

**State:** Arkansas **Filing Company:** The Lincoln National Life Insurance Company  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** MG Application  
**Project Name/Number:** Application (Combo Life/LTC)/MGF10276

## Filing at a Glance

Company: The Lincoln National Life Insurance Company  
Product Name: MG Application  
State: Arkansas  
TOI: L08 Life - Other  
Sub-TOI: L08.000 Life - Other  
Filing Type: Form  
Date Submitted: 10/18/2012  
SERFF Tr Num: LCNC-128698187  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: MGF10276  
  
Implementation: On Approval  
Date Requested:  
Author(s): Sue Pape, Randi Johnson  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 10/23/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** MG Application  
**Project Name/Number:** Application (Combo Life/LTC)/MGF10276

**Filing Company:** The Lincoln National Life Insurance Company

## General Information

Project Name: Application (Combo Life/LTC)  
Project Number: MGF10276  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:

Status of Filing in Domicile: Pending  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Individual  
Individual Market Type:  
Filing Status Changed: 10/23/2012  
State Status Changed: 10/23/2012  
Created By: Randi Johnson  
Corresponding Filing Tracking Number:

Deemer Date:  
Submitted By: Sue Pape

### Filing Description:

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

Re: NEW SUBMISSION

MGF10276 Application for Life Insurance – Part I

We submit the above noted form for your review and approval. Application form MGF10276 is new and does not replace any other forms previously approved by your Department. 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, this form complies with all the applicable laws and regulations of your state.

Upon approval, the above noted application will be used in applying for our previously approved combination life/long-term care products and for any combination life/long-term care products and policy forms which may subsequently be approved for use in your state.

We reserve the right to have this application completed using a telephone application process and also to make these forms available electronically subject to compliance with the Uniform Electronic Transactions Act, and to the extent applicable, the Federal ESIGN Act.

We have bracketed several items within the form as variable information to allow for flexibility in the content of the form. These items include Service Office address, MIB, Inc. address and phone numbers, form page numbers, and rider/option selections. As we may develop new riders or benefit options in the future, we reserve the right to add or modify such information. It is our understanding that changes to the bracketed items for new issues will not require a new filing of this form. No change in the variable areas will be made which will be in conflict with the laws, rules and regulations of your state. We confirm that the brackets will not actually appear on the form at issue.

This form appears in final printed format as issued from a laser printer. Upon approval, we reserve the right to change the format of the form without altering the approved language, though it is possible page numbers may change.

Thank you for your attention to this filing. Please do not hesitate to contact me if you require any additional information that may assist with your review.

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## Company and Contact

### Filing Contact Information

Sue Pape, Director, Product Compliance Sue.Pape@lfg.com  
 350 Church Street 860-466-1492 [Phone]  
 MPM-10 860-466-1348 [FAX]  
 Hartford, CT 06103-1106

### Filing Company Information

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

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

Company	Amount	Date Processed	Transaction #
The Lincoln National Life Insurance Company	\$50.00	10/18/2012	64010888

State: Arkansas Filing Company: The Lincoln National Life Insurance Company  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/23/2012	10/23/2012

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	MoneyGuard Application for Life Insurance - Part I	Sue Pape	10/19/2012	10/19/2012

SERFF Tracking #:

LCNC-128698187

State Tracking #:

Company Tracking #:

MGF10276

State:

Arkansas

Filing Company:

The Lincoln National Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

MG Application

Project Name/Number:

Application (Combo Life/LTC)/MGF10276

## Disposition

Disposition Date: 10/23/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Form (revised)	MoneyGuard Application for Life Insurance - Part I		Yes
Form	MoneyGuard Application for Life Insurance - Part I	Replaced	Yes

SERFF Tracking #:

LCNC-128698187

State Tracking #:

Company Tracking #:

MGF10276

State:

Arkansas

Filing Company:

The Lincoln National Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

MG Application

Project Name/Number:

Application (Combo Life/LTC)/MGF10276

## Amendment Letter

Submitted Date: 10/19/2012

Comments:

Updated Form Attached

Good morning -

An updated copy of application form MGF10276 has been attached to the Form Schedule to correct a typo.

