

SERFF Tracking Number: LCNC-128289799 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number:
Company Tracking Number: LR630
TOI: L06I Individual Life - Variable Sub-TOI: L06I.002 Single Life - Flexible Premium
Product Name: LR630 Accelerated Benefits Rider for Chronic Illness
Project Name/Number: LR630 Accelerated Benefits Rider for Chronic Illness/LR630

Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: LR630 Accelerated Benefits SERFF Tr Num: LCNC-128289799 State: Arkansas

Rider for Chronic Illness

TOI: L06I Individual Life - Variable

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

Sub-TOI: L06I.002 Single Life - Flexible
Premium

Co Tr Num: LR630

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Raymond Fortier, James
Kane, Randi Johnson

Disposition Date: 06/27/2012

Date Submitted: 06/22/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: LR630 Accelerated Benefits Rider for Chronic Illness

Status of Filing in Domicile: Pending

Project Number: LR630

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: 06/27/2012

State Status Changed: 06/27/2012

Deemer Date:

Created By: Randi Johnson

Submitted By: James Kane

Corresponding Filing Tracking Number:

Filing Description:

Hon. Jay Bradford

Commissioner of Insurance

Compliance-Life & Health

Attn: Joe Musgrove

1200 West Third Street

Little Rock, AR 72201-1904

SERFF Tracking Number: LCNC-128289799 State: Arkansas
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Re. Individual Life Insurance Policy Form and Application
LR630 Accelerated Benefits Rider for Chronic Illness
LFF10249 Accelerated Benefits Rider for Chronic Illness Application Supplement
The Lincoln National Life Insurance Company
Group & NAIC #: 020-65676

Dear Mr. Musgrove:

We are submitting the required number of copies of the above referenced policy forms for your review and approval. These are new forms and will not replace any previously approved forms.

The Accelerated Benefits Rider for Chronic Illness is not intended to provide health, nursing home or long term care insurance. The rider is not intended to be a qualified long term care insurance contract under 7702B(b) of the Internal Revenue Code. The rider has been written to conform to the requirements of the Accelerated Death Benefit Regulations of your state, or, if your state has no such regulation, the NAIC Accelerated Benefits Model Regulation. The benefits paid under this rider are intended to be treated as accelerated death benefits under section 101(g)(1) of the Code.

The Accelerated Benefits Rider for Chronic Illness will be marketed through properly licensed agents in the general insurance market. This rider will be available for issue ages 20 to 80 and will be available for sex distinct and unisex issues. This rider provides for the advance payment of a portion of the death benefit, upon occurrence of a Qualifying Event provided all of the terms and conditions of this rider have been met. There are two Qualifying Events, as defined in the rider: (1) the Insured is certified as Chronically Ill; or (2) the Insured is certified as Terminally Ill. Chronic Illness benefits are available in either monthly payments or a one-time lump sum payment. If the Chronic Illness one-time lump sum is paid, the benefit will be reduced by an actuarial discount, and both the policy and this rider will terminate as noted in the rider's "Termination" provision. The Terminal Illness benefit is available in a lump sum that will be also be reduced by an actuarial discount however; the policy and rider will not terminate. There is no waiting period to receive a benefit under this rider and we do not require proof of incurred expenses for you to receive benefits under this rider. There are no restrictions on the use of the benefit payments.

A monthly cost of insurance charge for the rider will be deducted as part of the policy's monthly deduction. There is no administrative fee. Upon accelerated benefits being paid, the policy will not lapse as long as the rider is in force. For each policy month the policyowner receives a rider benefit payment, we will send the policyowner a monthly report showing the change in current values under the policy.

This rider is only available at issue. Upon approval, the rider may be used with previously approved individual flexible premium variable life insurance policies and any individual flexible premium variable life insurance policies, which may be approved in the future.

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Accelerated Benefits Rider for Chronic Illness Application Supplement

Upon approval, the supplement will be used in applying for the above-noted Accelerated Benefits Rider for Chronic Illness and other Accelerated Benefits Riders which may be approved in the future. The supplement will become a part of the life insurance policy. The supplement will be used in conjunction with previously approved application LFF06321, which was approved on 06/16/2008 under file # JEPL-125673253. Upon approval, the supplement may be used with previously approved individual life insurance policies, both variable and fixed, and any individual life insurance policies, which may be approved in the future.

We reserve the right to have this supplement completed using a telephone application process and also to make this form available electronically subject to compliance with the Uniform Electronic Transactions Act, and to the extent applicable, the Federal ESIGN Act. Please note; if used in a telephone application process or electronic capacity, there will be no additional reflexive or scripted questions.

A copy of the Accelerated Benefits Rider for Chronic Illness Disclosure has been included as informational. At the time of application, the applicant will be provided with the Accelerated Benefits Rider for Chronic Illness Disclosure (form LFF10251) and the applicant and agent will both sign the disclosure. This disclosure is submitted for informational purposes only.

We have bracketed certain items in the forms as variable information because they may change for new issues in the future (but not in-force policies). These items include: officer names/signatures and the service office address, all factors, rates and charges. It is our understanding that changes to the bracketed items for new issues will not require a new filing of these forms. We confirm that the brackets will not actually appear on the forms at issue.

These forms appear in final printed format as issued from a laser printer. We do, however, use different computer publishing systems. It is therefore possible that actual issued forms may have a different font style than the submitted forms. As a result, page breaks may occur at different lines, line wording may not match up exactly, and the format may change.

This filing is being submitted concurrently to our Home State of Indiana and is pending approval. The rider and supplement achieve the following Flesch scores: Rider 57.00 and Supplement 51.00. The appropriate certification(s), transmittal and filing fee are included, as applicable. To the best of our knowledge and belief, the filing complies with all the laws and regulations of your state.

We trust that the information provided is satisfactory and look forward to your response. Should you require any additional information, please feel free to contact me toll-free at 1-800-258-3648, ext. 5426, or via the fax number or email address shown below.

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Sincerely,

James P. Kane
Senior Analyst, State Filing
E-mail: James.Kane@lfg.com
Fax: (603) 226-5128
State Narrative:

Company and Contact

Filing Contact Information

James Kane, Analyst, Product Compliance james.kane@lfg.com
One Granite Place 603-226-5426 [Phone]
Concord, NH 03301

Filing Company Information

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

Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? No
Fee Explanation: Two forms at \$50.00 per form.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Lincoln National Life Insurance Company	\$100.00	06/22/2012	60366199

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/27/2012	06/27/2012

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Disposition

Disposition Date: 06/27/2012

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	Yes
Supporting Document	Application	Yes	Yes
Supporting Document	Life & Annuity - Actuarial Memo	No	No
Supporting Document	Compliance Certification	Yes	Yes
Supporting Document	LFF10251 ABR Application Disclosure	Yes	Yes
Form	Accelerated Benefits Rider for Chronic Illness	Yes	Yes
Form	Accelerated Benefits Rider for Chronic Illness Supplement	Yes	Yes

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Form Schedule

Lead Form Number: LR630

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LR630	Policy/Cont	Accelerated Benefits ract/Fratern al Illness Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		57.000	LR630 ABR for Chronic Illness GENERIC.pdf
	LFF10249	Application/ Enrollment Form	Accelerated Benefits Rider for Chronic Illness Supplement	Initial		51.000	LFF10249 ABR Supplement GENERIC Bracketed.pdf

The Lincoln National Life Insurance Company

Accelerated Benefits Rider for Chronic Illness (*Lincoln LifeEnhance*SM Accelerated Benefits Rider)

THE BENEFITS PAID UNDER THIS RIDER ARE INTENDED TO BE TREATED AS ACCELERATED DEATH BENEFITS UNDER SECTION 101(g)(1) OF THE INTERNAL REVENUE CODE OF 1986, AS AMENDED (THE "CODE"). THE COMPANY CONSIDERS THE BENEFITS PAID UNDER THIS RIDER THAT DO NOT EXCEED THE MAXIMUM PER DIEM LIMIT AS PRESCRIBED BY LAW TO BE ELIGIBLE FOR EXCLUSION FROM INCOME UNDER SECTION 101(a) OF THE CODE TO THE EXTENT THAT ALL APPLICABLE QUALIFICATION REQUIREMENTS UNDER THE CODE ARE MET. IF BENEFITS ARE PAID IN EXCESS OF THE APPLICABLE PER DIEM LIMIT, OR IF BENEFITS ARE PAID AND ALL APPLICABLE QUALIFICATION REQUIREMENTS ARE NOT MET, THE BENEFITS MAY CONSTITUTE TAXABLE INCOME TO THE RECIPIENT. THIS RIDER IS NOT INTENDED TO BE A QUALIFIED LONG-TERM CARE INSURANCE CONTRACT UNDER SECTION 7702B(b) OF THE CODE. THE TAX TREATMENT OF THE ACCELERATED DEATH BENEFITS MAY CHANGE, AND YOU SHOULD ALWAYS CONSULT AND RELY ON THE ADVICE OF A QUALIFIED TAX ADVISOR.

