for Life Insurance	10/05/2011	B65 - Bracketed.pdf (Superseded)
08/31/2011	Form	Executive Benefits Corporate Owner Application for Life Insurance Part II Application	10/05/2011	B66_B - Bracketed.pdf (Superseded)

Executive Benefits Individual Owner  
Part I and Part II  
Application for Life Insurance



**B63**  
**(Standard Version)**

**IMPORTANT NOTICE**

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

**(Please give a copy of these notices to 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 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: [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)]

<b>CORPORATION INFORMATION</b>	
1. Corporation Name	2. Taxpayer Identification Number
3. Address ( <i>Street, City, State, ZIP</i> )	

<b>PLAN ADMINISTRATION CONTACT</b> ( <i>Send all correspondence to named contact in Brokers Office of Servicing Agent</i> )	
4. Name	5. Telephone Number ( <i>include area code</i> )
6. Address ( <i>Street, City, State, ZIP</i> )	

<b>PROPOSED INSURED INFORMATION</b>			
7. Proposed Insured ( <i>First, Middle Initial, Last</i> )			8. Place of Birth
9. Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please provide country, type of visa, expiration date and green card information) _____			
10. Date of Birth ( <i>mm/dd/yy</i> )	11. Social Security Number	12. <input type="checkbox"/> Male <input type="checkbox"/> Female	13. Driver's License # & State
14. Occupation	15. Salary \$	16. Date of Hire ( <i>mm/dd/yy</i> )	
17. Home Address ( <i>No., Street, PO Box, City, State, ZIP</i> )			

<b>GENERAL RISK INFORMATION For Proposed Insured</b>
--

*If you answered "No" to question 18, or "Yes" to questions 21-24, explain in the space provided on Page 2.*

18. Have you been actively at work on a full time basis (at least 30 hours/week) performing all duties of your regular occupation, at your customary place of employment for the past 3 months? (Disregard vacation days, normal non-working days and absences that total less than 4 consecutive days). If "No", specify: _____	<b>Yes</b>	<b>No</b>																
	<input type="checkbox"/>	<input type="checkbox"/>																
19. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? ( <i>If "Yes", list below.</i> )	<input type="checkbox"/>	<input type="checkbox"/>																
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Type	Date First Used: ( <i>month/year</i> )	Date Last Used: ( <i>month/year</i> )	Amount and Frequency:															
20 a. 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? ( <i>If "Yes", an Aviation Supplement is required; this includes balloon pilots.</i> )	<input type="checkbox"/>	<input type="checkbox"/>																
b. 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? ( <i>If "Yes", an Avocation Supplement is required.</i> )	<input type="checkbox"/>	<input type="checkbox"/>																
c. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? ( <i>If "Yes", a Foreign Travel or Residence Supplement is required.</i> )	<input type="checkbox"/>	<input type="checkbox"/>																

**GENERAL RISK INFORMATION For Proposed Insured (Continued)**

21. In 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, revoked or restricted? (If "Yes," please provide what type and dates in the "Details" space provided.)	Yes	No
22. Have you ever applied for any life, health or disability insurance which was denied, postponed, required an extra premium or was issued for a reduced amount? (If "Yes", please provide what type and dates in the "Details" space provided.)		
23. Have you ever been convicted or are you waiting 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.)		
24. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? (If "Yes", please indicate if Retired or Active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.)		
25. <b>Details:</b> (If you answered "No" to question 18 or "Yes" to question 21-24 list details in this section; please include question number details pertain to and attach an additional sheet of paper, if necessary. )		

**MEDICAL RISK INFORMATION For Proposed Insured**

*If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided on page 3.*

26. <b>Have you ever had an indication of, or been treated by a licensed medical professional for:</b>	Yes	No
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 complication 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 or 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 medically or surgically treated condition not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
27. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immuno Deficiency Syndrome or an AIDS related condition?	<input type="checkbox"/>	<input type="checkbox"/>
28. Do you use alcoholic beverages? (If "Yes", Provide type, Frequency & Amount)		
Type _____ Frequency _____ Amount _____	<input type="checkbox"/>	<input type="checkbox"/>
29. 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"/>
30. In the past 5 years have you ever used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	<input type="checkbox"/>	<input type="checkbox"/>
31. 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"/>
32. 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"/>
33. 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: (Attach an additional sheet of paper, if necessary.)		

