Lincoln Financial Group®

The Lincoln National Life Insurance Company
Service Office: PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as "the Company")

MEDICAL SUPPLEMENT
(Part II of Application)

Proposed Insured _____ Date of Birth *(mm/dd/yy)* _____

1. Provide full name/address/phone number of personal physician(s) and any other physicians seen:

Name Address Phone

Name Address Phone

a) Date and reason of last visit: _____

b) Tests performed & treatment received: _____

(If you answer "Yes" to any of the following questions, please give details in space provided in #11.)

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

10. Have you ever used tobacco or products containing nicotine? *(If "Yes", check all that apply.)* ☐ Yes ☐ No

Type:	Cigarettes ☐	Cigar ☐	Pipe ☐	Chew Tobacco ☐	Snuff ☐	Nicotine Patches/ Gum ☐
Date First Used: *(month/year)*						
Date Last Used: *(month/year)*						
Amount and Frequency:						

11. List all medication and dosages you are currently taking or have taken in the last 30 days, to include prescriptions, over the counter drugs, aspirin and herbal supplements.

12. Details: *(List details from "Yes" answered questions above; please include question number.)*

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

COMPLETE QUESTIONS 14-18 IF PROPOSED INSURED IS AGE 70 OR OLDER. IF NOT, PROCEED TO SIGNATURE SECTION ON NEXT PAGE.

14. Point to three objects and ask the Proposed Insured to tell you what they are and indicate that you are going to ask them to recall these later. Record the 3 objects (i.e., pencil, chair, clock).

15. Does the Proposed Insured:

	Yes	No
a) Use any assistive devices for walking such as a wheelchair, walker, or cane, or have difficulty ambulating? *(If "Yes", provide details.)*	☐	☐
b) Drive? *(If "No", when and why did they stop?)*	☐	☐
c) Have a history of falls in the past year? *(If "Yes", how many and provide details.)*	☐	☐
d) Exercise? *(If "Yes", what type and how often?)*	☐	☐
e) Need any assistance with the following activities: *(If "Yes", provide details.)*		
Bathing	☐	☐
Dressing	☐	☐
House Cleaning	☐	☐
Handling Finances	☐	☐
Taking Medication	☐	☐

16. Ask the Proposed Insured today's date including the year, day of week, month and day of the month. Record his/her response.

17. Ask the Proposed Insured to recall the three objects identified earlier. Record his/her response.

18. In the space below this question, ask the Proposed Insured to draw a clock face, mark the hours and draw the hands to show the time 11:10.

I certify that I made this examination at _____ o'clock ☐ AM. ☐ P.M. on the _____ day of _____ , _____

_____
Signature of Examiner Designation

Each of the Undersigned declares that:

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

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

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

_____ _____
Signature of Examiner **Printed Name of Examiner**

MEDICAL EXAMINER'S REPORT

19a. Height *(In Shoes)*	b. Did you measure?	c. Weight *(Clothed)*	d. Did you weigh?
_____ft. / _____ in.	☐ Yes ☐ No	_____ lbs.	☐ Yes ☐ No

d. Any change in weight in the past year? *(If "Yes", provide amount, if gain or loss.)* ☐ Yes ☐ No Amount _____ ☐ Gain ☐ Loss

20. **BLOOD PRESSURE** *(If above 140/90, report additional readings below)*:				21. **PULSE**	At Rest	After Exercise	3 Min. Later
Systolic				Rate			
Diastolic				Irregularities per minute			

22. **HEART** Is there any: Enlargement ☐ Yes ☐ No Edema ☐ Yes ☐ No
Dyspnea ☐ Yes ☐ No Murmur(s) ☐ Yes ☐ No *(If more than one murmur describe each separately.)*

☐ Constant	☐ Intermittent	☐ Transmitted	☐ Localized
☐ Systolic	☐ Presystolic	☐ Diastolic	
☐ Soft (Gr. 1-2)	☐ Mod. (Gr. 3-4)	☐ Loud (Gr. 5-6)	

Location:	**Transmission:**

	Yes	**No**
23. Is there any abnormality of the following: (Circle Applicable items and give details. If more room is needed, provide details in Examiner's Confidential Opinion.)		
a. Eyes, ears, nose, mouth or pharynx? *(If vision or hearing is markedly impaired, indicate degree and correction.)*	☐	☐
b. Skin; lymph nodes; veins or peripheral arteries? (include scars)	☐	☐
c. Peripheral arteries or pulses?	☐	☐
d. Nervous system? (include reflexes, gait, paralysis)	☐	☐
e. Respiratory system?	☐	☐
f. Abdomen? (include scars)	☐	☐
g. Endocrine system? (include thyroid)	☐	☐
h. Musculoskeletal system? (include spine, joints, amputations, muscle strength)	☐	☐
i. Mental status?	☐	☐
24. Is there any use of adaptive devices? (cane, walker, wheelchair)	☐	☐
25. Is appearance unhealthy or older than stated age?	☐	☐
26. Are you aware of additional medical history; signs, symptoms or laboratory findings? *(A confidential report may be sent to the Medical Director.)*	☐	☐
a. Are you related to the Applicant?	☐	☐
b. Are you associated with the Applicant in any business or financial ventures?	☐	☐
27. Have you any reason to believe that the Applicant uses or has used alcoholic beverages or drugs to excess?	☐	☐
28. If you do any of the following, please indicate:	☐	☐

Sent to Lab:	To Field Office:	☐ Other
☐ Blood Profile ☐ Urine Specimen	☐ Chest X-Ray ☐ EKG	_____

29. **EXAMINER'S CONFIDENTIAL OPINION:**

URINALYSIS: ALWAYS SEND A URINE SPECIMEN AND BLOOD SAMPLE (IF APPLICABLE) TO APPROPRIATE LAB.

Medical Examiner (Please Print)	**Examination Company P.O. Address**	**Examiner #**
Name of Agent (Please Print)	**Dated at** *(City and State)*	**Date**

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NOTICE AND CONSENT FOR HIV - RELATED TESTING

To evaluate your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an AlDS-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result: _____

_____

If you do not wish to know the results of the test, initial here: _____. In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If you want to know the results of the test but do not at present have a private physician, initial here:_____. The result will be sent to you at the address provided by registered mail with delivery restricted to you only. If you desire the results to be mailed to some person other than yourself who is not a physician, print that person name and address here:

_____. The result will be sent to that person by registered mail with restricted delivery.

Consent

I have read and I understand this Notice and Consent for AIDS-related Testing. I voluntarily consent to the withdrawal of blood and/or other bodily fluid from me, the testing of that blood and/or other bodily fluid, and the disclosure of the test results as described above.

I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive. I understand that this consent can be withdrawn at any time prior to the drawing of the blood and/or other bodily fluid for testing.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____

Name of Proposed Insured (Please Print) Signature of Proposed Insured or Parent/Guardian

_____ _____

Address Date Signed