Thank you -

Sue

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
MGF10276	Application/Enrollment Form	MoneyGuard Application for Life Insurance - Part I	Initial				52.000	MGF10276.pdf

SERFF Tracking #:

LCNC-128698187

State Tracking #:

Company Tracking #:

MGF10276

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## Form Schedule

Lead Form Number: MGF10276

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		MGF10276	AEF	MoneyGuard Application for Life Insurance - Part I	Initial:	52.000	MGF10276.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

**(Please give a copy of this notice to the Proposed Insured.)**

## **IMPORTANT NOTICE**

Since you are applying for insurance, we would like you to know more about our underwriting process.

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## **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, cognitive assessment and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

## **CONSUMER REPORT**

As a part of our routine procedure for processing your initial application, we may request a 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, driving records, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews may be conducted with a business, banks, accountants, or other financial advisors as designated by the applicant. Public records are carefully reviewed.

Past experience shows that information from 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.

If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

## **CONTESTABILITY**

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

## **PHARMACY BENEFIT MANAGER (RX DATABASE SEARCH)**

As part of our routine procedure for determining eligibility for insurance, we may request information on the medications you are taking provided by a Pharmacy Benefit Manager. The report we will receive typically contains the name of the medication, the number of prescriptions filled and the time frame the medications were prescribed. If any adverse action is taken based on the information provided, we will notify you in writing and also provide you with the name, address and telephone number of the provider if you wish to obtain a copy of the pharmaceutical report.

## **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. Information for consumers about MIB may be obtained on [www.mib.com](http://www.mib.com).

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) ].

## MoneyGuard® Application For Life Insurance - Part I

(Please Print in Blue or Black Ink)

### Proposed Insured

- 1a. Name (First, Middle Initial, Last) \_\_\_\_\_ 1b.  Male  Female
- 1c. Residence Address (No., Street, P.O. Box): \_\_\_\_\_  
 (City, State, ZIP): \_\_\_\_\_
- 1d. US Citizen:  Yes  No If No, what country?: \_\_\_\_\_ Visa Type if non-US citizen: \_\_\_\_\_
- 1e. Date of Birth (mm/dd/yy): \_\_\_\_\_ 1f. SSN: \_\_\_\_\_

### Policy Information

- 2a. Plan of Insurance: \_\_\_\_\_ 2b. Specified Amount: \$ \_\_\_\_\_
- 2c. [Convalescent Care Benefits Rider Duration: \_\_\_\_\_ 2d. Extension of Benefits Rider Duration: \_\_\_\_\_
- 2e. Optional Inflation Protection: \_\_\_\_\_
- 2f. Other Benefits/Riders/Options]: \_\_\_\_\_

### Billing Information

- 3a. Premium Frequency: \_\_\_\_\_ 3b. Premium Amount: \$ \_\_\_\_\_
- 3c. Source of Premium (Inheritance, loan, business activity): \_\_\_\_\_

### Existing and Pending Insurance Information

- 4a. Are you considering stopping premium payments, surrendering, replacing, forfeiting, or assigning your existing life policies or annuities? (If Yes, please complete and sign all required life insurance and annuity replacement forms and complete Question 4c.)  Y  N
- 4b. Are you considering reducing your benefits or borrowing funds from your existing life policies or annuities to pay premiums due on the applied for policy? (If Yes, please complete and sign all required life insurance and annuity replacement forms and complete Question 4c.)  Y  N
- 4c. Please list in the space below all existing life insurance policies, annuity contracts currently in force with this or any other company. **If none, check this box**

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Check here if 1035 Exchange
	\$			<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

- 4d. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? (If Yes, please provide details in question 4h below.)  Y  N
- 4e. Will the policy applied for replace any medical, health or long-term care insurance contract currently in force with this or any other company? (If Yes, please provide details in question 4c above and complete and sign all required replacement forms.)  Y  N
- 4f. Has any long-term care insurance contract lapsed, been surrendered or otherwise terminated in the past 24 months? (If Yes, please provide details in question 4h below.)  Y  N
- 4g. Currently, or within the past 12 months have you had any long-term care policies or riders (including healthcare service or health maintenance organization contracts) in force or pending?  Y  N
- 4h. List details from Questions 4d and 4f above.