This rider is attached to and made a part of the Policy to which it is attached (the "Policy"). The effective date of this rider is the Policy Date. In this rider, "we", "our" or "us" means The Lincoln National Life Insurance Company; "you" and "your" means the Owner of the Policy; and "Insured" means the person named in the Policy Specifications whose life is insured under the Policy.

This rider uses terms found in the Policy. Those terms have the same meaning as in the Policy unless we have indicated a change. The rider also contains terms that are not used in the Policy. Such terms may be defined within the sentences where they appear or they may be found in the "Definitions" section of this rider.

The Specified Amount, Accumulation Value, Net Accumulation Value and Surrender Value, if any, will be reduced if you receive accelerated death benefits under this rider as explained in the "Impact of Rider Benefits on Policy and Other Riders" provision.

The payment of a Chronic Illness one-time lump sum will cause termination of both this rider and the Policy in accordance with this rider's "Termination" provision.

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Definitions

Activities of Daily Living (“ADLs”) The 6 basic functional abilities which measure the Insured’s ability for self care and ability to live independently without Substantial Assistance from another individual. They are:

1. Bathing – The Insured’s ability to wash himself or herself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
2. Continence – The Insured’s ability to maintain control of bowel or bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
3. Dressing – The Insured’s ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
4. Eating – The Insured’s ability to feed himself or herself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
5. Toileting – The Insured’s ability to get to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. Transferring – The Insured’s ability to move into or out of a bed, chair or wheelchair.

Benefit Period A period of time not to exceed twelve consecutive months. Such period begins on the Monthly Anniversary Day after our receipt of all documentation provided by you necessary to satisfy all Conditions for Eligibility for Benefit Payments. A new Benefit Period will begin no earlier than the end of the current Benefit Period.

Chronically Ill (Chronic Illness) The Insured has been certified, within the preceding 12 months, by a Licensed Health Care Practitioner as:

1. Being unable to perform (without Substantial Assistance from another individual) at least 2 Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
2. Requiring Substantial Supervision from another individual to protect the Insured from threats to health and safety due to Severe Cognitive Impairment; AND
3. Needing Services pursuant to a Licensed Health Care Practitioner’s Plan of Care as set forth in Written Certification or Written Re-certification, specifying such Services are likely to be needed for the rest of the Insured’s life.

If the Licensed Health Care Practitioner certifies that the Insured will need Services for the rest of the Insured’s life, the 90 day requirement noted in 1. above is satisfied by the expectation that the Insured will be unable to perform at least 2 Activities of Daily Living prospectively.

Cost Basis The aggregate amount of premiums or other consideration you have paid for the Policy, less the aggregate amount you have received under the contract that was not included in your taxable income, and less reductions in values due to benefit payments under this rider as described in the “Impact of Rider Benefits on Policy and Other Riders” provision.

Gross Death Benefit Proceeds Death Benefit Proceeds (as defined in the Policy) not reduced by any Indebtedness as defined in the Policy.

Licensed Health Care Practitioner A physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of Treasury, or qualifications to our satisfaction. The Licensed Health Care Practitioner (a) must be acting within the scope of his or her license in the state of licensure when providing Written Certification or Written Re-certification required by this rider; and (b) may not be you, the Insured, or your or the Insured's immediate family.

Maximum Monthly Benefit The maximum amount you are eligible to elect on a monthly basis.

Maximum Statutory Adjustable Policy Loan Interest Rate This maximum rate is determined as follows:

The rate will not be more than the higher of the following:

1. The published monthly average (defined below) for the calendar month ending 2 months before the date on which the rate is determined; or
2. The rate used to compute the Fixed Account under the Policy plus 1 percent.

The published monthly average referred to above is defined as:

1. Moody's Corporate Bond Yield Average - Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto; or
2. In the event that Moody's Corporate Bond Yield Average - Monthly Average Corporates is no longer published, a substantially similar average, established by regulation, or other method, issued by the Insurance Department of the state or other jurisdiction where the Policy is delivered.

Monthly Benefit Amount If elected, the amount payable to you as a Chronic Illness benefit on a monthly basis, subject to the Maximum Monthly Benefit.

Plan of Care A written document signed by a Licensed Health Care Practitioner which outlines the individualized medical treatment and non-medical assistance and Services which are prescribed because the Insured suffers from loss of functional capacity or from a Severe Cognitive Impairment. The plan must specify where the care is to be provided; the type, frequency, and duration of all medication, therapy, and Services required. It must also describe the likelihood of improvement or deterioration of the Insured's condition within the next 12 months from the date the Plan of Care was prepared and must also describe the supporting evidence upon which the Licensed Health Care Practitioner has based his or her conclusions and prognosis. Such supporting evidence may include either documents or information relevant to the assessment of loss of functional capacity or to the assessment of Severe Cognitive Impairment, or both.

Per Diem Limit The maximum daily benefit used in determining the Chronic Illness Maximum Monthly Benefit. The Internal Revenue Service establishes this limit annually on January 1st. We will use the limit in effect at the beginning of each Benefit Period for the entire Benefit Period.

Remaining Benefit Amount The Original Benefit Amount less the amount of all Chronic Illness Monthly Benefit Amounts paid and, if applicable, less the Terminal Illness benefit paid divided by the applicable Terminal Illness actuarial discount factor.

Services The necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services needed by a Chronically Ill Insured.

Severe Cognitive Impairment Deterioration or loss in the Insured's intellectual capacity that is:

- a. comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
- b. measured and confirmed by clinical evidence and standardized tests that reliably measure impairment in the following areas:
 1. the Insured's short-term or long-term memory;
 2. the Insured's orientation as to person (such as who they are), place (such as their location), and time (such as day, month, and year); and
 3. the Insured's deductive or abstract reasoning, including judgment as it relates to safety awareness.

Substantial Assistance Hands-on assistance or the presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to the Insured while the Insured is performing the Activities of Daily Living.

Substantial Supervision Continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Insured from threats to his or her health or safety (such as may result from wandering) due to Severe Cognitive Impairment.

Terminally Ill (Terminal Illness) The Insured's life expectancy is reduced to 12 months or less.

Terminally Ill (Terminal Illness) Certification Before any benefit can be paid for Terminal Illness, you must furnish evidence satisfactory to us. Such evidence must include a certification of the Insured's medical condition from a Licensed Health Care Practitioner. The certification must state that in the Licensed Health Care Practitioner's opinion the Insured's life expectancy has been reduced to 12 months or less.

Written Certification Written documentation required in a form satisfactory to us completed by a Licensed Health Care Practitioner, at your or the Insured's expense, certifying that the Insured is Chronically Ill as defined herein, including a Plan of Care, and specifying that Services are likely to be needed for the rest of the Insured's Life.

Written Re-certification Written Certification that we must receive and approve prior to the start of each Benefit Period following the initial Benefit Period in order for you to be eligible for Chronic Illness Monthly Benefit Amounts in such subsequent Benefit Period, provided all other Conditions for Eligibility for Benefit Payments are met.

