Lincoln Financial Group®

Medical Supplement (Part II of Application)

Please check appropriate underwriting company:

☐ **The Lincoln National Life Insurance Company:** PO Box 21008, Greensboro, NC 27420-1008
☐ **Lincoln Life & Annuity Company of New York:** PO Box 21008, Greensboro, NC 27420-1008
☐ **First Penn-Pacific Life Insurance Company:** PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as the "Company")

Proposed Insured: _____ /_____ /_____ /_____
(First) (Middle) (Last) (Suffix)

Date of Birth *(mm/dd/yyyy)*: _____ /_____ /_____

1. What is your Height? _____ ft. / _____ in.
2. What is your Weight? _____ lbs.
   a. Has your current weight changed by more than 10 pounds within the past 12 months? ☐ Y ☐ N
   b. If "Yes," by how many pounds?: _____ lbs. ☐ Gain ☐ Loss
   c. If "Yes," reason for weight change? ☐ intentional ☐ unintentional ☐ due to pregnancy
   d. If weight change was due to pregnancy, are you currently pregnant? ☐ Y ☐ N

Personal Medical History

If you answer "Yes" to any question below, indicate which medical condition(s) apply and provide details in Number 16.

3. In the past 10 years have you been diagnosed by, or been treated by a licensed medical professional for:

a. **Medical Conditions of the Heart or Cardiovascular System:** ☐ Y ☐ N

- ☐ Aneurysm
- ☐ Arrhythmia/Irregular Heartbeat
- ☐ Atrial Fibrillation
- ☐ Carotid Artery Disease
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Valve Disorder
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Peripheral Vascular Disease
- ☐ Stent or Bypass
- ☐ Any Other Heart or Cardiovascular Condition

b. **Mental Health Conditions:** ☐ Y ☐ N

- ☐ Anxiety/Stress/Panic Attacks
- ☐ Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ Bipolar
- ☐ Depression
- ☐ Post-Traumatic Stress Disorder (PTSD)
- ☐ Any Other Mental Health Condition

c. **Cancer and Precancerous Conditions:** ☐ Y ☐ N

- ☐ Abnormal PAP Smear
- ☐ Barrett's Esophagus
- ☐ Basal Cell/Squamous Cell Cancer of the Skin
- ☐ Bladder Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Melanoma
- ☐ Prostate Cancer
- ☐ Renal/Kidney Cancer
- ☐ Thyroid Cancer
- ☐ Uterine Cancer
- ☐ Any Other Cancer or Precancerous Condition

d. **Metabolic or Endocrine Medical Conditions:** ☐ Y ☐ N

- ☐ Diabetes Mellitus
- ☐ Hyperthyroidism/Graves' Disease
- ☐ Hypothyroidism (Low)
- ☐ Pre-diabetes/Impaired Glucose Tolerance
- ☐ Pituitary Adenoma/Tumor
- ☐ Any Other Metabolic or Endocrine Condition

e. **Medical Conditions of the Lungs and Respiratory System:** ☐ Y ☐ N

- ☐ Asthma
- ☐ Emphysema/Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Pulmonary Fibrosis
- ☐ Sarcoidosis
- ☐ Sleep apnea
- ☐ Any Other Lung or Respiratory Condition

f. **Medical Conditions of the Gastrointestinal System:** ☐ Y ☐ N

- ☐ Cirrhosis
- ☐ Crohn's Disease
- ☐ Diverticulitis
- ☐ Esophagitis
- ☐ Fatty Liver
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Pancreatitis
- ☐ Ulcer(s)
- ☐ Ulcerative Colitis
- ☐ Any Other Gastrointestinal Condition

g. **Blood Disorders:** ☐ Y ☐ N

- ☐ Anemia
- ☐ Clotting Disorder
- ☐ Deep Vein Thrombosis
- ☐ Hemochromatosis
- ☐ Hemophilia
- ☐ Monoclonal Gammopathy of Uncertain Significance
- ☐ Pulmonary Embolism
- ☐ Thrombocytopenia/ITP
- ☐ Any Other Blood Disorder

