Lincoln Financial Group®

Please check appropriate underwriting company:
☐ **The Lincoln National Life Insurance Company,** Service Office: PO Box 21008, Greensboro, NC 27420-1008
☐ **Lincoln Life & Annuity Company of New York,** Service Office: PO Box 21008, Greensboro, NC 27420-1008
☐ **First Penn-Pacific 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 *(please print name)* _____ Date of Birth *(mm/dd/yy)* _____

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

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 provide further information in the "Details" space provided.**

		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 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 (excluding HIV)?	☐	☐
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?	☐	☐
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?	☐	☐
	b) Any tumor, cancer, cysts, melanoma, lymphoma, or any disorder of the lymph nodes?	☐	☐
	c) Anemia, leukemia, clotting disorder or any other blood disorder?	☐	☐
	d) Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	☐	☐
	e) Asthma, emphysema, allergies, 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 as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐
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 a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	☐	☐
9.	In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐

10. 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:

11. 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.

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

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)			

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 **Printed Name of Proposed Insured**
(Parent or Guardian if under 14 years of age)

_____ _____
Signature of Witness (Examiner/Licensed Representative/Agent) **Printed Name of Witness** (Examiner/Licensed Representative/Agent)

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SENIOR SUPPLEMENT

Proposed Insured *(please print name)* _____

Complete Questions 1 to 11 if Proposed Insured is Age 70 or Older, otherwise please proceed to Page 2 for all ages.

ACTIVITIES OF DAILY LIVING

		Yes	No
1.	Does the Proposed Insured:		
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

2. 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

3. 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).

4. ***Please wait for 5 minutes prior to asking the Proposed Insured to recall the three objects mentioned in question 3.*** Ask the Proposed Insured to recall the three objects identified earlier. Record his/her response.

CLOCK DRAW

5. In the space below 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 second warrant your observations concerning why timing was delayed.*

6. Record time taken for complete process: _____ (seconds only)
7. Was the Proposed Insured able to rise from the chair with ease and unassisted in one attempt? ☐Yes ☐No If "No", record observation below.
8. 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:
9. Was the Proposed Insured's gait steady? ☐Yes ☐No If "No", record observation below.
10. 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.
11. 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.
12. **Record any observations noted in the Get Up and Go Exam:**

Continue to Page 2 for all ages

For Paramed and MD Exam complete questions 13-15

13a.) 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

14. **BLOOD PRESSURE** *(If above 140/90, report additional readings below):*				15. **PULSE**	At Rest	After Exercise	3 Min. Later
Systolic				Rate			
Diastolic				Irregularities per minute			

For MD Exam complete questions 16-23

16. **HEART** Is there any: Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No Edema ☐ 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
17. 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?	☐	☐
18. Is there any use of adaptive devices? (cane, walker, wheelchair)	☐	☐
19. Is appearance unhealthy or older than stated age?	☐	☐
20. 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?	☐	☐
21. Have you any reason to believe that the Applicant uses or has used alcoholic beverages or drugs to excess?	☐	☐
22. If you do any of the following, please indicate:	☐	☐

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

23. **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**

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 Medical 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)