



Please check the appropriate servicing address of the underwriting company:

- Lincoln Life & Annuity Company of New York, Life Service Office: PO Box 21008, Greensboro, NC 27420-1008
- Lincoln Life & Annuity Company of New York, Annuity Service Office: PO Box 2348, Fort Wayne, IN 46801-2348 (hereinafter referred to as "the Company")

### AUTHORIZATION FOR RELEASE OF INFORMATION

I (the undersigned) authorize any licensed physician, medical practitioner, hospital, clinic or any other medically related facility, insurance support organizations, insurance company, Medical Information Bureau (MIB), or other organization, institution or person that has any records or knowledge of:

Proposed Insured/Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

or the proposed insured's health, including but not limited to transaction records, employment records, financial records, and complete medical records (including information regarding insurance, demographics, referral documents and records from other facilities) or if other, indicate here: \_\_\_\_\_

to give all such information to Lincoln Life & Annuity Company of New York (the Company), their licensed representatives and/or their reinsurers, MediConnect.net Inc, GiS, or if other, indicate here: \_\_\_\_\_

I understand that an authorization for release or disclosure of psychotherapy notes may not be combined with an authorization for release or disclosure of any other information (a separate authorization must be completed for release or disclosure of psychotherapy notes).

I understand that the information obtained may be used by the Company to determine eligibility for insurance, or to administer my coverage. The Company may not give the information to any person or entity except: 1) a reinsurer, or other insurers to whom I have applied or may apply; 2) MIB; or 3) any other person or entity who performs business or legal services in connection with the administration of my insurance coverage. I understand that some of these people or entities may not be covered by federal or state privacy regulations and that the information they receive may be redisclosed, however the Company contractually requires them to protect the information we disclose to them. Information may be disclosed as allowed by law or regulation.

I understand this consent may be revoked in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my policy with that Company. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signing. To initiate revocation of this Authorization direct all correspondence to the address above.

I understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application.

I agree that a copy of the Authorization shall be as valid as the original. I may have a copy upon request.

I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Proposed insured/patient or legal representative (Next-of-kin or legal guardian to sign only if patient is a minor, legally incompetent, or deceased))

Relationship to proposed insured/patient of personal/legal representative signing for proposed insured/patient: \_\_\_\_\_



# Lincoln Life & Annuity Company of New York

Life Service Office: PO Box 21008, Greensboro, NC 27420-1008 • (800) 487-1485

## AUTHORIZATION TO DISCLOSE POLICY INFORMATION

### Letter of Notification:

In accordance with New York Insurance Department Regulation 60, please furnish the information needed for completing the enclosed Disclosure Statement.

Please forward the information to:

Agent or Broker's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Agent or Brokers's Telephone Number: \_\_\_\_\_ Agent or Brokers's Fax Number: \_\_\_\_\_

I authorize the release of information on the below mentioned policy(ies), as is needed to complete New York's required Disclosure Statement. This authorization is valid until revoked by me in writing.

1) _____	_____	_____
Policyowner's Signature	Date	Print Name of Policyowner
_____	_____	_____
Address	Policy Owner Date of Birth	SSN
_____	_____	_____
City	State	Zip Code

2) _____	_____	_____
Policyowner's Signature	Date	Print Name of Policyowner
_____	_____	_____
Address	Policy Owner Date of Birth	SSN
_____	_____	_____
City	State	Zip Code

### Replaced Company Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Replaced Policy(ies) Information:

Replaced Policy No. 1: \_\_\_\_\_ Replaced Policy No. 2: \_\_\_\_\_

Replaced Policy No. 3: \_\_\_\_\_ Replaced Policy No. 4: \_\_\_\_\_

Note to Agent or Broker: Provide one copy each to the replacing insurer identified at the top of this form, the policy owner, and for each replaced company identified at the bottom of this form.

**GA CHANNEL MONEYGUARD® RESERVE TICKET**

**INSURED INFORMATION**

First Name: \_\_\_\_\_ MI \_\_\_\_ Last Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Address \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Gender:  Male  Female  Smoker or  Non-Smoker Date of Birth: \_\_\_\_\_

**INSURED CONTACT INFORMATION - (This Information Will Be Critical To Complete The Underwriting Process!!)**

Primary Phone Number: \_\_\_\_\_ ext. \_\_\_\_\_ Secondary Phone Number: \_\_\_\_\_

**CONTRACT INFORMATION**

**NOTE: Policy will be issued if approved with Specified Amount, Premium amount and frequency, Inflation Option, Benefit Duration and Non-Fortetiture Benefit Option as indicated on illustration or simplified quote accompanying this ticket.**

Contract State: \_\_\_\_\_  
 Owner (if not Insured): \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Primary Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Contingent Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_

Use additional page to list additional owner/beneficiary information.