h. **Medical Conditions of the Brain and Nervous System:** ☐ Y ☐ N

- ☐ Concussion
- ☐ Falls
- ☐ Headaches/Migraines
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Restless Leg Syndrome
- ☐ Seizures/Epilepsy
- ☐ Stroke/Transient Ischemic Attack
- ☐ Syncope/Fainting
- ☐ Transient Global Amnesia
- ☐ Traumatic Brain Injury
- ☐ Vertigo
- ☐ Any Other Brain or Nervous System Condition

i. **Medical Conditions of the Bones, Joints and Muscles:** ☐ Y ☐ N

- ☐ Arthritis
- ☐ Autoimmune Disorder
- ☐ Chronic Pain
- ☐ Connective Tissue Disease
- ☐ Joint Replacement
- ☐ Osteoporosis/Osteopenia
- ☐ Spine/Disc Disorder
- ☐ Systemic Lupus Erythematosus (SLE)
- ☐ Any Other Bone, Joint or Muscle Condition

j. **Any disorder of the eyes, ears, nose or throat?** ☐ Y ☐ N

k. **Any non-cancer related disorder of the testicles, prostate, breasts, ovaries, uterus or cervix?** ☐ Y ☐ N

l. **Alzheimer's disease, dementia, or any cognitive impairment?** ☐ Y ☐ N

If you answer "Yes" to any question below, provide details in Number 16.

4. Have you ever tested positive for the Human Immunodeficiency Virus (HIV) or been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome (AIDS) or an AIDS-related condition? ☐ Y ☐ N

5. Have you ever been diagnosed by, or been treated by a licensed medical professional for any immune system disorder (excluding HIV or AIDS)? ☐ Y ☐ N

6. Other than previously disclosed, in the past five years:

   a. Have you been a patient in a hospital or medical facility? ☐ Y ☐ N

   b. Excluding tests for HIV (AIDS virus), have you had an EKG, x-ray, blood or urine test, or any other diagnostic test? ☐ Y ☐ N

   c. Excluding tests for HIV (AIDS virus), have you been advised by a licensed medical professional to have any hospitalization, surgery, EKG, x-ray, blood or urine test, or any other diagnostic test which has not been completed? ☐ Y ☐ N

7. Do you drink alcoholic beverages? ☐ Y ☐ N

   a. If "Yes": I have _____ (#) drinks per ☐ day ☐ week ☐ month ☐ year ☐ Other *(Provide details in Number 16)*

8. In the past five years have you used marijuana or cannabis-based products (not including CBD)? *(If "Yes" complete 8a-b)* ☐ Y ☐ N

   a. How frequently do you use marijuana or cannabis-based products?

   I use _____ (#) times per ☐ day ☐ week ☐ month ☐ year ☐ Other *(Provide details in Number 16)*

   b. Was this prescribed to you by a licensed medical professional? *(If "Yes," provide the condition for which this was prescribed in Number 16.)* ☐ Y ☐ N

9. Have you ever used tobacco or products containing nicotine (including, but not limited to: cigarettes, cigars, electronic cigarettes, vapers, chewing tobacco, snuff, nicotine gum and/or patches)? ☐ Y ☐ N

   a. If "Yes," list below:

Type:	Last Used:

   b. If type includes "Cigars," how many cigars did you smoke in the past year? _____

10. Have you received medical treatment or counseling by a licensed medical professional for drug or alcohol abuse, or has a licensed medical professional advised you to limit or stop your use of alcohol or any prescription or non-prescription medication? ☐ Y ☐ N

11. In the past 10 years have you used cocaine or non-prescription stimulants, depressants, hallucinogens, narcotics, inhalants, or other illegal, restricted or controlled substances? ☐ Y ☐ N

12. Have you taken, or have you been advised by a licensed medical professional to take, any prescription medication(s) within the past 30 days (excluding over the counter drugs and/or supplements) for any reason(s) not previously disclosed? ☐ Y ☐ N

13. Please answer the following questions about your **biological parents or siblings**:

   a.

	Age if Living	Age at Death	If this person died prior to age 65, was cause of death due to coronary artery disease, heart attack, or stroke?	History Unknown
Father				☐
Mother				☐

   b. If you have biological siblings, have any died prior to age 65 due to coronary artery disease, heart attack or stroke?