What This Rider Provides

This rider provides for the acceleration of up to 100% of the Original Benefit Amount, as determined below, upon occurrence of a Qualifying Event provided all of the terms and conditions of this rider have been met. There are two Qualifying Events, defined below: (1) the Insured is certified as Chronically Ill; or (2) the Insured is certified as Terminally Ill.

Depending on which Qualifying Event occurs and the benefit payment option you have chosen, the Original Benefit Amount will be determined as follows, assuming all the Conditions for Eligibility for Benefit Payments have been satisfied:

- A. For Chronic Illness where you have elected In Writing to receive benefits in a one-time lump sum as determined on the date all Conditions for Eligibility for Benefit Payments have been satisfied:
 1. the Policy's Gross Death Benefit Proceeds, see "Definitions"; or

2. If a Premium Reserve Rider is attached to the Policy, the Policy's Gross Death Benefit Proceeds less the Premium Reserve Rider Accumulation Value. The Premium Reserve Rider Surrender Value will be paid to you prior to the calculation of the Original Benefit Amount. Refer to the "Impact on Other Riders on the Policy" provision for details.
- B. For Chronic Illness where you have elected In Writing to receive Monthly Benefit Amounts and for Terminal Illness as determined on the Monthly Anniversary Day after our receipt of all documentation provided by you necessary to satisfy all Conditions for Eligibility for Benefit Payments:
1. the Gross Death Benefit Proceeds after change to Death Benefit Option I (as described in the "Impact of Rider Benefits on Policy and Other Riders" provision); or
 2. If a Premium Reserve Rider is attached to the Policy, you can elect to have the Premium Reserve Rider Surrender Value paid to you prior to the calculation of the Original Benefit Amount. Refer to the "Impact on Other Riders on the Policy" provision for details.

There is no waiting period to receive a benefit under this rider once all Conditions for Eligibility for Benefit Payments have been satisfied and benefits will be paid retroactively to the date of our receipt of all documentation provided by you that is necessary to satisfy all Conditions for Eligibility for Benefit Payments. Furthermore, we do not require proof of incurred expenses for you to receive benefits under this rider. This rider's benefits will only be paid to the Owner of the Policy and will only be paid by check or other method made available by us. Any benefit paid during the Policy's Contestable Period is subject to the "Incontestability" provision of the Policy.

Your Benefit Payment Options

(1) For a Chronic Illness Qualifying Event

You may elect In Writing to receive the benefit as either (a) Monthly Benefit Amounts or (b) a one-time lump sum payment.

- (a) **Monthly Benefit Amounts** - Provided all Conditions for Eligibility for Benefit Payments have been satisfied, you may elect to receive accelerated monthly benefit payments (the "Monthly Benefit Amount") without losing the option of electing a one-time lump sum payment of the Remaining Benefit Amount.

For each Benefit Period in which you qualify to receive benefits, you may elect In Writing a Monthly Benefit Amount equal to or greater than the Minimum Monthly Benefit but not exceeding the Maximum Monthly Benefit. Both the Minimum Monthly Benefit and the Maximum Monthly Benefit are shown on the Policy Specifications. Please note that the Monthly Benefit Amount is not cumulative. The entire Maximum Monthly Benefit may be taken, but if not, the remaining portion cannot be added to future payments. By electing a Monthly Benefit Amount less than the Maximum Monthly Benefit, the amount of the Original Benefit Amount available for later benefit payments (the "Remaining Benefit Amount") will be reduced more slowly; however, you should consider that you may or may not re-qualify for future Written Re-certifications.

The largest amount that may be elected is the Maximum Monthly Benefit. As shown on the Policy Specifications, the Maximum Monthly Benefit may not exceed the lesser of the percentage of the Original Benefit Amount or the monthly equivalent of the Per Diem Limit (see "Definitions" above). At the time of claim and for each subsequent Benefit Period, defined above, we will notify you of your Maximum Monthly Benefit.

Sixty (60) days prior to the end of each Benefit Period, we will send you documentation for Written Re-certification. As part of this documentation, if your Maximum Monthly Benefit is based on the Per Diem Limit and the Per Diem Limit increases, we will provide you with an adjusted Maximum Monthly Benefit. If your Maximum Monthly Benefit is based on the Per Diem Limit, the Maximum Monthly Benefit in this documentation will be based on a 30 day Policy Month. If you elect the Maximum Monthly Benefit, the actual amount you receive will be adjusted based on the number of days in each Policy Month. To minimize a possible delay or interruption in your Chronic Illness Monthly Benefit Amount payments, provide your Written Re-certification within the requested timeframe.

- (b) **One-Time Lump Sum** - If you elect a one-time lump sum payment, the Remaining Benefit Amount will be multiplied by the applicable Chronic Illness one-time lump sum actuarial discount factor when determining the amount of the payment (as described in the "Actuarial Discount Factors" provision). **The payment of a one-time lump sum will cause termination of both this rider and the Policy in accordance with this rider's "Termination" provision.**

(2) For a Terminal Illness Qualifying Event

The maximum Terminal Illness benefit payment will be the lesser of: 1) 50% of the Remaining Benefit Amount; or 2) \$250,000. **Note: This benefit will only be paid once and will be paid as a lump sum. If you elect In Writing less than the maximum benefit, the remainder will not be available at a later date.** The amount accelerated will be greater than the Terminal Illness benefit payment and will be determined by dividing the requested benefit payment by the applicable Terminal Illness actuarial discount factor (as described in the "Actuarial Discount Factors" provision). The amount accelerated will not be allowed to exceed the Remaining Benefit Amount.

Subject to meeting all Conditions for Eligibility for Benefit Payments, you may elect to receive accelerated benefits under multiple Qualifying Events and multiple benefit payment options as follows:

- (a) Chronic Illness in Monthly Benefit Amounts and then at a later date elect the Chronic Illness one-time lump sum payment; or
- (b) Chronic Illness Monthly Benefit Amounts and then at a later date elect to receive the Terminal Illness benefit. In the same Policy Month, you may receive both a Chronic Illness Monthly Benefit Amount and the Terminal Illness benefit; or
- (c) Chronic Illness Monthly Benefit Amounts, then at a later date elect to receive the Terminal Illness benefit and finally receive the Chronic Illness one-time lump sum payment; or
- (d) Terminal Illness benefit and then at a later date elect to receive a Chronic Illness benefit in either Monthly Benefit Amounts or the one-time lump sum payment, or both.

Actuarial Discount Factors

A Chronic Illness one-time lump sum actuarial discount factor will be applied to the Chronic Illness one-time lump sum and a Terminal Illness actuarial discount factor will be applied to the Terminal Illness amount accelerated. This actuarial discount factor reflects the early payment of benefits available under the Policy. The actuarial discount factor used will be based on a mortality assumption and an interest rate which has been declared by us in effect on the date the benefit payment is determined. The maximum interest rate used shall not exceed the greater of:

- a) the current yield on 90 day treasury bills available on the date the benefit payment is determined; or
- b) the current Maximum Statutory Adjustable Policy Loan Interest Rate in effect on the date the benefit payment is determined.

When Benefit Payments Begin and End

Any benefit payable under an option chosen by you will be paid to you no later than the first Monthly Anniversary Day following the date we approve all documentation necessary to satisfy all Conditions for Eligibility for Benefit Payments. Provided all of the Conditions for Eligibility for Benefit Payments are met and during any Benefit Period, any subsequent Chronic Illness Monthly Benefit Amounts will be payable on each Monthly Anniversary Day following the date of the first Monthly Benefit Amount payment. We will pay a proportionate amount of the Monthly Benefit Amount for the number of days between the date of our receipt of all documentation necessary to satisfy all Conditions for Eligibility for Benefit Payments and the start of the Benefit Period.

