Good Health Statement and Insurability Supplement

Please check appropriate underwriting company:

☐ **The Lincoln National Life Insurance Company:** PO Box 21008, Greensboro, NC 27420-1008
☐ **Lincoln Life & Annuity Company of New York:** PO Box 21008, Greensboro, NC 27420-1008
☐ **First Penn-Pacific Life Insurance Company:** PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as the "Company")

___________________________ /___________________________ /_________________________________ /________
Proposed Insured Name: *(First)* *(Middle)* *(Last)* *(Suffix)*

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

If any question below is answered "Yes," you must provide details in Number 4, and no representative of the Company is authorized to deliver the Policy* or collect any premium without prior approval from the underwriter at the Company.

1. Since the date of your signed application and/or completed telephonic or electronic application that is made a part of the Policy:	**Proposed Insured**
a. Has an application for life, long-term care, health or disability insurance been taken on your life with any other insurance company or has any life, long-term care, health or disability insurance on your life been reinstated, declined, postponed or modified?	☐ Y ☐ N
b. Have you participated in any previously un-admitted activities including; aviation; underwater diving; mountain climbing; aerial sports; auto, motorcycle or boat racing; heli-skiing; rodeo sports; equine sports; BASE jumping or wingsuit flying; canyoning; highlining/tricklining; Parkour or Rooftopping; Speedflying; boxing, kickboxing, Muay Thai or MMA/Cage Fighting?	☐ Y ☐ N
c. Have you been convicted of, or are you awaiting trial for, a motor vehicle violation or a criminal offense?	☐ Y ☐ N
2. Within the past five years, have you received any treatment by a licensed medical professional for any illness or injury, been examined by or consulted with a licensed medical professional, or been advised by a licensed medical professional to seek treatment for any reason **not previously stated** in the application?	☐ Y ☐ N
3. Since the date of your most recent medical evidence submitted to the Company, have you had any change that would cause any answers and statements in the Application for Individual Life Insurance – Part I, Medical Supplement (Part II) and any additional supplements to be different from those given when you completed those forms?	☐ Y ☐ N
4. Question # Details *(If more space is needed, use the Continuation of Details Supplement.)*	

The Undersigned declares that:

I agree that this Good Health Statement and Insurability Supplement will be considered an amendment and/or supplement to my application. I have read, or have had read to me, the completed Good Health Statement and Insurability Supplement before signing below. All statements and answers in this Good Health Statement and Insurability Supplement are correctly recorded, and are full, complete and true to the best of my knowledge and belief.

I understand that if any answers provided on this Good Health Statement and Insurability 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)

____
Signature of Licensed Agent, Broker or Registered Representative

____
Printed Name of Licensed Agent, Broker or Registered Representative

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