Company	Issue Date (mm/dd/yy)	Date of Lapse, Surrender or Termination (mm/dd/yy)	Long-Term Care Max Daily Benefit	Replacement or Change of Policy?	In Force	Applied For
				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>

- 4i. Do your long-term care policies or riders include Home Health Care coverage?  Y  N
- 4j. Are you currently covered by Medicaid?  Y  N
- 4k. Do you believe that you have a long term need for this coverage?  Y  N

### General Risk - Proposed Insured

5. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.
- Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Address: \_\_\_\_\_
- Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Address: \_\_\_\_\_
- Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Address: \_\_\_\_\_
- a. Date and reason of last visit: \_\_\_\_\_
- Tests performed & treatment received: \_\_\_\_\_
6. 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
- (If you answer Yes to any of the following questions, please give details and list medications in the Details section provided below.)*
- 7a. Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment or business for at least 30 hours per week?  Y  N
- 7b. Currently, or within the past 10 years, have you received or applied for any disability benefits, including Worker's Compensation, Social Security Disability Insurance or any other form of disability insurance?  Y  N
- 7c. Within the past 10 years, have you been told you have, been diagnosed with, and/or been treated by a physician, and/or taken medication for:
- 1) Syncope, vertigo, tremor, or falls?  Y  N
  - 2) Angina, congestive heart failure, coronary artery disease, peripheral vascular disease or atrial fibrillation?  Y  N
  - 3) Transient ischemic attack (TIA)?  Y  N
  - 4) Parkinson's disease, Multiple Sclerosis, ALS, Muscular Dystrophy, Huntington's or Systemic Lupus?  Y  N
  - 5) Osteopenia, Osteoporosis or Rheumatoid Arthritis?  Y  N
  - 6) Alzheimer's disease, dementia or memory loss?  Y  N
- 7d. Currently, or within the last 5 years have you had any impairment, whether mental or physical, for which you need or receive assistance or supervision in performing any daily living activities such as bathing, dressing, eating, transferring or ambulation, toileting, or bowel or bladder control?  Y  N
- 7e. Do you use a wheelchair, walker or cane, oxygen, catheter, dialysis machine or other mechanical device?  Y  N
- 7f. Within the past 5 years have you been recommended admission or been admitted to a nursing home or received home health care, or are you currently living in a hospital or nursing facility?  Y  N
- 7g. Are you currently living in an Assisted Living facility or Independent Community?  Y  N
- 7h. Within the past 12 months have you used tobacco or products containing nicotine including but not limited to cigarettes, electronic cigarettes, pipes, chewing tobacco, snuff, nicotine gum and/ or patches or smoked more than 24 cigars?  Y  N
- 7i. Within the past 12 months, have you had or been advised to have a check-up, EKG, x-ray, blood, or urine test or any other diagnostic test?  Y  N
- 7j. Within the past 5 years, have you been a patient in a hospital, clinic, or other medical facility, or been advised to have any hospitalization or surgery which has not been completed?  Y  N
- 7k. Within the past 10 years, have you had any indication of, or been treated for:
- 1) Chest pain, high blood pressure, heart disease, heart murmur or other disorders of the heart or blood vessels?  Y  N
  - 2) Ulcers, colitis, jaundice, or other diseases of the stomach, liver, intestines, gallbladder, pancreas, kidney or urinary bladder?  Y  N
  - 3) Seizures, fainting, dizziness, epilepsy, stroke or paralysis?  Y  N
  - 4) Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?  Y  N
  - 5) Any tumor, cancer, cysts, skin disorder or any disorder of the lymph nodes?  Y  N

- 6) Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones or joints?  Y  N
- 7) Diabetes, thyroid, or other endocrine or glandular disorder?  Y  N
- 8) Anemia or any other blood disorder?  Y  N
- 9) Asthma, emphysema, shortness of breath, allergies, sleep apnea or any other disorder of the respiratory system?  Y  N
- 10) Any disorder of the eyes, ears, nose or throat?  Y  N
- 11) Any disorder of the testicles, prostate, breasts, ovaries, uterus or cervix?  Y  N
- 7l. Have you ever been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome or an AIDS related condition?  Y  N
- 7m. Do you use alcoholic beverages? (If "Yes", provide Type, Frequency & Amount.)  Y  N

- 7n. Within the past 10 years, have you been treated for drug or alcohol abuse or been advised by your physician to limit your use of alcohol or any medication, prescribed or not?  Y  N
- 7o. Within the past 10 years, have you used illegal or narcotic drugs not prescribed by a physician?  Y  N
- 7p. Within the past 5 years have you been consulted, examined or treated by any physician or practitioner for reasons not stated in this application?  Y  N
- 7q. List all medication and dosage you are currently taking, or have taken the last 30 days, include prescriptions and aspirin.  Y  N

7r. Details to General Risk Questions: (If more room is needed, use a separate sheet of paper and please make sure it is signed and dated.)