**DETAILS TO MEDICAL RISK INFORMATION QUESTIONS 26-32, if answered "Yes", please specify below.**

34. Number, nature and severity of condition, frequency of attacks, treatments received medication, dates, name, address & phone number of medical attendants and hospitals. (List details from "Yes" answered Medical Information; please include question number. *Attach an additional sheet of paper, if necessary.*)

Ques.	Details

**MEDICAL INFORMATION For Proposed Insured**

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

b. Date and reason of last visit:

c. Tests performed & treatment received:

36. Height \_\_\_\_\_ ft. / \_\_\_\_\_ in.      a. Has your weight changed by more than 10 pounds during the past 12 months?    Y    N  
 Weight \_\_\_\_\_ lbs.                      b. If "Yes," by how many pounds? \_\_\_\_\_    Gain    Loss

37.	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)			

**OWNER DESIGNATION (Select One - Please complete this section if the Insured is not the Owner)**

38.  Insured       Trust (Name of Trust, Trustee and Date of Trust)       Other: \_\_\_\_\_

39. Owner Name \_\_\_\_\_ 40. Taxpayer Identification/Social Security Number \_\_\_\_\_

41. Address (*Street, City, State, ZIP*) \_\_\_\_\_

42. Name of Trustee \_\_\_\_\_ 43. Date of Trust \_\_\_\_\_

**PAYOR DESIGNATION (Please complete if the Payor is other than the Owner)**

44. Payor Name \_\_\_\_\_

45. Address (*Street, City, State, ZIP*) \_\_\_\_\_

**BENEFICIARY DESIGNATION (Select One)**

46.  Individual (Provide Full Name, Social Security Number and Relationship)  
 Primary \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
 Address (Street, City, State, ZIP) \_\_\_\_\_  
 Primary \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
 Address (Street, City, State, ZIP) \_\_\_\_\_

47. Contingent \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
 Contingent \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

48.  Trust (Name of Trust, Trustee and Date of Trust)  Primary  Contingent TIN: \_\_\_\_\_

49.  Split Dollar (Enclose a copy of split dollar agreement)  Primary  Contingent

50.  Other:  Primary  Contingent

**POLICY INFORMATION**

51. Requested Policy Effective Date \_\_\_\_\_ 52. Billing Frequency  
 Annual  Semi-Annual  Quarterly  Monthly  Single Premium

53. Basic Plan  
 Corporate Universal Life \_\_\_\_\_  
 Corporate Variable Universal Life \_\_\_\_\_

54. Death Benefit Option  
 1  2  3

55. A.B.E. Allocations, if Selected  
 Year 1 \_\_\_\_\_  
 Year 2 \_\_\_\_\_  
 Year 3 \_\_\_\_\_  
 Year 4 \_\_\_\_\_  
 Year 5 \_\_\_\_\_  
 Year 6 \_\_\_\_\_  
 Year 7+ \_\_\_\_\_  
 See attached schedule if more than 7 years.]

56.  Guideline Premium Test  
 Cash Value Accumulation Test

57. Planned Premium Funding Schedule  
 Number of Years \_\_\_\_\_  
 Pay to Age \_\_\_\_\_

58. Other Rider(s) Selected  
 Term % \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Loan Spread Rider, if Selected  
 Option 1  Option 2  Option 3]

59. Coverage Information: (Select one)  
 Specified Amount \$ \_\_\_\_\_  See attached Census

**OTHER INSURANCE ON PROPOSED INSURED**

60. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefit 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 replacement forms.)

