Lincoln Financial Group®
You're In Charge®

# Lincoln's Tele-App preparation guide

## Get ready for your life insurance application phone interview

## With Lincoln's Tele-App, providing the important information needed to complete your life insurance application is just a phone call away.

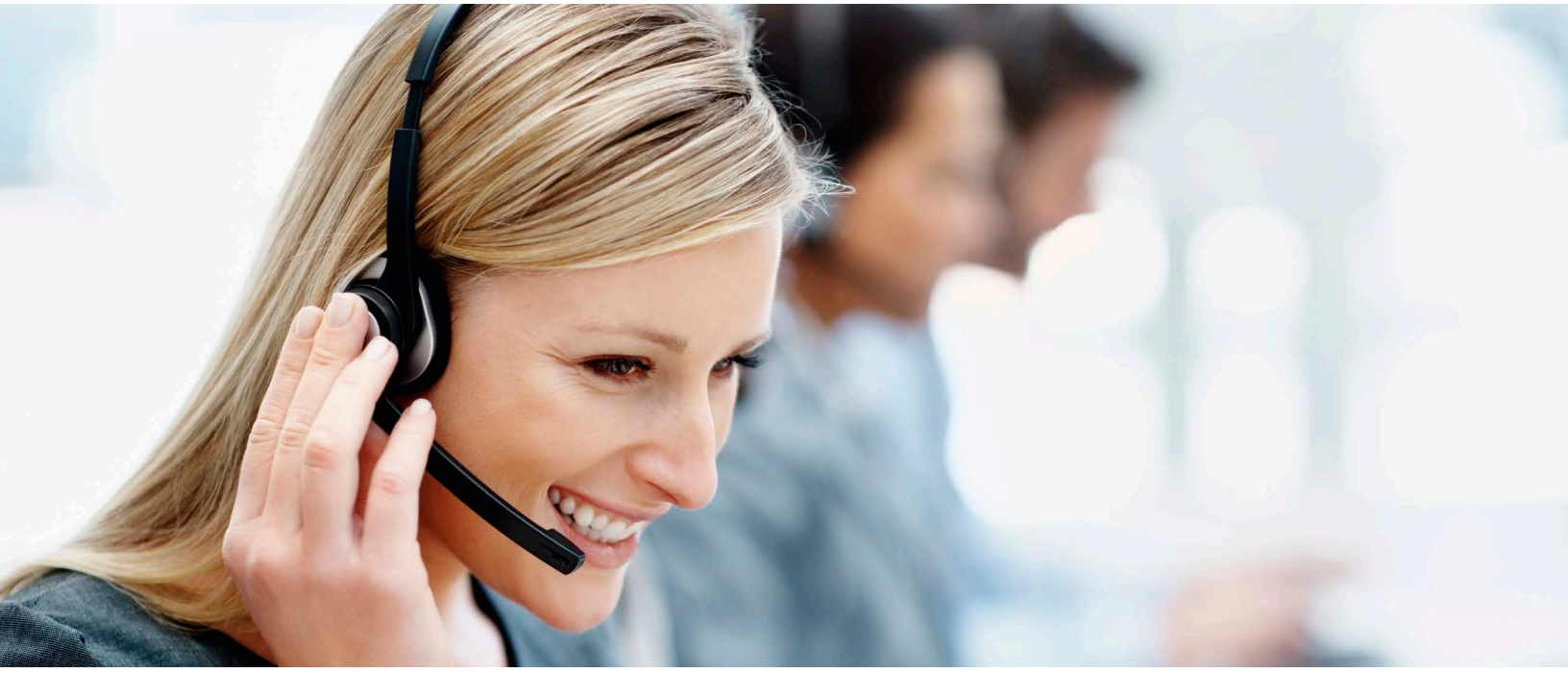
You can make your phone interview even smoother and simpler by completing the worksheet on the next few pages before your call. It ensures you'll have easy access to the detailed health and financial information you'll need during your interview.

## Here's how the Tele-App process works

1. You will receive an email from Lincoln with a link to schedule your Tele-App interview. Choose a time that's convenient for you. If no appointment is scheduled within 24–48 hours, a skilled Lincoln professional will call you to schedule your phone interview. An appointment reminder is available upon request, via text message or email.
2. Because the interview questions relate to your health history and financial information, schedule the call for a time and place that give you the privacy you need. No need to worry! We will keep your personal information confidential and secure.
3. Complete the worksheet that follows to ensure interview accuracy. It's for your use only.
4. Our Lincoln associate will call you at your scheduled time. The interview will take about 20 to 40 minutes and is conducted in English only. Have your completed worksheet ready.
5. After your interview, a paramed service will contact you to schedule labs, if required.

## Take charge with a fast, convenient phone interview process.

Complete the worksheet — it can save you time and promotes accuracy.





Insurance products issued by:
The Lincoln National Life Insurance Company

# Preinterview worksheet

Use a separate sheet of paper if there is not enough room in the space provided.