Question #	Date	Details/Reasons

**Owner Information** (If left blank, Proposed Insured will be the Owner.)

8a. Primary Owner  
 Full Name/Trust Name/Trustee Name(s): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date of Birth/Date of Trust: \_\_\_\_\_ SSN/Trust TIN: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Relationship to Proposed Insured: \_\_\_\_\_

8b. Contingent Owner  
 Full Name/Trust Name/Trustee Name(s): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date of Birth/Date of Trust: \_\_\_\_\_ SSN/Trust TIN: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Relationship to Proposed Insured: \_\_\_\_\_

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

9a. Primary Beneficiary  
 Full Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Relationship to Proposed Insured: \_\_\_\_\_

9b. Contingent Beneficiary

Full Name/Trust Name/Trustee Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth/Date of Trust: \_\_\_\_\_ SSN/Trust TIN: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship to Proposed Insured: \_\_\_\_\_

**Protection Against Unintended Lapse**

I, the Applicant/Owner, understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I also understand that I will be given the opportunity to change this written designation at any time. My selection is as follows:

- I elect NOT to designate another person to receive notice of lapse or termination.
- I designate the person(s) listed below to receive copies of any notice of lapse or termination.

Third Party Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**Agreement and Acknowledgement**

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

The Undersigned declares that:

1. This Application consists of: a) Part I Application; b) any amendments to the application(s) attached thereto; and c) any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. I further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me; 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.

I have paid \$ \_\_\_\_\_ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I acknowledge that I fully understand and accept its terms.

3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true to the best of my knowledge and belief. **Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.**
5. For employer owned life insurance policies, the Owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.

**State Disclosures**

**AL, AR, GU, ID, IA, MP, MS, MT, NV, NM, ND, SC, SD, VI, and WY Only.** 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.

**Trust Verification**

I hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

## Authorization

Each of the undersigned declares that:

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 authorize any medical professional, hospital or other medical institution, Pharmacy Benefit Manager, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me or my physical or mental health, employment, finances, transactions or other information relevant to my insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I authorize the Company to disclose information related to my insurability to other insurers to whom I may apply for coverage.

I acknowledge receipt of the Privacy Notice and the Important Notice containing the Consumer Report and MIB, Inc. information. The authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I 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.

## Inflation Protection Coverage

I have reviewed the Outline of Coverage and the charts that compare the benefits and premiums of the [Convalescent Care Benefits Rider and Extension of Benefits Rider] with and without Optional Inflation Protection. I understand and agree that I will be issued a rider or riders with default Compound Increases at 5%, UNLESS I choose another option below:

- I hereby **REJECT** default Compound Increases at 5% and apply for Optional Inflation Protection as shown in the Policy Information section, question [2e], on page 1.
- I hereby **REJECT** all options for Optional Inflation Protection.

## Signatory Section

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

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

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

## To Be Completed By Agent Only (All questions are required to be answered.)

- (i) Does the applicant have any existing life insurance policies or annuities?  Y  N
- (ii) Do you know or have you any reason to believe that replacement of insurance is involved?  Y  N  
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.
- (iii) List all Long-Term Care or Health Insurance that: 1) You have sold to the Proposed Insured that is still in force. 2) You have sold to the Proposed Insured in the last 5 years that is no longer in force.

Company	Policy Number	Year of Issue	
			<input type="checkbox"/> In Force <input type="checkbox"/> No Longer In Force
			<input type="checkbox"/> In Force <input type="checkbox"/> No Longer In Force

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

I declare that I have provided the Proposed Insured with the Important Notice as well as a copy of the Privacy Practices Notice.

I declare that I have provided each Owner(s) with a copy of the Privacy Practices Notice.

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

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

SERFF Tracking #:

LCNC-128698187

State Tracking #:

Company Tracking #:

MGF10276

State:

Arkansas

Filing Company:

The Lincoln National Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

MG Application

Project Name/Number:

Application (Combo Life/LTC)/MGF10276

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Readability Certification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	This filing is for an application, which is attached to the Form Schedule.		

