



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")

Alcohol Use Supplement

Proposed Insured Name (print name): _____ Date of Birth (mm/dd/yy): _____

1. Do you presently use alcoholic beverages? Yes No If "No," date of last drink: _____
If "Yes," please indicate quantity:

	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

2. Did you ever drink substantially more than at present? Yes No
If "Yes," during what time period? Dates From _____ To _____
Please indicate quantity:

	Beer	Wine	Liquor
Daily			
Weekly			
Monthly			

Why did you change your drinking habits?

3. Are you active in Alcoholics Anonymous or other recovery groups? Yes No How Long: _____

4. Have you ever consulted a licensed medical professional or received treatment because of you alcohol use? Yes No
If "Yes," indicate name and address of any licensed medical professional, hospital or treatment center and dates of treatment:

5. Are you presently taking, or have you ever taken Antabuse or any other medication to control your drinking? Yes No
If "Yes," indicate date of last use and name of the licensed medical professional who prescribed it:

6. In the past 5 years have you been convicted of driving under the influence of alcohol? Yes No
If "Yes," give dates and drivers license number:

7. Have you ever used any other drugs, except over the counter drugs or those prescribed by a licensed medical professional? Yes No (If answered "Yes," please complete the Drug Usage Supplement.)

8. Please indicate any additional relevant information:

I have read or have had read to me the completed Alcohol Use Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete and true to the best of my knowledge and belief. I agree that this Alcohol Use Supplement constitutes a part of my 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 _____ (city, state) (month) (year)

Signature of Proposed Insured
(Signature of Parent or Guardian if under 18 years of age)

Signature of Licensed Agent, Broker or Registered Representative

Printed Name of Licensed Agent, Broker or Registered Representative

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