**Important numbers**

| | | | |
|---|---|---|---|
| Your Social Security number | | Your driver's license number | |

**Financial information**

| Your annual earned income | Other recurring income | Your net worth (assets minus liabilities) |
|---|---|---|
| | | |

| **Beneficiary(ies)** | Primary beneficiary (1) | Primary beneficiary (2) | Contingent beneficiary |
|---|---|---|---|
| Name | | | |
| Date of birth | | | |
| Address | | | |
| Phone number | | | |
| Email address | | | |
| SSN or TIN | | | |
| Relationship | | | |
| Trust name | | | |
| Trustee name | | | |
| Date of trust | | | |
| Share percentage (total must equal 100%) | | | |

**Third party designation** (We will notify this person about a policy lapse grace period.)

| Name | Address | Phone number |
|---|---|---|
| | | |

**Existing insurance information**

List every life insurance policy and annuity contract you currently have in-force, and any life insurance or annuity you've applied for, but have not yet been issued.

| Company name | Policy number | Issue date | Face amount | Replacing |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |

**Additional owner information**

| | |
|---|---|
| If you are not the owner of the policy, provide the SSN or TIN of the individual, entity or trust that will own the policy. | Number |
| If the owner of the policy is a trust, provide the name and date of the trust. | Name |
| | Date |
| Policyowner email address | |

### Physical stature

| Height | | Weight | |
|---|---|---|---|

### Medical information

Provide the following information about any doctors you have seen.

| Name of your primary care physician | Complete mailing address | Phone number | Date of last visit | Reason(s) for visit |
|---|---|---|---|---|
| | | | | |

| Names of other doctors you've seen | Complete mailing address | Phone number | Date of last visit | Reason(s) for visit |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

### Medical tests

List any medical tests you've had, along with the following supporting information.

| Name/type of test | Date of test | Result of test (if known) | Who has the results? |
|---|---|---|---|
| | | | |
| | | | |

### Hospitals and medical facilities

Provide the following information about hospital or medical facility admissions.

| Name and complete mailing address of the hospital/medical facility | Phone number | Date of admission(s) | Reason for admission(s) | Name of doctor (attending MD) who may have the records |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

### Family medical history

| Have any of your parents or siblings died due to coronary disease, heart attack or stroke before age 65? | ☐ Yes ☐ No | If so, what was the age of death? | |
|---|---|---|---|

### Medications and/or supplements

Provide the following information about prescription medication and/or supplements you are currently taking.

| Prescription name | Dosage and frequency | Who prescribed this medication? | Reason prescribed |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

**If you have any of the conditions listed, please be prepared to provide the following information.**

| | | | |
|---|---|---|---|
| Asthma | | | |
| Date of diagnosis | Have you been diagnosed with status asthmaticus? ☐ Yes ☐ No | Frequency of symptoms | Do you require oral steroids? ☐ Yes ☐ No |
| Crohn's disease | | | |
| Date of diagnosis | Did you require surgical treatment? ☐ Yes ☐ No | Did you require hospitalization for this condition? ☐ Yes ☐ No | Did you require steroids or immunosuppressants? ☐ Yes ☐ No |
| Diabetes | | | |
| Date of diagnosis | Provide most recent A1C result. | Complications from diabetes? | Type of treatment |
| Hypertension (high blood pressure) | | | |
| Date of diagnosis | Did you require hospitalization for this condition? ☐ Yes ☐ No | Complications from high blood pressure? | Type of treatment |
| Multiple sclerosis | | | |
| Date of diagnosis | Do you have limitations on activities of daily living? ☐ Yes ☐ No | Complications from multiple sclerosis? | Type of treatment |
| Seizure disorder | | | |
| Date of diagnosis | Did you require hospitalization for this condition? ☐ Yes ☐ No | Frequency of seizures/date of last seizure | Type of treatment |
| Sleep apnea | | | |
| Date of diagnosis | Did you require surgical treatment? ☐ Yes ☐ No | If CPAP is required? ☐ Yes ☐ No / How often? | Did you have follow-up sleep studies? ☐ Yes ☐ No |
| Ulcerative colitis | | | |
| Date of diagnosis | Did you require surgical treatment? ☐ Yes ☐ No | Dates of colonoscopies | Did you require steroids or immunosuppressants? ☐ Yes ☐ No |

**Hobbies, avocations, and aviation activity**
We will be asking you for details on your hobbies and other avocations (including aviation activities). Provide the following details for each hobby or avocation you engage in. After reviewing your responses, we may have some follow-up questions.

**Hobbies/avocations** (any type of racing, scuba diving, skydiving, hang gliding, etc.)

| | | |
|---|---|---|
| Activity | | |
| Number of hours performed in the last 12 months | | |
| Number of hours expected in the next 12 months | | |
| Certifications/licenses held | | |
| Location of activity performed | | |
| Speeds, depths,heights attained | | |

**Aviation**

| | | | |
|---|---|---|---|
| Type of aircraft flown | | License(s) held | |
| | | | |
| Are you a student pilot? | Total hours flown solo | Total hours expected to fly in the next 12 months | Are you qualified under Instrument Flight Rules (IFR)? |
| ☐ Yes ☐ No | | | ☐ Yes ☐ No |

| |
|---|
| Not a deposit |
| Not FDIC-insured |
| Not insured by any federal government agency |
| Not guaranteed by any bank or savings association |
| May go down in value |



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Tele-App is not available in the state of New York.