Application for Portable Coverage for Group Term Life Insurance

How to apply: This form must be completed by the Applicant and the Employer. The completed application must be sent within 31 days after
termination of coverage under the Former Plan to:

Lincoln Life Assurance Company of Boston, Group Insurance Department, P.O. Box 0821, Carol Stream, IL 60132-0821

Part A: To Be Completed By Primary Applicant

Name: *(Last, First, MI)*			
Sex: ☐ Male ☐ Female	Social Security Number:		Date of Birth:
Email Address:	Telephone Number:		
Mailing Address: (Street, City, State, Zip)			
Spouse/Domestic Partner Name: *(Last, First, MI)*			
Sex: ☐ Male ☐ Female	Spouse /Domestic Partner Social Security Number:	Spouse /Domestic Partner Date of Birth:	

Dependent Children to Be Covered *(Last, First, MI)*	SS#	Sex (M/F)	Date of Birth

The portable life coverage amount will be your current basic, basic and optional, optional
coverage amount unless you designate a decreased amount. (Please round coverage to the nearest thousand).
Your life insurance coverage will be matched with an equal amount of Accidental Death and Dismemberment Insurance unless you opt not to select that coverage.

NOTE: An Evidence of Insurability Form must be completed and submitted with this application if you are requesting preferred rates. A Primary Applicant is not eligible for coverage if they are not actively at work on the day immediately preceding the day their coverage terminates. A Primary Applicant is not eligible for portable coverage if they have an injury or sickness which has a material effect on life expectancy. An injury or sickness which has a material effect on life expectancy is a condition that, according to generally accepted medical opinion, may contribute to or result in death within the next 5 years. Examples include, but are not limited to, cancers and lung diseases.

Primary Applicant:

Life
☐ check to opt out of AD&D match

Amount of insurance
$ ____________________

Spouse or Domestic Partner:

Life
☐ check to opt out of AD&D match

Amount of insurance
$ ____________________

Dependent Child(ren):

Life
☐ check to opt out of AD&D match

Amount of insurance
$ ____________________

How will premiums be paid? ☐ quarterly ☐ annually

Designation of Beneficiary by Primary Applicant

☐ I designate the following person(s) as a primary beneficiary(ies) for any Lincoln Financial Group payment upon my death. I understand I have the right to change this designation at any time.

☐ My designation of beneficiary is on a separate form which is signed, dated and attached.

The amount of insurance that is paid to you or your beneficiary will be decreased by any amount of contribution owed to Lincoln Life Assurance Company of Boston.

Full Name (Last, First, MI)	Relationship	Date of Birth (Mo/Day/Yr)	Address (Street, City,State,Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated. Total:				

If the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Full Name (Last, First, MI)	Relationship	Date of Birth (Mo/Day/Yr)	Address (Street, City,State,Zip)	Share %

I certify that I do not have an injury or sickness which has a material effect on life expectancy.
I understand that Lincoln Financial is relying on this certification as a material condition in providing portable coverage.

The statements above are true to the best of my knowledge and belief, and I agree that they shall form a part of the contract of insurance applied for. I understand that this application is subject to the applicable fraud statement listed on the next page.

______________________________ ____________________
Signature of Primary Applicant Date

NOTE: Employer MUST complete Part B information on the last page.

Fraud Statements

Residents of all states EXCEPT those listed below: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, submits an application or files a statement of claim containing any false, incomplete or misleading information commits a fraudulent insurance act and may be subject to criminal or civil penalties.

CO:	It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
FL:	Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
DC/LA/TX:	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
KY:	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any 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.
MD:	Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
ME/TN/VA/WA:	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
NJ:	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
NY:	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 any 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
OH:	Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
OK:	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
PA:	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 any 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.

Part B --TO BE COMPLETED BY EMPLOYER

<table>
<tr><td colspan="4">Employer (Firm Name and Division):</td></tr>
<tr><td colspan="2">Employer's Address (Street, City, State, Zip):</td><td colspan="2">Group Life Policy Number:</td></tr>
<tr><td>Name of Person Eligible for Portable Group Term Life Insurance:</td><td>Class (if Applicable)</td><td>Sex:
☐ Male ☐ Female</td><td>Date Eligibility for Group Life Insurance Ceased:</td></tr>
<tr><td colspan="3">Amount of Basic, Optional, Basic & Optional current Group Life Insurance:
Applicant Amount $ _________ Spouse Amount $ __________
Dependent Amount $ __________</td><td>Date this person was first insured under the Group Life Insurance Policy:</td></tr>
<tr><td colspan="2">Reason for Termination of Primary Applicant's Group Life coverage:
☐ Employment terminated or membership in an eligible class terminated
☐ Class of eligible persons terminated</td><td colspan="2">Was this person actively at work on the date of separation?
☐ Yes
☐ No
☐ N/A</td></tr>
<tr><td colspan="2">Employer Signature:</td><td colspan="2">Date:</td></tr>
</table>