**Policy Dating: Note - Insured's Issue Age Will Be Determined By Age On The Date The Ticket Is Received By Lincoln**

**INFORCE COVERAGE/REPLACEMENT INFORMATION - (Required State Replacement Paperwork Must Be Submitted With Ticket along with inforce illustration or simplified quote. Needs to be completed if client is replacing ANY kind of coverage or will be taking funds from another policy to pay the premium on the MoneyGuard Reserve contract. State Replacement form must be completed for all NAIC states even when insurance is not being replaced.)**

Please list below all existing life insurance policies, long term care policies and annuity contracts in force. Use additional page if necessary. **If client has no existing coverage, please proceed to the next section.**

Replacement or Change of Policy?	1035 Exchange?	Company	Policy Number	Face Amount	Issue Date
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				

**GA/Writing Agent INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ SSN/TIN: \_\_\_\_\_ Split % \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ SSN/TIN: \_\_\_\_\_ Split % \_\_\_\_\_  
 First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ SSN/TIN: \_\_\_\_\_ Split % \_\_\_\_\_

**Primary Case Contact:** \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**NOTE: We will send all correspondence concerning this case to the address listed below. This includes where the policy is sent for the GA/Writing Agent to deliver to the client.**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**GA associated with this business (if applicable):** \_\_\_\_\_

I certify that my client has answered the Pre-Screening questions and to the best of my knowledge he/she is a good candidate for MoneyGuard Reserve. In addition, I certify that I have presented my client with the Outline of Coverage (Required Disclosure Statement in NY) and Simplified Quote (Single Premium Only) or a fully signed illustration. If I have not submitted premium and TIA or replacement paperwork, my client and I have identified funds to purchase MoneyGuard Reserve and I have received authorization to move funds if my client is approved for coverage.

\_\_\_\_\_  
 Signature of Agent Date

**FOR AGENT BROKER USE ONLY. NOT TO BE USED WITH THE PUBLIC.**

# Lincoln *MoneyGuard*® Reserve

## Personal History Interview Instructions

Instructions should be left with the client to prepare for the Personal History Interview. This information DOES NOT need to be sent back to Lincoln!

Dear valued prospective Lincoln *MoneyGuard* Reserve client:

Preparing in advance for your telephone interview will expedite the interview process. Please complete the Pre-interview worksheet (immediately following this section) prior to your interview. Please allow at least 45 minutes to complete the interview. It will be beneficial for you to be in a place where you are alone and free from distractions.

If you are taking medication, please have your prescription bottles handy for the interview process, so that it will be easy for you to provide the name and dosage of the medication.

Please be prepared to confirm your Social Security number, and the Social Security numbers or tax I.D. numbers of the individuals/entities that will be the owner and beneficiary(ies).

Also, please be ready to confirm your existing life insurance policy information. We'll verify company names, coverage amounts, dates of issue, and if you are replacing the policies, the policy numbers.

You will be asked about your medical history including diagnoses, symptoms, and conditions for which you are or have been treated. Be sure you are prepared to give detailed information about your health.

This interview will require your participation in a series of memory exercises. The outcome of your application will be based on the information given during this interview only. Be sure you take your time and give it your full attention. Lincoln will not contact your doctor or access your medical records in order to make an underwriting offer.

We look forward to our upcoming conversation and thank you for applying for Lincoln *MoneyGuard* Reserve.

Lincoln Financial Group

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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[www.LincolnFinancial.com](http://www.LincolnFinancial.com)

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Affiliates are separately responsible for their own financial and contractual obligations.

LCN0909-2033987

LIF-MGR-09-0008

MGR-PHI-BRC001\_Z01

PEM 9/09 Z01

Order code: MGR-PHI-BRC001



Hello future.®

## Preinterview worksheet

### Important numbers

Your Social Security number

### Additional owner information

If you are not the owner of the policy, please provide the Tax ID or the Social Security number of whoever the owner will be.

Number

### Existing life insurance information

Please list every life insurance policy you currently have in-force AND any life insurance you've applied for which has not yet been issued. Please use another piece of paper if there is not enough room in the space provided.

Company name	Policy number (if available)	Issue date	Face amount

### Third party designation (to receive grace period of lapse notices)

Name	Address	Phone number

### Beneficiary(ies)

	Beneficiary (1)	Beneficiary (2)
Name		
Social Security number		
Relationship		
Trust name		
Trustee name(s)		
Date of trust		
Contingent name		
Social Security number		
Relationship		

## Medications

Please provide the following information about the prescription medication you are currently taking, including vitamins and herbal supplements.

Prescription name	Dosage and frequency
1	
2	
3	
4	
5	
6	

## Social history

Type of residence	Tobacco use	Alcohol use

## Medical history

Please list any medical conditions you have or have ever been diagnosed with. Please use a separate sheet of paper if there is not enough room in the space provided.

Condition	Date of diagnosis	Symptoms	Type and date of treatment	Tests done and results	Date of last doctor visit
1					
2					
3					

Have you had to alter any of your daily activities? Please check Yes or No.

Do you need assistance with:

Cooking  Yes  No

Continence  Yes  No

Dressing  Yes  No

Yard work  Yes  No

Shopping  Yes  No

Cleaning  Yes  No

Carrying groceries  Yes  No

Do you participate in any recreational activities? If so, what are they?

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If you have any of the following conditions, please be ready to provide the following information.