Chronic Illness Monthly Benefit Amounts will end when any of the following occur:

- (1) the Insured fails to meet any one of the Conditions for Eligibility for Benefit Payments;
- (2) you notify us to discontinue Monthly Benefit Amount payments; or
- (3) this rider terminates.

In the event you request that we discontinue Monthly Benefit Amount payments and then, at a later date, you desire to begin a new Benefit Period, we will allow you to do so provided all of the Conditions for Eligibility for Benefit Payments are met.

Conditions for Eligibility for Benefit Payments

You are eligible to receive an accelerated benefit payment if the Policy and this rider are In Force when all of the following requirements are met:

1. Our receipt and approval of the following documentation provided by you:
 - a. Certification of either:
 - i. For Chronic Illness, Written Certification or Written Re-certification by a Licensed Health Care Practitioner that the Insured is a Chronically Ill individual; or
 - ii. For Terminal Illness, Terminally Ill Certification by a Licensed Health Care Practitioner that the Insured is Terminally Ill.
 - b. Our receipt of consent to make such payment, In Writing, of any assignee of record named under the Policy or any irrevocable beneficiary named under the Policy.
2. We complete, at our discretion and expense, a personal interview with, and an assessment of, the Insured, including examination or tests by a Licensed Health Care Practitioner of our choice; and our receipt of copies of any relevant medical records from a health care provider involved in the Insured's care; and
3. The Insured is living at the time all of the above requirements are met.

Reduction in Benefit Payment Due to Indebtedness

Any Chronic Illness Monthly Benefit Amount or Terminal Illness benefit paid under this rider will be first used to repay a portion of any outstanding Indebtedness under the Policy. The portion to be repaid will be determined by the product of the following:

$[(A + B) / C] * D$ where:

- A. is the balance in the Loan Account;
- B. is any accrued loan interest not yet charged;

- C. is the Remaining Benefit Amount immediately prior to a benefit payment; and
- D. is either i. or ii. noted below depending on the Qualifying Event:
 - i. the Chronic Illness Monthly Benefit Amount; or
 - ii. the Terminal Illness benefit payment divided by the applicable Terminal Illness actuarial discount factor.

If the Chronic Illness one-time lump sum benefit payment is elected, the benefit payment will be reduced by any outstanding Indebtedness under the Policy.

Impact on Other Riders on the Policy

If any of the following riders are attached to your Policy, this rider may have an impact on any benefits provided under such rider.

Premium Reserve Rider: For Chronic Illness Monthly Benefit Amounts and Terminal Illness benefit, you may elect In Writing to either include the Premium Reserve Rider Accumulation Value in the calculation of the Original Benefit Amount or receive a payment of the Premium Reserve Rider Surrender Value. Either action will terminate the Premium Reserve Rider. If you elect to include the Premium Reserve Rider Accumulation Value in the calculation of the Original Benefit Amount, the Premium Reserve Rider Accumulation Value will be transferred to the Policy's corresponding Fixed Account value, Sub-Account(s) value, and/or Loan Account value and the Premium Reserve Rider's Transfer Load will be waived. If you elect the Chronic Illness one-time lump sum payment, you will receive a payment of the Premium Reserve Rider Surrender Value and the Premium Reserve Rider will terminate.

Waiver of Monthly Deduction Rider: If you are on Total Disability as provided under any Waiver of Monthly Deduction Rider, we will continue to waive the monthly deductions falling due under the Policy once payment of an accelerated benefit begins under this rider.

Enhanced Surrender Value Rider: Once payment of an accelerated benefit under this rider begins, the Enhanced Surrender Value Rider will terminate.

Impact of Rider Benefits on Policy and Other Riders

Benefit payments under this rider will reduce certain policy and rider values by multiplying such values by a Reduction Ratio noted below. The values that will be reduced are as follows:

1. Specified Amount;
2. Fixed Account value;
3. The value of each Sub-Account;
4. Your "Cost Basis" in the Policy, see "Definitions" above;
5. Premiums paid to date;
6. No-Lapse Value of any No-Lapse Enhancement Rider, if attached to the Policy;
7. Reset Account Value of any No-Lapse Enhancement Rider, if attached to the Policy;
8. Guaranteed Minimum Death Benefit of any No-Lapse Enhancement Rider, if attached to the Policy; and
9. Reset Death Benefit of any No-Lapse Enhancement Rider, if attached to the Policy.

Any reduction will occur on the Monthly Anniversary Day prior to the Monthly Deduction. The proportion by which the above values will be reduced will be based on a Reduction Ratio, determined as follows:

A. Chronic Illness Benefit Payments:

Each Monthly Benefit Amount will reduce the above values by a Reduction Ratio of $(b-a)/b$ where:

- a. is the Monthly Benefit Amount, and
- b. is the Remaining Benefit Amount immediately prior to a benefit payment.

B. Terminal Illness Benefit Payment:

The payment of a Terminal Illness benefit will reduce the above values by a Reduction Ratio of $(b-a)/b$ where:

- a. is the Terminal Illness benefit payment divided by the applicable Terminal Illness actuarial discount factor, and
- b. is the Remaining Benefit Amount immediately prior to the benefit payment.

The Loan Account will be reduced as noted in the "Reduction in Benefit Payment Due to Indebtedness" provision.

For each Policy Month you receive a rider benefit payment, we will send you a monthly report showing the change in current values under your Policy.

If a Death Benefit Option other than Death Benefit Option I (Level) is in effect, the Death Benefit Option will be changed to Death Benefit Option I (Level) prior to the first benefit payment. No further Death Benefit Option changes are permitted.

The Surrender Charges as shown on the Policy Specifications will be waived.

If there is any premium in a premium deposit fund, this premium will be returned to you and will be treated as a normal return of premium and not as a benefit payment under this rider. If we return any accrued interest with the premium amount, the interest will be reported as taxable income to you.

If the Policy includes a "No-Lapse" provision, the provision will terminate. This does not apply to any "No-Lapse" provided by rider.

You may not make a change in Specified Amount, a change in the Insured's Premium Class as shown on this rider's Policy Specifications, or add rider benefits or increase the amount of rider benefits.

Further, we reserve the right to transfer all value of each Sub-Account(s) to the Fixed Account.

If the death of the Insured occurs prior to the date you satisfy all Conditions for Eligibility for Benefit Payments, we will pay the Death Benefit Proceeds. If the death of the Insured occurs while benefits are being received under this rider, we will pay the Death Benefit Proceeds, which may be less than the Remaining Benefit Amount, and the Death Benefit Proceeds will be reduced by any decrease in the Remaining Benefit Amount after the date of the Insured's death.

Cost of Insurance

This rider's Cost of Insurance will be part of the Monthly Deduction made under the Policy. Also, this rider's Cost of Insurance will be part of the No-Lapse Value Monthly Deduction and Reset Account Value Monthly Deduction under the No-Lapse Enhancement Rider, if attached to the Policy. The amount deducted each Policy Month will be calculated as (A) multiplied by (B) where:

(A) is the applicable rate found in the "Guaranteed Cost of Insurance Rate Per \$1,000 of Policy Net Amount at Risk or Rider Net Amount At Risk" table of rates shown on the Policy Specifications; and (B) is either i. or ii. noted below:

- i. For any Policy Month prior to acceleration of the death benefit, the Policy's net amount at risk divided by \$1,000; or
- ii. Following acceleration of the death benefit, for any Policy Month in which benefits are not payable, this rider's net amount at risk divided by \$1,000.

This rider's net amount at risk is equal to the Remaining Benefit Amount at the beginning of the Policy Month, divided by the Net Amount at Risk Discount Factor shown on the Policy Specifications, minus the Policy's Accumulation Value at the beginning of the Policy Month after the deduction of the Monthly Administrative Fee but prior to the deduction for the monthly Cost of Insurance.

Each Policy Month you receive a Chronic Illness Monthly Benefit Amount or the Terminal Illness benefit, this rider's Cost of Insurance will be waived.

