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.

FAX TO: (860) 466-3010 **OR**
OVERNIGHT TO:
MoneyGuard Streamlined Underwriting Unit
350 Church St.
Hartford, CT 06103

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-Forteiture 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
☐ Yes ☐ No	☐ Yes ☐ No				
☐ Yes ☐ No	☐ Yes ☐ 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 *MoneyGuar*d 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

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

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?

____

____

____

____

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 ☐ Yes ☐ No	How many vessels	Angioplasty with or without stent ☐ Yes ☐ No	Heart attack ☐ Yes ☐ No	Last stress test and results

Important disclosures. Please read.

Lincoln *MoneyGuard*® 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*® 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.

Lincoln Financial Group®

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.)

Has your client ever been diagnosed with:	**YES**	**NO**
Alzheimer's Disease or Dementia, or taking any medication for memory loss?	☐	☐
Emphysema, chronic obstructive pulmonary disease (COPD) or congestive heart failure?	☐	☐
Parkinson's Disease, Multiple Sclerosis or Muscular Dystrophy?	☐	☐
Rheumatoid Arthritis or taking methotrexate, prednisone, enbrel or remicade for joint pain?	☐	☐
Osteoporosis that is untreated or with a history of compression fractures or height loss of two inches or more?	☐	☐
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?	☐	☐
Cancer (other than non-melanoma skin cancer) within the last 6 months?	☐	☐
Type 1 diabetes?	☐	☐

Is your client:	**YES**	**NO**
Currently being treated for a medical condition or having medical treatment, a pending consult or surgery recommended but not yet completed?	☐	☐
On dialysis?	☐	☐
Using Oxygen for any reason?	☐	☐
The recipient of an organ transplant?	☐	☐

Does your client:	**YES**	**NO**
Use a cane of any variety, walker or wheelchair on a regular or intermittent basis?	☐	☐
Take any narcotic drug or prescription pain medication on a regular basis?	☐	☐
Have an implantable defibrillator?	☐	☐
Currently collect disability benefits?	☐	☐
Have a handicap parking permit?	☐	☐

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.

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REGULATION 60 - APPENDIX 10C
INSURANCE DEPARTMENT OF THE STATE OF NEW YORK

IMPORTANT NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS

THIS NOTICE IS FOR YOUR BENEFIT AND REQUIRED BY REGULATION NO. 60

YOU ARE CONTEMPLATING THE PURCHASE OF A LIFE INSURANCE POLICY OR ANNUITY CONTRACT IN CONNECTION WITH THE SURRENDER, LAPSE OR CHANGE OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS. THE AGENT OR BROKER IS REQUIRED TO GIVE YOU THIS NOTICE TOGETHER WITH A SIGNED DISCLOSURE STATEMENT CONTAINING THE SUMMARY RESULT COMPARISON FOR THE NEW LIFE INSURANCE POLICY OR ANNUITY CONTRACT AND ANY LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS TO BE CHANGED THAT SETS FORTH THE FACTS OF THE TRANSACTION AND ITS ADVANTAGES AND DISADVANTAGES TO YOU. YOUR DECISION COULD BE A GOOD ONE - OR A MISTAKE - SO MAKE SURE YOU UNDERSTAND THE FACTS. YOU SHOULD:

1. CAREFULLY STUDY THE DISCLOSURE STATEMENT, WHICH INCLUDES A SUMMARY RESULT COMPARISON, UNTIL YOU ARE SURE YOU UNDERSTAND FULLY THE EFFECT OF THE TRANSACTION.
2. ASK THE COMPANY, AGENT OR BROKER FROM WHOM YOU BOUGHT YOUR EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS TO REVIEW WITH YOU THE TRANSACTION AND THE DISCLOSURE STATEMENT. YOU MAY BE ABLE TO EFFECT THE CHANGES YOU DESIRE MORE ADVANTAGEOUSLY WITH THEM. THEIR CUSTOMER SERVICE TELEPHONE NUMBER IS CONTAINED IN THE DISCLOSURE STATEMENT.
3. CONSULT YOUR TAX ADVISOR. THERE MAY BE UNFAVORABLE TAX IMPLICATIONS ASSOCIATED WITH THE CONTEMPLATED CHANGES TO YOUR EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

As a general rule, it is often not advantageous to drop or change existing coverage in favor of new coverage, whether issued by the same or a different insurance company. Some of the reasons it may be disadvantageous are:

1. The amount of the annual premium under an existing life insurance policy may be lower than that called for by a new life insurance policy having the same or similar benefits. Any replacement of the same type of policy will normally be at a higher premium rate based upon the insured's then attained age.
2. Since the initial costs of a life insurance policy are charged against the cash value increases in the earlier life insurance policy years, the replacement of an old life insurance policy by a new one results in the policyholder sustaining the burden of these costs twice. Annuity contracts usually contain provision for surrender charges, therefore a replacement involving annuity contracts may result in the imposition of surrender charges.
3. The incontestable and suicide clauses begin anew in a new life insurance policy. This could result in a claim being denied under the new life insurance policy that would have been paid under the life insurance policy that was replaced.
4. An existing life insurance policy or annuity contract often has more favorable provisions than a new life insurance policy or annuity contract in areas such as loan interest rate, settlement options, disability benefits and tax treatment.