61. Amount of all life insurance presently in force or applied for. **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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please attach a list of any other additional insurance on a separate sheet. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? \$ \_\_\_\_\_

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

**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.

**SUITABILITY - COMPLETE THIS SECTION IF VUL ONLY**

- |   |  |
|---|--|
| 1. Have you, the Proposed Insured and the Owner, received a current Prospectus, or equivalent document for the policy applied for and have you had sufficient time to review? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 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"/> Yes <input type="checkbox"/> No |
| 3. Do you understand that the cash value may increase or decrease depending on the investment performance of the funds held in the Separate Account?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 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"/> Yes <input type="checkbox"/> No |

**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.**

**STATE DISCLOSURE**

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.

**AGREEMENT AND ACKNOWLEDGEMENT**

Under penalties of perjury I, the undersigned, certify that: (a) the tax identification or social security numbers as provided by me is correct; and (b) the holders of said numbers are not subject to any backup withholding of U.S. Federal income tax.

Each of the Undersigned declares that:

1. This Application consists of: a) this Executive Benefits Individual Owner Part I and Part II Application; b) Part III Medical Application, if required; c) any amendments to the application attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. This Executive Benefits Individual Owner Part I and Part II Application is fully completed.
2. I/We further agree that coverage will take effect under the Policy only when: 1) initial premium payment has been received; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured; and 3) the Proposed Insured remains 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.
3. If this is a request to exercise an option in an existing policy, the request will become effective in accordance with the terms of that option. If this is a request for change, any and all values may be used to pay for the change and to repay any loan indebtedness. The changed policy will be subject to any loan indebtedness not repaid. Any assignment in effect at the time of this request will apply to any new insurance issued.
4. No agent, broker or medical examiner has the authority to make changes or modify any Company contract or to waive any of the Company's requirements.
5. I HAVE READ, or have had read to me, the completed Application before signing. 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 or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
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.

**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 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/We authorize the Company to disclose information related to my insurability 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.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

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**

\_\_\_\_\_  
**Signature of Proposed Insured**

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

\_\_\_\_\_  
**Signature of Applicant/Owner/Trustee**

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

\_\_\_\_\_  
**Signed at (City and State)**

- 1) Based on information obtained from the Owner, I believe the investment is suitable for the Owner's objectives.
- 2) To the best of my knowledge, the source of funding for this policy does not include: (1) a non-recourse premium financing loan; or (2) any arrangement, other than a premium financing loan, which involves any person or entity with an interest in the potential for earnings based on the provision of funding for the policy.
- 3) Does the applicant have any existing life insurance policies or annuities?  Yes  No
- 4) 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.

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

\_\_\_\_\_  
**Signature of Broker, Agent or Licensed Representative**

\_\_\_\_\_  
**Name of Broker, Agent or Licensed Representative (Please Print)**

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

# Executive Benefits Corporate Owner Application for Life Insurance



**B65**  
**(Standard Version)**

**IMPORTANT NOTICE**

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

**(Please give a copy of these notices to 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 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: [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)]

**CORPORATION INFORMATION**

1. Corporation Name	2. Taxpayer Identification Number
3. Address ( <i>Street, City, State, ZIP</i> )	

**PLAN ADMINISTRATION CONTACT** (*Send all correspondence to named contact in Brokers Office of Servicing Agent*)

4. Name	5. Telephone Number ( <i>include area code</i> )
6. Address ( <i>Street, City, State, ZIP</i> )	

**OWNER DESIGNATION** (*Select One*)

7. <input type="checkbox"/> Corporation <input type="checkbox"/> Trust (Name of Trust, Trustee and Date of Trust) <input type="checkbox"/> Other: _____	
8. Owner Name	9. Taxpayer Identification/Social Security Number
10. Address ( <i>Street, City, State, ZIP</i> )	
11. Name of Trustee	12. Date of Trust