Waiver of Monthly Deductions

Once benefit payments begin, the Policy's Monthly Deductions will continue until the Policy's Net Accumulation Value, and, if attached to the Policy, the No-Lapse Enhancement Rider's No-Lapse Value, less Indebtedness, and Reset Account Value, less Indebtedness, are reduced to an amount insufficient to pay the Monthly Deduction. After this occurs, the Policy will not Lapse as long as this rider is In Force. We will stop billing you and will not allow premium payments unless otherwise agreed to by you and us. However, we will continue to accept loan repayments.

General Provisions

Exclusions

This rider does not provide an accelerated benefit for Chronic Illness resulting from:

1. Intentionally self-inflicted injury or attempted suicide, while sane or insane;
2. Any act or incident of insurrection or war, declared or undeclared;
3. The Insured's participation in, or attempting to participate in, a felony, riot, or insurrection; or
4. Alcoholism or drug addiction.

Reinstatement

You may reinstate this rider as part of your Policy if the Policy is terminated and reinstated. Such reinstatement will be subject to satisfactory evidence of insurability and all other terms and conditions of the Policy to which it is attached.

Rider Termination

This rider and all rights provided under it will terminate automatically upon whichever of the following occurs first:

1. The date you request In Writing to terminate this rider;
2. The Policy's Specified Amount exceeds the Specified Amount Limit as shown on the Policy Specifications;
3. The receipt of a Chronic Illness one-time lump sum payment which will cause the termination of both this rider and the Policy to which it is attached;
4. The Remaining Benefit Amount is reduced to zero which will cause the termination of both this rider and the Policy to which it is attached;
5. Termination of the Policy; or
6. The death of the Insured which will cause Death Benefit Proceeds to become payable under the Policy.

In addition, if you have received an accelerated benefit payment, this rider will terminate on the earliest of the following:

1. The date you take a partial surrender under the Policy; or
2. The date you take a loan under the Policy.

The Lincoln National Life Insurance Company

[]

[President]

ACCELERATED BENEFITS RIDER FOR CHRONIC ILLNESS SUPPLEMENT

Proposed Insured _____
 (please print name) _____ Date of Birth (mm/dd/yy) _____

GENERAL RISK INFORMATION

- | 1. Do you currently: | Yes | No |
|--|--------------------------|--------------------------|
| a) Need help, assistance or supervision in doing any of the following: bathing, eating, dressing, toileting, walking, transferring from bed to chair or maintaining continence? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Need help, assistance or supervision in performing any of the following everyday activities: taking medication, doing housework, laundry, managing money, using the phone, shopping or meal prep? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Use or require the use of any of the following medical devices: wheelchair, walker, multi-prong cane, hospital bed, dialysis, oxygen, motorized cart or stair lift? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Reside in, or are planning to enter a nursing home, assisted care living facility or other custodial facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Receive in home health care services or adult day care? | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Receive any type of disability benefit, Worker's Compensation, or Social Security Disability Insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Have a handicapped parking permit? | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Require occupational, physical or speech therapy? | <input type="checkbox"/> | <input type="checkbox"/> |

-
2. Within the past 10 years, have you experienced symptoms of, been diagnosed with, consulted a medical professional for, been treated for or advised to be tested or treated for:
- | | | |
|--|--------------------------|--------------------------|
| a) Memory loss, confusion or dementia? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Recurrent falls, paralysis, tremors, ongoing imbalance, or any condition which causes limited motion? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Ataxia, kidney failure, cirrhosis, Cystic Fibrosis, Multiple Sclerosis, Post polio syndrome, Parkinson's disease, Lou Gehrig's disease (ALS), Muscular Dystrophy, Multiple Myeloma, or Huntington's chorea? | <input type="checkbox"/> | <input type="checkbox"/> |

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

Signed in _____, this _____ day of _____
 (state) (month) (year)

Signature of Proposed Insured

SERFF Tracking Number: LCNC-128289799 State: Arkansas
 Filing Company: The Lincoln National Life Insurance Company State Tracking Number:
 Company Tracking Number: LR630
 TOI: L061 Individual Life - Variable Sub-TOI: L061.002 Single Life - Flexible Premium
 Product Name: LR630 Accelerated Benefits Rider for Chronic Illness
 Project Name/Number: LR630 Accelerated Benefits Rider for Chronic Illness/LR630

Supporting Document Schedules

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

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: Please refer to a specimen copy of previously approved application LFF06321, which was approved on 06/16/2008 under file # JEPL-125673253.		
Attachment: LFF06321 Generic Approved Form.pdf		

	Item Status:	Status Date:
Satisfied - Item: Life & Annuity - Actuarial Memo		
Comments: Please refer to the Actuarial Memorandum attached below.		
Attachment: LR630 ABR for Chronic Illness ASM.pdf		

	Item Status:	Status Date:
Satisfied - Item: Compliance Certification		
Comments:		
Attachment: AR Cert. of Compliance_UL_VUL_Term.pdf		

	Item Status:	Status

SERFF Tracking Number: LCNC-128289799 State: Arkansas
Filing Company: The Lincoln National Life Insurance Company State Tracking Number:
Company Tracking Number: LR630
TOI: L061 Individual Life - Variable Sub-TOI: L061.002 Single Life - Flexible Premium
Product Name: LR630 Accelerated Benefits Rider for Chronic Illness
Project Name/Number: LR630 Accelerated Benefits Rider for Chronic Illness/LR630

Date:

Satisfied - Item: LFF10251 ABR Application
Disclosure

Comments:

A copy of the Accelerated Benefits Rider for Chronic Illness Disclosure has been included as informational. At the time of application, the applicant will be provided with the Accelerated Benefits Rider for Chronic Illness Disclosure (form LFF10251) and the applicant and agent will both sign the disclosure. This disclosure is submitted for informational purposes only.

Attachment:

LFF10251 Application Disclosure GENERIC Bracketed.pdf

Arkansas

READABILITY CERTIFICATION

The Lincoln National Life Insurance Company

Re: **LR630 - Accelerated Benefits Rider for Chronic Illness**
LFF10249 - Accelerated Benefits Rider for Chronic Illness Application Supplement

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

<u>Form Number:</u>	<u>Flesch:</u>
LR630	57.00
LFF10249	51.00



Raymond Fortier, Assistant Vice President
Product Compliance & State Filing

Date: June 11, 2012

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 each Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

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

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: Box 105 Essex Station, Boston, MA 02112. You can reach MIB by phone toll free at (866) 692-6901. (TTY {866} 346-3642)

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APPLICATION FOR LIFE INSURANCE - PART I

APPLICANT INFORMATION - PROPOSED INSURED A (Required Section)		
1. Proposed Insured A <i>(First, Middle, Last)</i>	2. <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Date of Birth (If over age [70], please complete Section D) <i>(mm/dd/yy)</i>	4. Soc. Sec. No.	5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," what country?
6. Place of Birth <i>(State, Country)</i>	7. Driver's License # & State	
8. Home Address <i>(Street, City, State, ZIP)</i>		
9. Occupation/Duties	10. Employer	
11. Business Address <i>(Street, City, State, ZIP)</i>		
12. Annual Earned Income \$	13. Annual Unearned Income \$	14. Net Worth \$
15. In the last 5 years have you filed for bankruptcy? <input type="checkbox"/> Y <input type="checkbox"/> N <i>(If "Yes," please complete the Financial Supplement.)</i>	16. Primary Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	17. Work Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM

COVERAGE INFORMATION (As available per product)

18. Plan of Insurance _____ 19. Amount of Insurance \$ _____
(Specified Amount, if UL or VUL)

20. (i) Death Benefit Option *(Complete for Universal Life and Variable Universal Life Product only - not required for Term or Whole Life.)*
 Level Increase by Cash Value Increase by Premium Increase by Premium Less Policy Factor

(ii) Death Benefit Qualification Test (DBQT) - For IRS purposes, premiums will be tested using the Guideline Premium Test unless
 Cash Value Accumulation Test is checked (not available on all products or with all riders).
The DBQT cannot be changed after issue unless the terms of the policy require a change.