## READABILITY CERTIFICATION

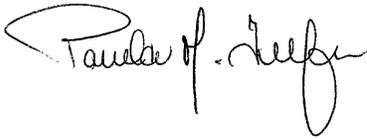
*The Lincoln National Life Insurance Company*

**Re: MGF10276 - Application for Life Insurance – Part I**

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

**Form Number:**  
MGF10276

**Flesch:**  
52



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Pamela Telfer, Vice President  
Product Compliance & State Filing

Date: 10/18/2012

**SERFF Tracking #:**

LCNC-128698187

**State Tracking #:****Company Tracking #:**

MGF10276

**State:**

Arkansas

**Filing Company:**

The Lincoln National Life Insurance Company

**TOI/Sub-TOI:**

L08 Life - Other/L08.000 Life - Other

**Product Name:**

MG Application

**Project Name/Number:**

Application (Combo Life/LTC)/MGF10276

## 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)
10/18/2012	Form	MoneyGuard Application for Life Insurance - Part I	10/19/2012	MGF10276.pdf (Superseded)

**(Please give a copy of this notice to the Proposed Insured.)**

## **IMPORTANT NOTICE**

Since you are applying for insurance, we would like you to know more about our underwriting process.

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## **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, cognitive assessment and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

## **CONSUMER REPORT**

As a part of our routine procedure for processing your initial application, we may request a 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, driving records, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews may be conducted with a business, banks, accountants, or other financial advisors as designated by the applicant. Public records are carefully reviewed.

Past experience shows that information from 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.

If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

## **CONTESTABILITY**

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

## **PHARMACY BENEFIT MANAGER (RX DATABASE SEARCH)**

As part of our routine procedure for determining eligibility for insurance, we may request information on the medications you are taking provided by a Pharmacy Benefit Manager. The report we will receive typically contains the name of the medication, the number of prescriptions filled and the time frame the medications were prescribed. If any adverse action is taken based on the information provided, we will notify you in writing and also provide you with the name, address and telephone number of the provider if you wish to obtain a copy of the pharmaceutical report.

## **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. Information for consumers about MIB may be obtained on [www.mib.com](http://www.mib.com).

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) ].

## MoneyGuard® Application For Life Insurance - Part I

(Please Print in Blue or Black Ink)

### Proposed Insured

- 1a. Name (First, Middle Initial, Last) \_\_\_\_\_ 1b.  Male  Female
- 1c. Residence Address (No., Street, P.O. Box): \_\_\_\_\_  
 (City, State, ZIP): \_\_\_\_\_
- 1d. US Citizen:  Yes  No If No, what country?: \_\_\_\_\_ Visa Type if non-US citizen: \_\_\_\_\_
- 1e. Date of Birth (mm/dd/yy): \_\_\_\_\_ 1f. SSN: \_\_\_\_\_

### Policy Information

- 2a. Plan of Insurance: \_\_\_\_\_ 2b. Specified Amount: \$ \_\_\_\_\_
- 2c. [Convalescent Care Benefits Rider Duration: \_\_\_\_\_ 2d. Extension of Benefits Rider Duration: \_\_\_\_\_
- 2e. Optional Inflation Protection: \_\_\_\_\_
- 2f. Other Benefits/Riders/Options]: \_\_\_\_\_

### Billing Information

- 3a. Premium Frequency: \_\_\_\_\_ 3b. Premium Amount: \$ \_\_\_\_\_
- 3c. Source of Premium (Inheritance, loan, business activity): \_\_\_\_\_

### Existing and Pending Insurance Information

- 4a. Are you considering stopping premium payments, surrendering, replacing, forfeiting, or assigning your existing life policies or annuities? (If Yes, please complete and sign all required life insurance and annuity replacement forms and complete Question 4c.)  Y  N
- 4b. Are you considering reducing your benefits or borrowing funds from your existing life policies or annuities to pay premiums due on the applied for policy? (If Yes, please complete and sign all required life insurance and annuity replacement forms and complete Question 4c.)  Y  N
- 4c. Please list in the space below all existing life insurance policies, annuity contracts currently in force with this or any other company. **If none, check this box**

Company	Face Amount	Policy Number	Issue Date (mm/dd/yy)	Check here if 1035 Exchange
	\$			<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

- 4d. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? (If Yes, please provide details in question 4h below.)  Y  N
- 4e. Will the policy applied for replace any medical, health or long-term care insurance contract currently in force with this or any other company? (If Yes, please provide details in question 4c above and complete and sign all required replacement forms.)  Y  N
- 4f. Has any long-term care insurance contract lapsed, been surrendered or otherwise terminated in the past 24 months? (If Yes, please provide details in question 4h below.)  Y  N
- 4g. Currently, or within the past 12 months have you had any long-term care policies or riders (including healthcare service or health maintenance organization contracts) in force or pending?  Y  N
- 4h. List details from Questions 4d and 4f above.