**PAYOR DESIGNATION** (*Please complete if the Payor is other than the Owner*)

13. Payor Name
14. Address ( <i>Street, City, State, ZIP</i> )

**BENEFICIARY DESIGNATION** (*Select One*)

15. <input type="checkbox"/> Corporation
16. <input type="checkbox"/> Trust Name of Trust _____ Trustee _____ Date of Trust _____ TIN _____
17. <input type="checkbox"/> Split Dollar ( <i>Enclose a copy of split dollar agreement</i> )
18. <input type="checkbox"/> Other:

**POLICY INFORMATION**

19. Requested Policy Effective Date _____	20. Billing Frequency <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> Single Premium		
21. Basic Plan <input type="checkbox"/> Corporate Universal Life _____ <input type="checkbox"/> Corporate Variable Universal Life _____		22. Death Benefit Option <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	[23.A.B.E. Allocations, if Selected Year 1 _____ Year 2 _____ Year 3 _____ Year 4 _____ Year 5 _____ Year 6 _____ Year 7+ _____ See attached schedule if more than 7 years.]
24. <input type="checkbox"/> Guideline Premium Test <input type="checkbox"/> Cash Value Accumulation Test	25. Planned Premium Funding Schedule <input type="checkbox"/> Number of Years _____ <input type="checkbox"/> Pay to Age _____	[26. Other Rider(s) Selected Term % _____ _____ _____ Loan Spread Rider, if Selected <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3]	
27. Coverage Information: <i>(Select one)</i> Specified Amount \$ _____ <input type="checkbox"/> See attached Census			

**OTHER CORPORATE OWNED/SPONSORED INSURANCE**

28. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefit 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 replacement forms.)*

29. Amount of all life insurance presently in force or applied for. **If none, check this box:**      
 Please indicate the Type of coverage: Business **(B)**; Key Person **(K)**.

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

Please attach a list of any other additional insurance on a separate sheet. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? \$ \_\_\_\_\_

**SUITABILITY - COMPLETE THIS SECTION IF VUL ONLY**

30. Type of Business: \_\_\_\_\_

31. Approximate net annual income  
 Under \$1,000,000     \$1,000,001 to \$10,000,000     10,000,001 to \$50,000,000     Over \$50,000,000

32. Total Assets  
 Under \$1,000,000     \$1,000,001 to \$10,000,000     10,000,001 to \$50,000,000     Over \$50,000,000

33. Investment Objectives *(check all applicable objectives)*  
 Capital Preservation     Current Income     Growth     Tax Advantage/Deferral     Growth and Income  
 Other (please specify): \_\_\_\_\_

34. Please provide a brief description of your insurance objective in obtaining this coverage:  
 \_\_\_\_\_  
 \_\_\_\_\_

35. Source of Premium Dollars: *(check one)*     Corporate     Individual     Trust

36. Does the Policy Owner have any affiliation with, or work for, a member of a Stock Exchange or the National Association of Securities Dealers, Inc., or other entity in dealing as agent or principal in securities? (If "Yes", provide the name and address of the company below.)     Yes     No  
 Company Name and Address: \_\_\_\_\_

**SUITABILITY - COMPLETE THIS SECTION IF VUL ONLY (Continued)**

37. Have the proper corporate resolutions been adopted authorizing the acquisition of this coverage and exercise of rights there under? Lincoln Life reserves the right to require you to provide a copy of such resolutions.  Yes  No
38. Have you, the Owner, received a current Prospectus, or equivalent document for the policy applied for and have you had sufficient time to review?  Yes  No
39. 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?  Yes  No
40. Do you understand that the cash value may increase or decrease depending on the investment performance of the funds held in the Separate Account?  Yes  No
41. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?  Yes  No

**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.**

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

**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.

**STATE DISCLOSURE**

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.