21. Save Age? Y N *(If not saving age, policy will be current dated.)*

22. Additional Benefits and Riders: <i>(If applicable)</i>	<input type="checkbox"/> Waiver of Premium
<input type="checkbox"/> [Supplemental Coverage \$ _____]	<input type="checkbox"/> Waiver of Monthly Deductions
<input type="checkbox"/> Term on Spouse/Other Insured Rider \$ _____ <i>(Please complete Section B - Applicant Information - Proposed Insured B)</i>	<input type="checkbox"/> Waiver of Specified Premium \$ _____
<input type="checkbox"/> Accelerated Benefit Rider	<input type="checkbox"/> Children's Term Insurance Rider] <i>(Complete Child's Supplement)</i>
<input type="checkbox"/> Other Benefits and Riders <i>(not listed above)</i> . (Please provide full details: e.g. coverage amounts/percentages/etc.):	

BILLING INSTRUCTIONS (As available per product)

23. Premium Mode: Annual Semi-Annual Quarterly Monthly (EFT) Other _____

24. Modal Planned Premium: \$ _____ 25. Lump Sum: \$ _____ 1035 Exchange

26. Special Billing: *(check one, if applicable)* New List Bill Existing List Bill Number: _____

27. Source of Premium: _____ 28. Automatic Premium Loan: Y N
(inheritance, loan, business activity) *(Complete for Whole Life only.)*

29. Premium Notices To: *(check one only.) (Please note we cannot bill to your agent.)*
 Owner in Question 31 Owner in Question 37 Insured at Business Insured at Residence Other *(indicate below)*

30. Special Instructions:

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

31. Owner Name	
32. Owner Address	
33. Relationship to Proposed Insured(s)	34. Owner Soc. Sec. No. / TIN
35. Date of Birth/Trust Date	36. Citizen of (Country)
37. Owner Name	
38. Owner Address	
39. Relationship to Proposed Insured(s)	40. Owner Soc. Sec. No. / TIN
41. Date of Birth/Trust Date	42. Citizen of (Country)
43. Is this policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? <input type="checkbox"/> Y <input type="checkbox"/> N	

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

Select Primary (P) or Contingent (C) Beneficiary for each line completed. If Trust, check here .

44.	a. Name/Trust name & Trustees <input type="checkbox"/> P <input type="checkbox"/> C	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
45.	a. Name/Trust name & Trustees <input type="checkbox"/> P <input type="checkbox"/> C	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
46.	a. Name/Trust name & Trustees <input type="checkbox"/> P <input type="checkbox"/> C	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
47.	a. Name/Trust name & Trustees <input type="checkbox"/> P <input type="checkbox"/> C	b. Soc. Sec. No./TIN
		c. Relationship to Proposed Insured
48.	Special Instructions	

APPLICANT INFORMATION - PROPOSED INSURED A

49. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Y N
(If "Yes", please complete and sign all required replacement forms.)

50. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*

If none, check this box:

Please indicate the Type of coverage: Business (B); Key Person (K); or Personal (P).

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

51. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? (If "Yes," please provide details in the space provided.) Y N

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

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

53. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? (If "Yes", please complete the Premium Financing Supplement.) Y N

54. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? (If "Yes", provide further information in the "Details" space provided.) Y N

GENERAL RISK INFORMATION - PROPOSED INSURED A

55. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? (If "Yes", an Aviation Supplement is required; this includes balloon pilots.) Y N

56. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? (If "Yes", an Avocation Supplement is required.) Y N

57. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? (If "Yes", a Foreign Travel or Residence Supplement is required.) Y N

58. 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, restricted or revoked? (If "Yes," please indicate what type and dates in the "Details" space provided.) Y N

59. Have you ever been convicted of or are you awaiting trial for a felony? (If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in the "Details" space provided.) Y N

60. 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.) Y N

61. 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:

MEDICAL INFORMATION - PROPOSED INSURED A (Answer this section only when required.)

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

a. Date and reason of last visit:

b. Tests performed & treatment received:

63. 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

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

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

SECTION A - HEALTH SUMMARY

APPLICANT INFORMATION - PROPOSED INSURED A

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

1. Proposed Insured A <i>(First, Middle, Last)</i>	2. Date of Birth <i>(mm/dd/yy)</i>
► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.	
	Yes No
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. Have you ever had any indication of, or been treated by a licensed medical professional for:	
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	<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, shortness of breath, 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, 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"/>
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 & Amount.)</i>	<input type="checkbox"/> <input type="checkbox"/>
Type _____ Frequency _____ Amount _____	
8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	<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. 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.	
11. Details: <i>(List details from questions answered "Yes" and please specify to which question numbers details pertain.)</i>	

SECTION B - ADDITIONAL INSURED

APPLICANT INFORMATION - PROPOSED INSURED B

1. Proposed Insured B <i>(First, Middle, Last)</i>		2. <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Date of Birth (If over age [70], please complete Section D) <i>(mm/dd/yy)</i>	4. Soc. Sec. No.	5. Are you a citizen of the United States? <input type="checkbox"/> Y <input type="checkbox"/> N If "No," what country?	
6. Place of Birth <i>(State, Country)</i>	7. Driver's License # & State		
8. Home Address <i>(Street, City, State, ZIP)</i>			
9. Occupation/Duties		10. Employer	
11. Business Address <i>(Street, City, State, ZIP)</i>			
12. Annual Earned Income \$		13. Annual Unearned Income \$	
14. Net Worth \$		15. In the last 5 years have you filed for bankruptcy? <input type="checkbox"/> Y <input type="checkbox"/> N <i>(If "Yes," please complete the Financial Supplement.)</i>	
16. Primary Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM		17. Work Phone # <input type="checkbox"/> AM <input type="checkbox"/> PM	

18. Beneficiary for applicable Rider: a. Name		
b. Soc Sec. No./TIN	c. Relationship to Proposed Insured B	

19. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? Y N
(If "Yes", please complete and sign all required replacement forms.)

20. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*
If none, check this box:
 Please indicate the Type of coverage: Business (B); Key Person (K); or Personal (P).

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

21. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? *(If "Yes," please provide details in the space provided.)* Y N

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

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

23. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes", please complete the Premium Financing Supplement.)* Y N

24. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide further information in the "Details" space provided.)* Y N

GENERAL RISK INFORMATION - PROPOSED INSURED B

25. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? *(If "Yes", an Aviation Supplement is required; this includes balloon pilots.)* Y N

26. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? *(If "Yes", an Avocation Supplement is required.)* Y N

27. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? *(If "Yes", a Foreign Travel or Residence Supplement is required.)* Y N

28. 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, restricted or revoked? *(If "Yes," please indicate what type and dates in space provided below.)* Y N

29. Have you ever been convicted of or are you awaiting trial for a felony? *(If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in space provided below.)* Y N

30. 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, on the space provided below.)* Y N

31. 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: <i>(month/year)</i>	Date Last Used: <i>(month/year)</i>	Amount and Frequency:

MEDICAL INFORMATION - PROPOSED INSURED B *(Answer this section only when required.)*

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

a. Date and reason of last visit:

b. Tests performed & treatment received:

33. 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

34.	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)			

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

SECTION C - HEALTH SUMMARY

APPLICANT INFORMATION PROPOSED INSURED B

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

1. Proposed Insured B <i>(First, Middle, Last):</i>	2. Date of Birth <i>(mm/dd/yy):</i>																																																																					
<p>► If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>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?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>4. 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SECTION D - DEFINED AGE QUESTIONNAIRE
(Complete if either Proposed Insured is age [70] or over.)