5. There may have been changes in your health since the purchase of the existing coverage.
6. The insurance company with which you have existing coverage can often make a desired change on terms that would be more favorable than if you replaced existing coverage with new coverage.

YOU HAVE THE RIGHT, WITHIN 60 DAYS FROM THE DATE OF DELIVERY OF A NEW LIFE INSURANCE POLICY OR ANNUITY CONTRACT, TO RETURN IT TO THE INSURER AND RECEIVE AN UNCONDITIONAL FULL REFUND OF ALL PREMIUMS OR CONSIDERATIONS PAID ON IT, OR IN THE CASE OF A VARIABLE OR MARKET VALUE ADJUSTMENT POLICY OR CONTRACT, A PAYMENT OF THE CASH SURRENDER BENEFITS PROVIDED UNDER THE POLICY OR CONTRACT, PLUS THE AMOUNT OF ALL FEES AND OTHER CHARGES DEDUCTED FROM GROSS CONSIDERATIONS OR IMPOSED UNDER THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, AND MAY HAVE THE RIGHT TO REINSTATE OR RESTORE ANY LIFE INSURANCE POLICIES AND ANNUITY CONTRACTS THAT WERE SURRENDERED, LAPSED OR CHANGED IN THE TRANSACTION TO THEIR FORMER STATUS TO THE EXTENT POSSIBLE AND IN ACCORDANCE WITH THE INSURER'S PUBLISHED REINSTATEMENT RULES TO THE EXTENT SUCH RULES ARE NOT INCONSISTENT WITH THE PROVISIONS OF THIS PART.

IMPORTANT: THIS RIGHT SHOULD NOT BE VIEWED AS REINSTATING OR RESTORING YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT TO THE SAME CONDITION AS IF IT HAD NEVER BEEN REPLACED. THERE MAY BE CONSEQUENCES IN REINSTATING OR RESTORING YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT, INCLUDING BUT NOT LIMITED TO:

- THE RIGHT TO REINSTATE OR RESTORE YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT APPLIES ONLY TO COMPANIES SUBJECT TO NEW YORK INSURANCE LAWS;
- YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT IS SUBJECT TO YOUR SPECIFIC COMPANY'S REINSTATEMENT RULES, WHICH MAY VARY FROM COMPANY TO COMPANY. THESE RULES MAY REQUIRE PAYMENT OF BOTH PREMIUM AND INTEREST; HOWEVER, YOU WILL NOT BE SUBJECT TO EVIDENCE OF INSURABILITY, OR A NEW CONTESTABLE OR SUICIDE PERIOD;
- YOU MAY NOT RECEIVE THE INTEREST OR INVESTMENT PERFORMANCE DURING THE PERIOD THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT WAS REPLACED; AND
- THERE MAY BE UNFAVORABLE FEDERAL INCOME TAX CONSEQUENCES AS A RESULT OF THE REINSTATEMENT OF YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT.

IMPORTANT: IN THE CASE OF A VARIABLE OR MARKET VALUE ADJUSTMENT POLICY OR CONTRACT, THE VALUE OF THE POLICY OR CONTRACT MAY INCREASE OR DECREASE DURING THE 60 DAY PERIOD DEPENDING ON THE PERFORMANCE OF THE UNDERLYING INVESTMENTS, WHICH MAY EFFECT THE VALUE OF THE REFUND YOU RECEIVE.

I HEREBY ACKNOWLEDGE THAT I READ THE ABOVE "IMPORTANT NOTICE" AND HAVE RECEIVED A COPY OF SAME.

DATE:_______________ SIGNATURE OF APPLICANT:____________________________

PRINT APPLICANT NAME: ______________________________

DATE:____________________ SIGNATURE OF APPLICANT:______________________________

PRINT APPLICANT NAME: ______________________________

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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:_______________________________________

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REGULATION 60 — APPENDIX 10A
INSURANCE DEPARTMENT OF THE STATE OF NEW YORK
DISCLOSURE STATEMENT

IMPORTANT - IT MAY NOT BE IN YOUR BEST INTEREST TO SURRENDER, LAPSE, CHANGE OR BORROW FROM EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS IN CONNECTION WITH THE PURCHASE OF A NEW LIFE INSURANCE POLICY OR ANNUITY CONTRACT WHETHER ISSUED BY THE SAME OR A DIFFERENT INSURANCE COMPANY. YOU ARE URGED TO CONTACT YOUR EXISTING AGENT OR BROKER OR INSURANCE COMPANY PRIOR TO COMPLETING THE TRANSACTION. THEY CAN HELP YOU DECIDE WHETHER THE REPLACEMENT IS IN YOUR BEST INTEREST.