**AGREEMENT AND ACKNOWLEDGEMENT**

The Signatures below represent the following:

Under penalties of perjury, I/We certify that (a) the tax identification or social security numbers as provided by me are correct; and (b) the holders of said numbers are not subject to any backup withholding or U.S. Federal income tax.

Each of the Undersigned declares that:

1. This Application consists of a) this Executive Benefits Corporate Owner Part I Application; b) the individual Consent to be Insured form (Guaranteed Issue), or Modified Simplified Consent form (Modified SI), or Part II (Simplified or Fully Underwritten) Applications; c) Part III Medical Application, if required; any amendments to the Application attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. This Application for Life Insurance – Part I, Part II, Modified Simplified Consent or Consent to be Insured form are fully completed.
2. I/We further agree that coverage will take effect under the Policy only when: 1) initial premium has been received; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured; and 3) the Proposed Insured remains in the same state of health and insurability as described in each consent or application form that was completed to determine eligibility at the time conditions 1) and 2) are met.
3. If this is a request to exercise an option in an existing policy, the request will become effective in accordance with the terms of that option. If this is a request for change, any and all values may be used to pay for the change and to repay any loan indebtedness. The changed policy will be subject to any loan indebtedness not repaid. Any assignment in effect at the time of this request will apply to any new insurance issued.
4. 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.
5. No agent, broker or medical examiner has the authority to make changes or modify any Company contract or to waive any of the Company's requirements.

**AGREEMENT AND ACKNOWLEDGEMENT (Continued)**

- 6. I/WE HAVE READ, or have had read to me, the completed Application before signing. 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 or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
- 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.

**List Individuals authorized to sign for the Owner:**

<b>Printed Name</b>	<b>Title</b>	<b>Signature</b>

<b>Printed Name</b>	<b>Title</b>	<b>Signature</b>

If there are additional individuals who should be authorized to sign on behalf of the Owner please send/attach a separate listing.

**SIGNATORY SECTION**

<b>Signature of Applicant/Owner/Trustee</b>	<b>Date</b>

**Officer's Title if policy is owned by a Corporation**

**Signed at (City and State)**

- 1) Based on information obtained from the Owner, I believe the investment is suitable for the Owner's objectives.
- 2) To the best of my knowledge, the source of funding for this policy does not include: (1) a non-recourse premium financing loan; or (2) any arrangement, other than a premium financing loan, which involves any person or entity with an interest in the potential for earnings based on the provision of funding for the policy.
- 3) Does the applicant have any existing life insurance policies or annuities?  Yes  No
- 4) 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.

I declare that I have accurately answered all questions contained in this section.  
 I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

<b>Signature of Broker, Agent or Licensed Representative</b>	<b>Name of Broker, Agent or Licensed Representative (Please Print)</b>	<b>Date</b>

Executive Benefits  
Corporate Owner Application  
for Life Insurance  
Part II Application



**B66**  
**(Standard Version)**

**[B]**

**IMPORTANT NOTICE**

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

**(Please give a copy of these notices to 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 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: [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)]

**PROPOSED INSURED INFORMATION**

1. Proposed Insured ( <i>First, Middle Initial, Last</i> )		2. Place of Birth	
3. Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please provide country, type of visa, expiration date and green card information): _____			
4. Date of Birth ( <i>mm/dd/yy</i> )	5. Social Security Number	6. <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Driver's License # & State
8. Occupation	9. Salary \$	10. Date of Hire ( <i>mm/dd/yy</i> )	
11. Home Address ( <i>No., Street, PO Box, City, State, ZIP</i> )			
12. I have been notified by my employer that the maximum amount of insurance coverage that will be issued is: \$ _____ I understand that this form, or a copy of this form, will be given to the Owner and included as part of the policy/contract.			