Company	Issue Date (mm/dd/yy)	Date of Lapse, Surrender or Termination (mm/dd/yy)	Long-Term Care Max Daily Benefit	Replacement or Change of Policy?	In Force	Applied For
				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>

- 4i. Do your long-term care policies or riders include Home Health Care coverage?  Y  N
- 4j. Are you currently covered by Medicaid?  Y  N
- 4k. Do you believe that you have a long term need for this coverage?  Y  N

### General Risk - Proposed Insured

5. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.
- Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Address: \_\_\_\_\_
- Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Address: \_\_\_\_\_
- Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Address: \_\_\_\_\_
- a. Date and reason of last visit: \_\_\_\_\_
- Tests performed & treatment received: \_\_\_\_\_
6. 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
- (If you answer Yes to any of the following questions, please give details and list medications in the Details section provided below.)*
- 7a. Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment or business for at least 30 hours per week?  Y  N
- 7b. Currently, or within the past 10 years, have you received or applied for any disability benefits, including Worker's Compensation, Social Security Disability Insurance or any other form of disability insurance?  Y  N
- 7c. Within the past 10 years, have you been told you have, been diagnosed with, and/or been treated by a physician, and/or taken medication for:
- 1) Syncope, vertigo, tremor, or falls?  Y  N
  - 2) Angina, congestive heart failure, coronary artery disease, peripheral vascular disease or atrial fibrillation?  Y  N
  - 3) Transient ischemic attack (TIA)?  Y  N
  - 4) Parkinson's disease, Multiple Sclerosis, ALS, Muscular Dystrophy, Huntington's or Systemic Lupus?  Y  N
  - 5) Osteopenia, Osteoporosis or Rheumatoid Arthritis?  Y  N
  - 6) Alzheimer's disease, dementia or memory loss?  Y  N
- 7d. Currently, or within the last 5 years have you had any impairment, whether mental or physical, for which you need or receive assistance or supervision in performing any daily living activities such as bathing, dressing, eating, transferring or ambulation, toileting, or bowel or bladder control?  Y  N
- 7e. Do you use a wheelchair, walker or cane, oxygen, catheter, dialysis machine or other mechanical device?  Y  N
- 7f. Within the past 5 years have you been recommended admission or been admitted to a nursing home or received home health care, or are you currently living in a hospital or nursing facility?  Y  N
- 7g. Are you currently living in an Assisted Living facility or Independent Community?  Y  N
- 7h. Within the past 12 months have you used tobacco or products containing nicotine including but not limited to cigarettes, electronic cigarettes, pipes, chewing tobacco, snuff, nicotine gum and/ or patches or smoked more than 24 cigars?  Y  N
- 7i. Within the past 12 months, have you had or been advised to have a check-up, EKG, x-ray, blood, or urine test or any other diagnostic test?  Y  N
- 7j. Within the past 5 years, have you been a patient in a hospital, clinic, or other medical facility, or been advised to have any hospitalization or surgery which has not been completed?  Y  N
- 7k. Within the past 10 years, have you had any indication of, or been treated for:
- 1) Chest pain, high blood pressure, heart disease, heart murmur or other disorders of the heart or blood vessels?  Y  N
  - 2) Ulcers, colitis, jaundice, or other diseases of the stomach, liver, intestines, gallbladder, pancreas, kidney or urinary bladder?  Y  N
  - 3) Seizures, fainting, dizziness, epilepsy, stroke or paralysis?  Y  N
  - 4) Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?  Y  N
  - 5) Any tumor, cancer, cysts, skin disorder or any disorder of the lymph nodes?  Y  N

- 6) Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones or joints?  Y  N
- 7) Diabetes, thyroid, or other endocrine or glandular disorder?  Y  N
- 8) Anemia or any other blood disorder?  Y  N
- 9) Asthma, emphysema, shortness of breath, allergies, sleep apnea or any other disorder of the respiratory system?  Y  N
- 10) Any disorder of the eyes, ears, nose or throat?  Y  N
- 11) Any disorder of the testicles, prostate, breasts, ovaries, uterus or cervix?  Y  N
- 7l. Have you ever been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome or an AIDS related condition?  Y  N
- 7m. Do you use alcoholic beverages? (If "Yes", provide Type, Frequency & Amount.)  Y  N

