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: *(First)* *(Middle)* *(Last)* *(Suffix)*

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

► **If you answer "Yes" to any of the following questions, provide details including, but not limited to, the treating practitioner's name and contact information, medications, and any other treatment prescribed, in Number 16 below.**

		Yes	No
1.	What is your Height? _____ft./_____in. Weight? _____ lbs.		
	a. Has your weight changed by more than 10 pounds in the last 12 months?	☐	☐
	b. If "Yes," by how many pounds: _____ ☐ Gain ☐ Loss		
	c. Was this weight change ☐ intentional, ☐ unintentional or ☐ due to pregnancy?		
2.	**Have you ever been diagnosed by, or been treated by a licensed medical professional for:**		
	a. Arrhythmia/irregular heartbeat, atrial fibrillation or high blood pressure?	☐	☐
	b. Any other heart disease?	☐	☐
	c. Cancer, lymphoma or leukemia?	☐	☐
	d. Anemia?	☐	☐
	e. Any other blood disorder?	☐	☐
	f. Diabetes?	☐	☐
	g. Asthma, sleep apnea, sarcoidosis, COPD or emphysema?	☐	☐
	h. Any other disorder of the lungs or respiratory system?	☐	☐
	i. Seizures, epilepsy, fainting spells, multiple sclerosis, stroke or TIA?	☐	☐
	j. Parkinson's disease or Parkinsonism?	☐	☐
	k. Alzheimer's disease or other form of dementia?	☐	☐
	l. Any other disorder of the brain or nervous system?	☐	☐
	m. Anxiety, depression, bipolar disorder or attention deficit disorder?	☐	☐
	n. Any other psychiatric disorder?	☐	☐
	o. Ulcerative colitis, Crohn's disease, esophagitis (GERD), liver disease or pancreatitis?	☐	☐
	p. Any other disorder of the stomach, bowel or digestive system?	☐	☐
	q. Kidney stones, glomerulonephritis, nephritis, nephrotic syndrome, pyelonephritis or polycystic kidney disease?	☐	☐
	r. Any other disorder of the kidney or bladder?	☐	☐
	s. Rheumatoid arthritis, psoriatic arthritis, systemic lupus erythematosus or muscular dystrophy?	☐	☐
	t. Any other disorder of the bones, muscles or joints?	☐	☐
3.	Other than previously disclosed, have you been advised within the past 5 years by a licensed medical professional to have any hospitalization or surgery which has not been completed?	☐	☐
4.	Other than previously disclosed, in the past 5 years have you had an EKG, x-ray, blood or urine test or any other diagnostic test excluding tests for HIV (AIDS virus)?	☐	☐
5.	Other than previously disclosed, in the past 5 years have you been advised by a licensed medical professional to have an EKG, x-ray, blood or urine test or any other diagnostic test excluding tests for HIV (AIDS virus)?	☐	☐
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	Other than previously disclosed, in the past 5 years have you been a patient in a hospital or other medical facility?	☐	☐
8.	Do you use alcoholic beverages? If "Yes," provide Frequency and Amount. _____	☐	☐
9.	Have you received medical treatment or counseling for drug or alcohol abuse or been advised by a licensed medical professional to limit or discontinue your use of alcohol or any prescription or non-prescription medication?	☐	☐
10.	In the past 10 years have you used or experimented with marijuana, cocaine, or any other non-prescription stimulants, depressants, or narcotics?	☐	☐

11. 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)? **Yes** ☐ **No** ☐

a. If "Yes," list below:

Type:	Last Used:

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

12. Family History:

	History Unknown	Age if Living	Age at Death	If biological parent died prior to age 65, was cause of death due to coronary artery disease, heart attack, or stroke?
a. Biological Mother	☐			
b. Biological Father	☐			

c. Have any of your biological siblings died prior to age 65 due to coronary artery disease, heart attack, or stroke?
☐ Yes, age(s) at death: _____ ☐ No ☐ No siblings ☐ Unknown

13. Provide the full name, address and phone number of your primary care/personal physician:

Physician Name: _____ Phone: _____ - _____ - _____

Address *(Street)*: _____ Suite: _____

(City/State/ZIP): _____ /_____ /_____

a. Date of last visit *(MM/YYYY)*: _____ /_____

b. Reason for last visit: _____

Yes **No**

14. In the past 5 years have you consulted with, been examined by or been treated by a physician or practitioner for any reason not previously disclosed? ☐ ☐

15. Have you taken, or have you been advised to take, any prescription medication(s) within the past 30 days (excluding over the counter drugs and/or herbal supplements) for any reason(s) not previously disclosed? ☐ ☐

16. **Details**: *(List details from questions answered "Yes" and specify to which question numbers details pertain. If more space is needed use the Continuation of Details Supplement.)*

Ques. # Date Details/Reasons

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. 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 Witness (Examiner/Licensed Agent/Broker)

Printed Name of Witness (Examiner/Licensed Agent/Broker)

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

Lincoln Financial Group®

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

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)