**GENERAL RISK INFORMATION For Proposed Insured**

*If you answer "No" to question 13, or "Yes" to questions 15-19, explain in the space provided on Page 2.*

13. Have you been actively at work daily on a full-time basis (30 hours/week) performing all duties of your regular occupation, at your customary place of employment for the past 3 months? (Disregard vacation days, normal non-working days and absences that total less than 4 consecutive days.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? ( <i>If "Yes", list below.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No
Type	Date First Used: ( <i>month/year</i> )	Date Last Used: ( <i>month/year</i> )	Amount and Frequency:
15a. 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? ( <i>If "Yes", an Aviation supplement is required; this includes balloon pilots.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No
b. 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? ( <i>If "Yes", an Avocation Questionnaire is required.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? ( <i>If "Yes", a Foreign Travel or Residence Questionnaire is required.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No
16. In 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 license suspended, revoked or restricted? ( <i>If "Yes", please provide what type and dates in the "Details" space provided.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Have you ever applied for any life, health or disability insurance which was denied, postponed, required an extra premium or was issued for a reduced amount? ( <i>If, "Yes", please provide what type and dates in the "Details" space provided.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Have you ever been convicted or are you waiting trial for a felony? ( <i>If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? ( <i>If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.</i> )			<input type="checkbox"/> Yes <input type="checkbox"/> No

**GENERAL RISK INFORMATION For Proposed Insured (Continued)**

20. **Details:** (If you answered "No" to question 13, or "Yes" to questions 15-19 list details in this section; please include question number details pertain to and attach an additional sheet of paper, if necessary.)

**MEDICAL RISK INFORMATION For Proposed Insured**

If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided on page 3.

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| <b>21. Have you ever had an 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 complication 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 or 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 medically or surgically treated condition not listed above?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. 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"/> |
| 23. Do you use alcoholic beverages? (If "Yes", Provide type, Frequency & Amount)  |                          |                          |
| Type _____ Frequency _____ Amount _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. 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"/> |
| 25. In the past 5 years have you ever used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. 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"/> |
| 27. 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"/> |
| 28. 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: (Attach an additional sheet of paper, if necessary.) |                          |                          |



**OTHER INSURANCE**

33. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefit 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 replacement forms.)

34. Amount of other Corporate Sponsored life insurance presently in force or applied for: **If none, check this box:**   
 Please indicate the Type of coverage: Business **(B)**; Key Person **(K)**

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	
	\$			<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	
	\$			<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	
	\$			<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	
	\$			<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	

Please attach a list of any other additional insurance on a separate sheet. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? \$ \_\_\_\_\_

**[BENEFICIARY DESIGNATION**

35. Individual (Provide Full Name, Social Security Number and Relationship)

Primary \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
 Address (Street, City, State, ZIP) \_\_\_\_\_

Primary \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
 Address (Street, City, State, ZIP) \_\_\_\_\_

36.

Contingent \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Contingent \_\_\_\_\_ % SSN: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

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

**AGREEMENT AND ACKNOWLEDGEMENT**

Each of the Undersigned declares that:

1. This Application consists of: a) this Executive Benefits Individual Owner Application - Part I and Part II; b) Part III Medical Application, if required; c) any amendments to the application attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. This Application for Life Insurance - Part I and Part II is fully completed.
2. I/We further agree that coverage will take effect under the Policy only when: 1) initial premium payment has been received; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured; and 3) the Proposed Insured remains 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.
3. If this is a request to exercise an option in an existing policy, the request will become effective in accordance with the terms of that option. If this is a request for change, any and all values may be used to pay for the change and to repay any loan indebtedness. The changed policy will be subject to any loan indebtedness not repaid. Any assignment in effect at the time of this request will apply to any new insurance issued.
4. No agent, broker or medical examiner has the authority to make changes or modify any Company contract or to waive any of the Company's requirements.
5. I HAVE READ, or have had read to me, the completed Application before signing. 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 or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
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 DISCLOSURE**

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.

**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 disclosure 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 \_\_\_\_\_  
(city) (state) (month) (year)

\_\_\_\_\_  
**Signature of Proposed Insured**

\_\_\_\_\_  
**Witness**