FOR YOUR PROTECTION, the Insurance Department of the State of New York requires that you be given this Disclosure Statement, the IMPORTANT Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts and the Definition Of Replacement, together with policy information on all proposed and existing coverage affected.

Name of Applicant(s) ______________________ Telephone Number ______________________

Address ____

Name of Agent or Broker ______________________ Telephone Number ______________________

Agent or Broker's Address ____

The Information On Existing Coverage On This Form Was Obtained From:

☐ The following replaced company(ies): ______________________

☐ Approximations if the following replaced company(ies) failed to provide information in the prescribed time: ______________________

DISCLOSURE STATEMENT CONTINUED:

1. DESCRIPTION OF TRANSACTION:

Proposed Policy/Contract		Existing Policies/Contracts Affected (1)	(2)	(3)
		As of ________	As of ________	As of ________
________	Company Name	________	________	________
________	Customer Service Phone Number:	________	________	________
	Contract Number	#________	#________	#________
	Issue Date	________	________	________
________	Type of Insurance	________	________	________
$________	Base Policy Face Amount	$________	$________	$________
________	Rider ________	________	________	________
________	Rider ________	________	________	________
________	Rider ________	________	________	________
________	Rider ________	________	________	________
________	Rider ________	________	________	________
$________	Total Annualized Premium	$________	$________	$________
________	Current Surrender Charge	$________	$________	$________
________%	Guaranteed Interest Rate	________%	________%	________%
________%	Current Loan Interest Rate	________%	________%	________%
________	Current Loan Balance	________	________	________
________	Contestable Expiry Date	________	________	________
________	Suicide Expiry Date	________	________	________

DISCLOSURE STATEMENT CONTINUED:

Existing coverage to be changed by:

	(1)	(2)	(3)
Lapse or Surrender	☐	☐	☐
Amendment or Reissue	☐	☐	☐
Loan or Withdrawal	☐	☐	☐
Death Benefit Reduction To	$__________	$__________	$__________
Reduced Paid-Up For	$__________	$__________	$__________
Extended Term to	__________	__________	__________
Other	__________	__________	__________
Cash released by change	Year ____ $__________	$__________	$__________
	Year ____ $__________	$__________	$__________
	Year ____ $__________	$__________	$__________

Use of cash released: ____

2. SUMMARY RESULT COMPARISON:

Proposed With Existing Coverage Changed			Existing Coverage Unchanged	
Guaranteed	Non-Guaranteed		Guaranteed	Non-Guaranteed
		Annualized Premium		
$__________	$__________	Current Year	$__________	$__________
$__________	$__________	5 Years Hence	$__________	$__________
$__________	$__________	10 Years Hence	$__________	$__________
		Surrender Value		
$__________	$__________	End of 1st Year	$__________	$__________
$__________	$__________	5 Years Hence	$__________	$__________
$__________	$__________	10 Years Hence	$__________	$__________

DISCLOSURE STATEMENT CONTINUED:

Proposed With Existing Coverage Changed			Existing Coverage Unchanged	
Guaranteed	Non-Guaranteed		Guaranteed	Non-Guaranteed
		Death Benefit		
$________	$________	End of 1st Year	$________	$________
$________	$________	5 Years Hence	$________	$________
$________	$________	10 Years Hence	$________	$________
		Dividends		
	$________	End of 1st Year		$________
	$________	5 Years Hence		$________
	$________	10 Years Hence		$________

AGENT OR BROKER'S STATEMENT:

1. The primary reason(s) for recommending the new life insurance policy or annuity contract is (are):

____

____

2. The existing life insurance policy or annuity contract cannot meet the applicant's objectives because:

____

____

3. The advantages of continuing the existing life insurance policy or annuity contract without changes are:

____

____

DISCLOSURE STATEMENT CONTINUED:

REMARKS ____

____

____

☐ The attached proposal, including sales material, was used in this sale.
☐ No proposal or sales material was used in this sale.

If more than three existing life insurance policies or annuity contracts are to be affected by this transaction or if more than one new life insurance policy or annuity contract is proposed, Section 1 of this Disclosure Statement must be completed for such additional life insurance policies and annuity contracts. In addition, a composite comparison shall be completed of all existing life insurance policies or annuity contracts to all proposed life insurance policies or annuity contracts. The proposal, including sales material used in the sale of the proposed life insurance policy or annuity contract, must accompany the submission of this form to the insurer. Copies must be given to the applicant.

I have personally completed this form and certify that it is correct to the best of my knowledge and ability.

Date: ______________________________ Signature of Agent or Broker: ______________________________

I hereby acknowledge that I received and read the above Disclosure Statement before I signed the application for the new coverage.

Date: ______________________________ Signature of Applicant: ______________________________

Date: ______________________________ Signature of Applicant: ______________________________