1. Proposed Insured A *(First, Middle, Last)* _____

2. Proposed Insured B *(First, Middle, Last)* _____

	Proposed Insured A	Proposed Insured B
3. Will you, the proposed insured and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
4. Have you, the proposed insured, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf which will have an ownership or beneficial interest in this policy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Have you, the proposed insured, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the proposed insured, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
6. Have you, the proposed insured, ever sold a policy to a life settlement, viatical or other secondary market provider, or are you in the process of selling a policy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
7. Details: <i>(List details from questions answered "Yes" and please specify to which question numbers details pertain.)</i>		

OWNER INFORMATION

	Owner
8. Owner Name _____	
9. Will you, the proposed owner and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Have you, the proposed owner, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf?	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Have you, the owner, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the owner, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? <i>(If "Yes", please complete the Premium Financing Application Supplement.)</i>	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Details: <i>(List details from questions answered "Yes" and please specify to which question numbers details pertain.)</i>	

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

SUITABILITY

Complete only if applying for Variable Life Insurance and submit allocation form(s) with this Application:

1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	<input type="checkbox"/> Y <input type="checkbox"/> N
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	<input type="checkbox"/> Y <input type="checkbox"/> N
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	<input type="checkbox"/> Y <input type="checkbox"/> N
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	<input type="checkbox"/> Y <input type="checkbox"/> N

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, certify that the tax identification or social security number as provided by me is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Part I (including Sections A-D if needed); b) Part II Medical Application, if required; c) any amendments to the application(s) 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 shall be complete when it includes Application Information - Proposed Insured A, and any or none of the following (please check, as applicable, included Sections A-D):

- Section A- Health Summary -Proposed Insured A, Section B- Applicant Information -Proposed Insured B,
 Section C -Health Summary -Proposed Insured B, and Section D - Defined Age Questionnaire.

2. I/We further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me/us; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured(s); and 3) the Proposed Insured(s) remain in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.

I/We have paid \$ _____ to the Agent/Representative in exchange for the Temporary Life Insurance Agreement, and I/we acknowledge that I/we fully understand and accept its terms. (Please complete Temporary Life Insurance Agreement and submit with application.)

3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
5. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
6. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

AR, DC, KY, ME, NM, OH and PA Only. Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

TRUST VERIFICATION

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

AUTHORIZATION

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/us or my/our 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

Signed in _____, this _____ day of _____ (state) (month) (year)

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

Signature of Proposed Insured B (If coverage applied for)
(Parent or Guardian if under 14 years of age)

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

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

TO BE COMPLETED BY AGENT ONLY

(i) Does the applicant have any existing life insurance policies or annuities? Y N

(ii) Do you know or have you any reason to believe that replacement of insurance is involved? Y N

If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.

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

I 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 Licensed Agent, Broker or Registered Representative

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

APPLICABLE TO VARIABLE LIFE ONLY

I have reviewed the Application, Supplements, New Account Form and allocation forms and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

ARKANSAS

CERTIFICATE OF COMPLIANCE

The Lincoln National Life Insurance Company

**Re: LR630 - Accelerated Benefits Rider for Chronic Illness
LFF10249 - Accelerated Benefits Rider for Chronic Illness Application Supplement**

To the best of my knowledge and belief, the policy form listed above complies with the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance department.

To the best of my knowledge and belief we are in compliance with the requirements of Arkansas Code Ann. 23-79-138. We provide a document entitled which contains the required information.

To the best of my knowledge and belief we are in compliance with the requirements of Regulation 49 and we provide the required Guaranty Association notice.



Raymond P. Fortier, AVP
Product Compliance & State Filing

Date: June 11, 2012

ACCELERATED BENEFIT RIDER FOR CHRONIC ILLNESS DISCLOSURE

*Lincoln LifeEnhance*SM Accelerated Benefits Rider

This Disclosure provides a summary of the important features of this rider. It does not alter any of the rider's provisions. Eligibility and receipt of benefits provided by the rider will be governed in full by the actual terms and provisions set forth in the rider. Benefits may be taxable as income and assistance should be sought from a personal tax advisor. Benefits are not subject to approval of receipts for reimbursement and there is no waiting period. Receipt of an accelerated death benefit payment may adversely affect your eligibility for Medicaid or other government benefits and entitlements.

TAX QUALIFICATION

The benefits paid under this rider are intended to be treated as accelerated death benefits under section 101(g)(1) of the Internal Revenue Code of 1986, as amended (the "Code"). The Company considers the benefits paid under this rider that do not exceed the maximum Per Diem Limit as prescribed by law to be eligible for exclusion from income under section 101(a) of the Code to the extent that all applicable qualification requirements under the Code are met. If benefits are paid in excess of the applicable Per Diem Limit, or if benefits are paid and all applicable qualification requirements are not met, the benefits may constitute taxable income to the recipient. This rider is not intended to be a qualified long-term care insurance contract under section 7702B(b) of the Code. The tax treatment of the accelerated death benefits may change, and you should always consult and rely on the advice of a qualified tax advisor.

1. What is an accelerated benefit?

- An accelerated death benefit is all or a portion of the policy's death benefit that we will pay in advance when (a) the Insured has been certified by a Licensed Health Care Practitioner as being Chronically Ill or (b) the Insured has been certified by a Licensed Health Care Practitioner as Terminally Ill AND
- all of the Conditions for Eligibility for Benefit Payments have been satisfied.

2. When am I eligible for Benefit Payments?

- You are eligible to receive a benefit if the policy and rider are in force when all the Conditions for Eligibility for Benefit Payments have been satisfied.

3. What amount can I accelerate?

- Your Original Benefit Amount will equal the Death Benefit of the policy at the time that we received all requested paperwork properly completed (for the one-time lump sum option it is the date of claim approval), subject to your decision about whether to take the Premium Reserve Rider value (if your policy has that rider) in cash. Any acceleration of benefits will reduce your Original Benefit Amount and what is left to be accelerated will be known as the Remaining Benefit Amount. The Original Benefit Amount cannot be changed in any way after acceleration.

4. What are the payment options and what will the different benefit amounts be?

If you are certified as having a Chronic Illness, you will have two options: one-time lump sum and monthly.

The one-time lump sum will terminate the policy.

- The benefit will be calculated using the Original Benefit Amount or Remaining Benefit Amount (depending on whether you have received a previous benefit under the rider), discounted by a factor based on your age and the interest rate in effect at the time of claim.

The Maximum Monthly Benefit Amount is equal to the lesser of:

- The Original Benefit Amount multiplied by 2%; or
- The monthly equivalent of the Per Diem Limit, as declared by the Internal Revenue Service, that is in effect at the start of any 12-month benefit period. The amount for each month is dependent on number of days in that month.

The Maximum Monthly Benefit Amount is calculated at the start of each Benefit Period and remains fixed during that Benefit Period. There may be a small variance from month to month if the Maximum Monthly Benefit amount is based on the Per Diem Limit as the number of days in any month will determine the exact amount that can be distributed. You can choose to take less than the Maximum Monthly Benefit Amount, but you cannot add that to future payments.

If you are certified as having a Terminal Illness, you will have only one option:

- The terminal illness benefit is a lump sum benefit to exceed no more than 50% of the Original Benefit Amount (Remaining Benefit Amount if you have received a previous benefit under this rider) or \$250,000, whichever is less.

Whether certified under Chronic Illness or Terminal Illness, if there is Indebtedness, a portion of the benefit amount will be used to pay down the Indebtedness as provided in your rider.

5. What is the administrative expense fee?

- There is no administrative expense fee. There is a cost for the rider as disclosed in your policy.

6. How will accelerations impact my policy and riders?

- The Chronic Illness one-time lump sum will terminate the policy.
- For the Chronic Illness Maximum Monthly Benefit and the Terminal Illness Benefit, any benefit payment will reduce the policy values listed below. The new values can be calculated by multiplying the values in effect immediately prior to a payment by a Reduction Ratio equivalent to $(B-A) / B$ where A is the amount accelerated and B is the Remaining Benefit Amount immediately prior to payment.

The policy's values that are reduced based on the Reduction Ratio described above are:

- Specified Amount;
- Fixed Account value;
- The value of each Sub-Account;
- Your Cost Basis in the Policy;
- No-Lapse Value of any No-Lapse Enhancement Rider, if attached to the Policy;
- Reset Account Value of any No-Lapse Enhancement Rider, if attached to the Policy;
- Guaranteed Minimum Death Benefit of any No-Lapse Enhancement Rider, if attached to the Policy; and
- Reset Death Benefit of any No-Lapse Enhancement Rider, if attached to the Policy.

