EMPLOYEE APPLICATION FOR CONVERSION OF GROUP LONG TERM DISABILITY INSURANCE

1. Name _____
   (Last) (Full First) (Middle)
2. Sex: _____ Male _____ Female
3. Social Security No. _____
4. Birthdate: Month _____ Day _____ Year _____ Home Phone No. _____
5. Home Address (Street & No.) _____
   City _____ State _____ Zip Code _____
6. Application is being made according to the conversion privilege contained in Group Policy No. _____
   Issued to _____
   (Group Policyholder or Participating Employer) by The Lincoln National Life Insurance Company.
7. Occupation _____
8. Reason for requesting conversion:
   ____ You terminated employment on _____
   ____ Other (explain): _____
9. Your basic monthly earnings in effect just prior to your termination date: $_____
   (NOTE: Show Basic Monthly Earnings as defined by the former plan, exclusive of overtime, bonus and other extra pay.)
10. Are you covered or eligible for any other Group Long Term Disability insurance, other than The Lincoln National Life Insurance Company plan shown in part 6 above? ____ Yes _____ No (NOTE: Your application will be declined if you become eligible for other group LTD coverage within 31 days after The Lincoln National Life Insurance Company coverage ends.)
11. Are you now disabled from a sickness or injury? _____Yes _____No Are you retired? _____Yes _____No
12. This Conversion Policy provides 60% of your last basic monthly earnings not to exceed a maximum monthly benefit of $3,000, less other Income Benefits. However, this benefit percentage and maximum monthly benefit may not exceed the similar benefit percentage and maximum monthly benefit which were applicable to you on your termination date under former plan, less Other Income Benefits.
13. Premium Mode: Quarterly
    If you apply for insurance in the middle of a quarter your premium will be prorated.

The statements set forth above are true to the best of my knowledge and belief, and may be relied upon by the Insurance Company in considering this application. Further, my signature below acknowledges that I have received a copy of my statements as they appear on this application.

Signature of Applicant _____ Date _____

Signature of Witness _____ Date _____

Position and Title _____

Please forward the original of this Application and your first quarterly premium payment to The Lincoln National Life Insurance Company, Group Insurance Service Office, P.O. Box 2616, Omaha Nebraska 68103-2616.

Your Insurance will not become effective until your employer has completed the EMPLOYER QUESTIONNAIRE and you receive approval and an effective date for your Long Term Disability Conversion Insurance from The Lincoln National Life Insurance Company.

LRA _____ License # _____

For Group Insurance Service Office Use Only:

GROUP EMPLOYER QUESTIONNAIRE
FOR LONG TERM DISABILITY CONVERSION

To be completed by the Employer and forwarded to The Lincoln National Life Insurance Company, Group Insurance Service Office, P.O. Box 2616, Omaha, NE 68103-2616, with the terminating employee's Application for Conversion.

The Conversion Privilege is only available to those insured employees who have been covered under their employer's long term disability plan for at least 12 consecutive months. The insured employee must terminate for one of the following reasons:

1. Employee resigned; or
2. Employee is terminated for cause; or
3. Employee is laid off beyond the limits provided in this employer's LTD plan; or
4. Employee elects to go on an uninsured leave of absence.

Please furnish the following data regarding the terminated Employee who is applying for Group Long Term Disability Conversion Coverage.

1. Employee Name:

2. Group LTD Policy No.: Group ID#:

3. Employee's Date of hire:

4. Employee's effective date of insurance under your group LTD policy:

5. Date Employment terminated:
(The employee's date of termination should correspond with the date his or her insurance terminates.)

6. Employee's occupation on the date of termination:

7. Employee's last basic monthly earnings before termination:

8. Date notice of Conversion Privilege was given to the employee:

9. Was the employee covered under your present LTD policy (or policies) for at least 12 consecutive months?
_____ Yes _____ No

10. Did the employee leave employment as a result of retirement? _____ Yes _____ No

11. Is the employee now disabled from a sickness or injury? _____ Yes _____ No

12. Is there a disability claim for this employee pending for disability benefits under your LTD policy?
_____ Yes _____ No

To the best of my knowledge the above information given is correct and complete.

Name of Employer as it appears on the Group Policy

Employer's Name and Address (if a subsidiary or an affiliated Company)

Preparer's Signature and Title Date