Breast cancer	Size of tumor	Stage	Lymph node involvement	Type of treatment	
Prostate cancer	Pretreatment PSA	Gleason score	Stage	Type of treatment	Posttreatment PSA
Colon cancer	Dukes staging	Lymph node involvement			
Diabetes	Age of diagnosis	Type of treatment	Fasting blood glucose	Blood HgA1C	Confirmation of any of the following: retinopathy, neuropathy, nephropathy
Coronary heart disease	Bypass surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	How many vessels	Angioplasty with or without stent <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No	Last stress test and results

**Important disclosures. Please read.**

Lincoln *MoneyGuard*<sup>®</sup> Reserve is a universal life insurance policy with a rider that accelerates the specified amount of death benefit to pay for covered long-term care expenses. The cost of riders will be deducted from the policy value. **Guarantees are backed by the claims-paying ability of the issuer and are subject to policy terms and conditions.** The insurance policy and riders have limitations, exclusions, and/or reductions.

Lincoln *MoneyGuard*<sup>®</sup> Reserve is issued by The Lincoln National Life Insurance Company, Fort Wayne, IN, on Policy Form LN850 (8/05) with a Convalescent Care Benefits Rider (CCBR) on Rider Form LR851 (8/05). **The Lincoln National Life Insurance Company does not solicit business in the state of New York, nor is it authorized to do so. Contractual obligations are backed by the claims-paying ability of The Lincoln National Life Insurance Company.**

Policies sold in New York are issued by Lincoln Life & Annuity Company of New York, Syracuse, NY, on Policy Form LN850 (8/05) with a Convalescent Care Benefits Rider on Rider Form LR851 (8/05). **Contractual obligations are backed by the claims-paying ability of Lincoln Life & Annuity Company of New York.**

Products and features, including benefits, exclusions, limitations, terms, and definitions, may vary by state.

## MONEYGUARD® RESERVE PRE-QUALIFYING TOOL

Clients who have not been previously declined for long-term care coverage (by Lincoln or any other carrier) and can answer “NO” to ALL of the following questions are good candidates for *MoneyGuard*®. All others should be directed to alternative solutions.

(Note: This form is to be used as a reference for you and does not need to be submitted to Lincoln.)

<b>Has your client ever been diagnosed with:</b>	<b>YES</b>	<b>NO</b>
Alzheimer’s Disease or Dementia, or taking any medication for memory loss?	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema, chronic obstructive pulmonary disease (COPD) or congestive heart failure?	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson’s Disease, Multiple Sclerosis or Muscular Dystrophy?	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis or taking methotrexate, prednisone, enbrel or remicade for joint pain?	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis that is untreated or with a history of compression fractures or height loss of two inches or more?	<input type="checkbox"/>	<input type="checkbox"/>
A Stroke or Transient Ischemic Attack (TIA) within the last 24 months or heart attack, heart or carotid artery surgery within the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (other than non-melanoma skin cancer) within the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
Type 1 diabetes?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Is your client:</b>	<b>YES</b>	<b>NO</b>
Currently being treated for a medical condition or having medical treatment, a pending consult or surgery recommended but not yet completed?	<input type="checkbox"/>	<input type="checkbox"/>
On dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
Using Oxygen for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
The recipient of an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Does your client:</b>	<b>YES</b>	<b>NO</b>
Use a cane of any variety, walker or wheelchair on a regular or intermittent basis?	<input type="checkbox"/>	<input type="checkbox"/>
Take any narcotic drug or prescription pain medication on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
Have an implantable defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>
Currently collect disability benefits?	<input type="checkbox"/>	<input type="checkbox"/>
Have a handicap parking permit?	<input type="checkbox"/>	<input type="checkbox"/>

**Clients who can answer “No” to all questions are good candidates for MoneyGuard Reserve.**

NOTE: If your client has any surgery scheduled in the next two months, or if he/she has recently been advised to have surgery, you should wait to submit the case until the client is at least three months post-operation, fully recovered, back to 100% full activity, and released from doctors’ care.

**REGULATION 60 - APPENDIX 11**  
**INSURANCE DEPARTMENT OF THE STATE OF NEW YORK**  
**DEFINITION OF REPLACEMENT**

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

- (1) LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED?

YES \_\_\_\_ NO \_\_\_\_

- (2) CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES?

YES \_\_\_\_ NO \_\_\_\_

- (3) CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE?

YES \_\_\_\_ NO \_\_\_\_

- (4) REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES?

YES \_\_\_\_ NO \_\_\_\_

(5) ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES?

YES \_\_\_ NO \_\_\_

(6) CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID?

YES \_\_\_ NO \_\_\_

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE DEPARTMENT REGULATION No. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH A COMPLETED DISCLOSURE STATEMENT AND THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

DATE: \_\_\_\_\_

SIGNATURE OF APPLICANT: \_\_\_\_\_

PRINT APPLICANT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE OF APPLICANT: \_\_\_\_\_

PRINT APPLICANT NAME: \_\_\_\_\_

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION:

YES \_\_\_ NO \_\_\_

DATE: \_\_\_\_\_

SIGNATURE OF AGENT  
OR BROKER: \_\_\_\_\_

PRINT AGENT  
OR BROKER NAME: \_\_\_\_\_