We will send you monthly reports showing impact to some of these values.

Example of Chronic Illness Maximum Monthly Benefit Payment and its impact on policy values:

- Original Benefit Amount is \$500,000
- Benefit Period starting 4/14/13
- Maximum Benefit for the month is equal to the lesser of:
 - $2\% \times \$500,000 = \$10,000$
 - $\text{IRS Per Diem Limit} = \$300 \times \text{number of days in April (30)} = \9000
- Determine Reduction Ratio: $(500,000 - 9,000)/500,000 = 0.982$
- Apply Reduction Ratio to impacted values:
 - $\text{Specified Amount} = 500,000 \times 0.982 = 491,000$
 - $\text{Account Value} = 20,000 \times 0.982 = 19,640$
 - $\text{Remaining Benefit Amount} = 500,000 \times 0.982 = 491,000$

7. What is the premium due once acceleration has begun?

Zero. If policy and secondary guarantee values are insufficient to satisfy monthly deductions, we will waive the deductions to keep the policy from defaulting in all months after initial acceleration, even if no additional accelerations are processed. If you take a loan or withdrawal at any time after initial acceleration, even if the policy is not currently being accelerated, the rider and lapse protection will terminate.

8. What is the death benefit after acceleration has begun?

If death occurs after acceleration, we will pay out the Death Benefit at the time of death, reduced for any acceleration payments made after the date of death. The Remaining Benefit Amount is not paid upon death of the Insured.

DEFINITIONS

Activities of Daily Living (“ADLs”) The 6 basic functional abilities which measure the Insured's ability for self care and ability to live independently without Substantial Assistance from another individual. They are: Bathing – The Insured's ability to wash himself or herself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower; Continence – The Insured's ability to maintain control of bowel or bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag); Dressing – The Insured's ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs; Eating – The Insured's ability to feed himself or herself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously; Toileting – The Insured's ability to get to and from the toilet, getting on and off the toilet, and performing associated personal hygiene; Transferring – The Insured's ability to move into or out of a bed, chair or wheelchair.

Benefit Period A period of time not to exceed twelve consecutive months.

Such period begins on the Monthly Anniversary Day after our receipt of all documentation provided by you necessary to satisfy all Conditions for Eligibility for Benefit Payments. A new Benefit Period will begin no earlier than the end of the current Benefit Period.

Chronically Ill (Chronic Illness) The Insured has been certified, within the preceding 12 months, by a Licensed Health Care Practitioner as:

1. Being unable to perform (without Substantial Assistance from another individual) at least 2 Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
2. Requiring Substantial Supervision from another individual to protect the Insured from threats to health and safety due to Severe Cognitive Impairment; AND
3. Needing Services pursuant to a Licensed Health Care Practitioner's Plan of Care as set forth in Written Certification or Written Re-certification, specifying such Services are likely to be needed for the rest of the Insured's life.

If the Licensed Health Care Practitioner certifies that the Insured will need Services for the rest of the Insured's life, the 90 day requirement noted in 1. above is satisfied by the expectation that the Insured will be unable to perform at least 2 Activities of Daily Living prospectively.

Conditions for Eligibility for Benefit Payments

You are eligible to receive an accelerated benefit payment if the policy and this rider are In Force when all of the following requirements are met:

1. Our receipt and approval of the following documentation provided by you:
 - a. Certification of either:
 - i. For Chronic Illness, Written Certification or Written Re-certification by a Licensed Health Care Practitioner that the Insured is a Chronically Ill individual; or
 - ii. For Terminal Illness, Terminally Ill Certification by a Licensed Health Care Practitioner that the Insured is Terminally Ill.
 - b. Our receipt of consent to make such payment, In Writing, of any assignee of record named under the Policy or any irrevocable beneficiary named under the Policy.

2. We complete, at our discretion and expense, a personal interview with, and an assessment of, the Insured, including examination or tests by a Licensed Health Care Practitioner of our choice; and our receipt of copies of any relevant medical records from a health care provider involved in the Insured's care; and
3. The Insured is living at the time all of the above requirements are met.

Cost Basis The aggregate amount of premiums or other consideration you have paid for the Policy, less the aggregate amount you have received under the contract that was not included in your taxable income, and less reductions in values due to benefit payments under this rider as described in the "Impact of Rider Benefits on Policy and Other Riders" provision.

Licensed Health Care Practitioner A physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of Treasury, or qualifications to our satisfaction. The Licensed Health Care Practitioner (a) must be acting within the scope of his or her license in the state of licensure when providing Written Certification or Written Re-certification required by this rider; and (b) may not be you, the Insured, or your or the Insured's immediate family.

Plan of Care A written document signed by a Licensed Health Care Practitioner which outlines the individualized medical treatment and non-medical assistance and Services which are prescribed because the Insured suffers from loss of functional capacity or from a Severe Cognitive Impairment. The plan must specify where the care is to be provided; the type, frequency, and duration of all medication, therapy, and Services required. It must also describe the likelihood of improvement or deterioration of the Insured's condition within the next 12 months from the date the Plan of Care was prepared and must also describe the supporting evidence upon which the Licensed Health Care Practitioner has based his or her conclusions and prognosis. Such supporting evidence may include either documents or information relevant to the assessment of loss of functional capacity or to the assessment of Severe Cognitive Impairment, or both.

Per Diem Limit The maximum daily benefit used in determining the Chronic Illness Maximum Monthly Benefit. The Internal Revenue Service establishes this limit annually on January 1st. We will use the limit in effect at the beginning of each Benefit Period for the entire Benefit Period.

Remaining Benefit Amount The Original Benefit Amount less the amount of all Chronic Illness Monthly Benefit Amounts paid and, if applicable, less the Terminal Illness benefit paid divided by the applicable Terminal Illness actuarial discount factor.

Services The necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services needed by a Chronically Ill Insured.

Severe Cognitive Impairment Deterioration or loss in the Insured's intellectual capacity that is:

- a. comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
- b. measured and confirmed by clinical evidence and standardized tests that reliably measure impairment in the following areas:
 - 1) the Insured's short-term or long-term memory;
 - 2) the Insured's orientation as to person (such as who they are), place (such as their location), and time (such as day, month and year); and
 - 3) the Insured's deductive or abstract reasoning, including judgment as it relates to safety awareness.

Substantial Assistance Hands-on assistance or the presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to the Insured while the Insured is performing the Activities of Daily Living.

Substantial Supervision Continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Insured from threats to his or her health or safety (such as may result from wandering) due to Severe Cognitive Impairment.

Terminally Ill (Terminal Illness) The Insured's life expectancy is reduced to 12 months or less.

Terminally Ill (Terminal Illness) Certification Before any benefit can be paid for Terminal Illness, You must furnish evidence satisfactory to us. Such evidence must include a certification of the Insured's medical condition from a Licensed Health Care Practitioner. The certification must state that in the Licensed Health Care Practitioner's opinion the Insured's life expectancy has been reduced to 12 months or less.

Written Certification Written documentation required in a form satisfactory to us completed by a Licensed Health Care Practitioner, at your or the Insured's expense, certifying that the Insured is Chronically Ill as defined herein, including a Plan of Care, and specifying that Services are likely to be needed for the rest of the Insured's Life.

Written Re-certification Written Certification that we must receive and approve prior to the start of each Benefit Period following the initial Benefit Period in order for you to be eligible for Chronic Illness Monthly Benefit Amounts in such subsequent Benefit Period, provided all other Conditions for Eligibility for Benefit Payments are met.

I have received and read a copy of this disclosure.

Signed in _____, this _____ day of _____ (state) (month) (year)

Signature of Owner

Signature of Agent/Producer

Signature of Owner

Signature of Owner

Signature of Owner