- 7n. Within the past 10 years, have you been treated for drug or alcohol abuse or been advised by your physician to limit your use of alcohol or any medication, prescribed or not?  Y  N
- 7o. Within the past 10 years, have you used illegal or narcotic drugs not prescribed by a physician?  Y  N
- 7p. Within the past 5 years have you been consulted, examined or treated by any physician or practitioner for reasons not stated in this application?  Y  N
- 7q. List all medication and dosage you are currently taking, or have taken the last 30 days, include prescriptions and aspirin.  Y  N

7r. Details to General Risk Questions: (If more room is needed, use a separate sheet of paper and please make sure it is signed and dated.)

Question #	Date	Details/Reasons

**Owner Information** (If left blank, Proposed Insured will be the Owner.)

8a. Primary Owner  
 Full Name/Trust Name/Trustee Name(s): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date of Birth/Date of Trust: \_\_\_\_\_ SSN/Trust TIN: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Relationship to Proposed Insured: \_\_\_\_\_

8b. Contingent Owner  
 Full Name/Trust Name/Trustee Name(s): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date of Birth/Date of Trust: \_\_\_\_\_ SSN/Trust TIN: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Relationship to Proposed Insured: \_\_\_\_\_

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

9a. Primary Beneficiary  
 Full Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Relationship to Proposed Insured: \_\_\_\_\_

9b. Contingent Beneficiary

Full Name/Trust Name/Trustee Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth/Date of Trust: \_\_\_\_\_ SSN/Trust TIN: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship to Proposed Insured: \_\_\_\_\_

**Protection Against Unintended Lapse**

I, the Applicant/Owner, understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I also understand that I will be given the opportunity to change this written designation at any time. My selection is as follows:

- I elect NOT to designate another person to receive notice of lapse or termination.
- I designate the person(s) listed below to receive copies of any notice of lapse or termination.

Third Party Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**Agreement and Acknowledgement**

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

The Undersigned declares that:

- This Application consists of: a) Part I Application; b) any amendments to the application(s) attached thereto; and c) any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
- I further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me; 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.

I have paid \$ \_\_\_\_\_ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I acknowledge that I fully understand and accept its terms.

- No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
- I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true to the best of my knowledge and belief. **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.**
- 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.

**State Disclosures**

**AL, AR, GU, ID, IA, MP, MS, MT, NV, NM, ND, SC, SD, VI, and WY Only.** 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.

**Trust Verification**

I hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

## Authorization

Each of the undersigned declares that:

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 authorize any medical professional, hospital or other medical institution, Pharmacy Benefit Manager, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me or my physical or mental health, employment, finances, transactions or other information relevant to my insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I authorize the Company to disclose information related to my insurability to other insurers to whom I may apply for coverage.

I acknowledge receipt of the Privacy Notice and the Important Notice containing the Consumer Report and MIB, Inc. information. The authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I 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.

## Inflation Protection Coverage

I have reviewed the Outline of Coverage and the charts that compare the benefits and premiums of the Convalescent Care Benefits Rider and Extension of Benefits Rider with and without Optional Inflation Protection. I understand and agree that I will be issued a rider or riders with default Compound Increases at 5%, UNLESS I choose another option below:

- I hereby **REJECT** default Compound Increases at 5% and apply for Optional Inflation Protection as shown in the Policy Information section, question [2e], on page 1.
- I hereby **REJECT** all options for Optional Inflation Protection.

## Signatory Section

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

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

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

## To Be Completed By Agent Only (All questions are required to be answered.)

- (i) Does the applicant have any existing life insurance policies or annuities?  Y  N
- (ii) Do you know or have you any reason to believe that replacement of insurance is involved?  Y  N  
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.
- (iii) List all Long-Term Care or Health Insurance that: 1) You have sold to the Proposed Insured that is still in force. 2) You have sold to the Proposed Insured in the last 5 years that is no longer in force.

Company	Policy Number	Year of Issue	
			<input type="checkbox"/> In Force <input type="checkbox"/> No Longer In Force
			<input type="checkbox"/> In Force <input type="checkbox"/> No Longer In Force

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

I declare that I have provided the Proposed Insured with the Important Notice as well as a copy of the Privacy Practices Notice.

I declare that I have provided each Owner(s) with a copy of the Privacy Practices Notice.

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

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