   ☐ Yes, age(s) at death: _____ ☐ No ☐ Unknown ☐ No siblings

14. Provide the following information for your primary care or personal physician:

   Physician Name: _____

   Street Address: _____

   City/State/ZIP: _____ /_____ /_____

   Phone _____-_____-_____ Date of last visit: (mm/yyyy) _____ /_____

   Reason for last visit: _____

15. In the past five years have you consulted with, been examined by or been treated by a licensed medical professional for any reason not previously disclosed? ☐ Y ☐ N

16. **Details: For any questions answered "Yes," include details about the name of the condition, medications, treating licensed medial professional's name and contact information, date of diagnosis and treatment prescribed.** *(If more space is needed use the Continuation of Details Supplement.)*

Question #	Details

Signatory Section

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 Medical Supplement are correctly recorded and are full, complete and true to the best of my knowledge and belief. I agree that this Medical Supplement constitutes a part of the application for insurance and as such this application and its answers will be bound with the Policy* at issue. I understand that if this Policy is owned by someone other than myself that the Owner/Applicant will have access to my responses in this Medical Supplement. I understand that if any answers provided on this Medical Supplement 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.

Signed in: _____ _____ /_____ /_____
(State) Date (mm/dd/yyyy)

Signature of Proposed Insured
(Parent or Guardian if under 18 years of age)

Printed Name of Proposed Insured

Signature of Examiner or Licensed Agent

Printed Name of Examiner or Licensed Agent

* "Policy" may be referred to as "certificate".

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Examiner's Report

Proposed Insured *(please print name)*_____

For Paramed Exam complete vital questions 1–3 (all ages)

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

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

2. **BLOOD PRESSURE** *(Record three separate readings below):*				3. **PULSE**	At Rest	After Exercise	3 Min. Later
Systolic				Rate			
Diastolic				Irregularities per minute			

4. **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)	**Print Name of Proposed Insured**	**Date**

Continue to page 2 for Signatory Section

Senior Questionnaire – Complete Questions 5 to 16 if Proposed Insured is Age 70 or Older.

Activities of Daily Living

5. 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", describe the frequency and the circumstances of fall(s):	☐	☐
d) Exercise? If "Yes", what type and how often:	☐	☐

e) Need any assistance with the following activities: (If "Yes", provide details.)

Bathing ☐ Yes ☐ No House Cleaning ☐ Yes ☐ No Taking Medication ☐ Yes ☐ No
Dressing ☐ Yes ☐ No Handling Finances ☐ Yes ☐ No

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

Word Recall

7. 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).

8. ***Please wait for 5 minutes prior to asking the Proposed Insured to recall the three objects mentioned in question 7.*** Ask the Proposed Insured to recall the three objects identified earlier. Record his/her response.

Clock Draw

9. In the space to the right of this question, ask the Proposed Insured to draw the face of a clock, put the numbers in the correct positions and draw the hands to show the time “ten minutes after eleven.”

Get Up And Go - Instructions for Examiner: *Record observations and time it takes to rise from a straight back chair, walk 10 feet, turn, walk back to the chair and sit down. Time should be recorded in seconds. Expectation is that timing should be ≤15 seconds. Timings >15 seconds warrant your observations concerning why timing was delayed.*

10. Record time taken for complete process: _____ (seconds only)

11. Was the Proposed Insured able to rise from the chair with ease and unassisted in one attempt? ☐ Yes ☐ No
If “No”, record observation below.

12. Did the Proposed Insured walk without the use of a cane, other walking aid or without any type of assistance? ☐ Yes ☐ No
If “No”, indicate the type of aid:

13. Was the Proposed Insured’s gait steady? ☐ Yes ☐ No If “No”, record observation below.

14. When the Proposed Insured turned, was it without assistance, with a steady gait and without the use of a walking aid or without holding on to an object or wall? ☐ Yes ☐ No If “No”, record observation below.

15. Was the Proposed Insured able to sit back down without using any object for support such as the armchair or wall? ☐ Yes ☐ No
If “No”, record observation below.

16. Record any observations noted in the Get Up and Go Exam:

Signatory Section

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

I certify that I have asked the Proposed Insured all of the questions contained in this Examiner’s Report and that all statements and answers are correctly recorded and are full, complete and true.

Signature of Examiner **Designation** **Dated at** (City and State)