Lincoln Financial Group®

Please check appropriate underwriting company:
☐ **Jefferson-Pilot Life Insurance Company,** Service Office: PO Box 21008, Greensboro, NC 27420-1008
☐ **Jefferson Pilot Financial Insurance Company,** Service Office: PO Box 515, Concord, NH 03302-0515
☐ **The Lincoln National Life Insurance Company,** Service Office: PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as "the Company")

GUARANTEED ISSUE APPLICATION FOR LIFE INSURANCE

PROPOSED INSURED

1. Name *(First)* *(Middle)* *(Last)* | 2. ☐ Male ☐ Female

3. Place of Birth *(State, Country)* | 4. Social Security Number *(xxx-xx-xxxx)* | 5. Date of Birth *(mm/dd/yy)*

6a. Home Address *(Street)* *(City)* *(State)* | 6b. Home Address Zip Code

7. Employer
Washtenaw Community College | 8. Citizen of (Country)

9a. Business Address *(Street)* *(City)* *(State)*
4800 East Huron River Dr. Ann Arbor MI | 9b. Business Address Zip Code
48105

COVERAGE INFORMATION

10. Plan of Insurance (If VUL also complete Question 16, Premium Allocation and Disclosure Form)

11. Additional Benefits If Available *(Please List)*:

12. Amount of Insurance (Specified Amount, if UL or VUL) $

13. (i) Death Benefit Option *(Complete for Universal Life and Variable Universal Life Product only - not required for Term and Whole Life.)*
☐ Level ☐ Increase by Cash Value ☐ Increase by Premium ☐ Increase by Premium Less Policy Factor

(ii) Death Benefit Qualification Test - For IRS purposes, premiums will be tested using the Guideline Premium Test unless ☐ Cash Value Accumulation Test is checked (not available on all products). **Cannot be changed after issue.**

14. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? ☐ Yes ☐ No
(If "Yes", please complete and sign all required replacement forms and complete Question 15.)

15. What is the total amount of all in force insurance on your life? *(Please list in the box below.)* If none, check this box: ☐

Company	Policy Number	Issue Date *(mm/dd/yy)*	Replacement or Change of Policy?	Check here if 1035Exchange
			☐ Yes ☐ No	☐
			☐ Yes ☐ No	☐
			☐ Yes ☐ No	☐
			☐ Yes ☐ No	☐

16. **Complete only if applying for Variable Life Insurance with the Company. Submit Premium Allocation and Disclosure Form for Variable Universal Life with Application:**

Suitability

	Yes	No
1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	☐	☐
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	☐	☐
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	☐	☐
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	☐	☐

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

OWNER INFORMATION ***(If left blank, Proposed Insured(s) will be owner)***

▶ **If a Trust, provide Trustee Name(s), Trust Name.**

17. Owner Name *(First, Middle, Last)*	18. Citizen of (Country)
Washtenaw Community College	

19. Owner Address

4800 East Huron River, Ann Arbor, Michigan 48105

20. Owner Social Security or Tax ID #	21. Relationship to Proposed Insured(s)	22. Trust Date *(only if Trust is Owner)*
381784300	Employer	

23. Is the policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? ☐ Yes ☐ No

BENEFICIARY DESIGNATION ***Beneficiaries share equally unless otherwise indicated.***

▶ **If a Trust, provide Trustee Name(s), Trust Name and date of Trust.**

24. Primary Beneficiary(ies):	25. Social Security or Tax ID #:	26. Relationship to Proposed Insured:
27. Contingent Beneficiary(ies):	**28. Social Security or Tax ID #:**	**29. Relationship to Proposed Insured:**

BILLING INSTRUCTIONS AS AVAILABLE PER PRODUCT

30. Planned Premium: $ _____ 31. Lump Sum: $ _____ ☐ 1035 Exchange

32. Premium Frequency: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☒ Monthly (EFT)

☐ New List Bill ☒ Existing List Bill *(provide #)* J000

☐ PDF (Complete Transmittal) ☐ Other _____

33. Premium Notices To: *(check all that apply.) (Please note we cannot bill to your agent.)*

☐ Insured at Residence ☐ Insured at Business ☐ Owner ☐ Other _____

GENERAL RISK INFORMATION

34. What is your regular occupation? _____ Indicate length of time in your regular occupation _____

35. Have you ever used tobacco or products containing nicotine? *(If "Yes", check all that apply.)* ☐ Yes ☐ No

Type: Cigarettes ☐ Cigar ☐ Pipe ☐ Chew Tobacco ☐ Snuff ☐ Nicotine Patches/ Gum ☐

Date First Used: *(month/year)*						
Date Last Used: *(month/year)*						
Amount and Frequency:						

36. Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment or business for at least 30 hours per week? ☐ Yes ☐ No

36a If you answered "No" to question 35, please give details here:

37. Special Instructions:

SERVICE OFFICE ENDORSEMENTS (Attach an additional sheet of paper, if necessary)

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, declare that my tax identification or social security number as shown is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of any amendments to the application(s) attached thereto and any supplements, all of which are required by the Company for the plan, amount and benefits applied for.
2. No agent or broker has the authority to make or modify any Company contract or to waive any of the Company's requirements.
3. I HAVE READ, or have had read to me, the completed Guaranteed Issue Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true.
4. I understand that, in order to informally fund benefit obligations, the Company may need to increase the amount of insurance under existing Policies on my life from time to time. I hereby authorize the Company to effect such an increase or increases without providing any further notice to me.
5. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
6. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Only. *Warning:* Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of insurance fraud.

Washington Only. Any person who knowingly presents a false or fraudulent claim for the payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

AR, DC, KY, ME, NM, OH and PA Only. Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

Connecticut and Texas Only. Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, as determined by a court of competent jurisdiction.

Louisiana Only. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TRUST VERIFICATION

I/WE hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

SIGNATORY SECTION

Signed in _____, this _____ day of _____ _____
(state) (month) (year)

Signature of Proposed Insured
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

TO BE COMPLETED BY AGENT ONLY

(i) Does the applicant have any existing life insurance policies or annuities? ☐ Yes ☐ No

(ii) Do you know or have you any reason to believe that replacement of insurance is involved? ☐ Yes ☐ No
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.

(iii) I declare that I asked the Proposed Insured each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of the Proposed Insured which is not fully recorded in this application.

(iv) Identify any special compensation instructions or commission schedule or ☐ Check here if there is no special commission program:

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)

APPLICABLE TO VARIABLE LIFE ONLY

I have reviewed the Application, New Account Form and Premium Allocation and Disclosure Form and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

BENEFICIARY DESIGNATION FORM
Life Insurance Company of North America

CIGNA Group Insurance
Life • Accident • Disability

Employer Name Washtenaw Community College
Employee Name _____ Employee Social Security # _____
Current Address _____ City _____ State ____ ZIP _____
Home Phone _____ Work Phone _____ *please enter all dates in mm/dd/yyyy format*

Primary and Contingent Beneficiaries – Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

Basic Term Life Insurance, Life Insurance Company of North America - Policy No. FLX-963142

Employee's Primary Beneficiary(ies):	Relationship to Employee	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**

Basic Term Life Insurance, Life Insurance Company of North America - Policy No. FLX-963142

Spouse Beneficiary(ies):	Relationship to Employee	Social Security Number	Date of Birth	% (total must equal 100%)

Basic Term Life Insurance, Life Insurance Company of North America - Policy No. FLX-963142

Child(ren)'s Beneficiary(ies):	Relationship to Employee	Social Security Number	Date of Birth	% (total must equal 100%)

Voluntary Term Life Insurance, Life Insurance Company of North America - Policy No. FLX-963142

Employee's Primary Beneficiary(ies):	Relationship to Employee	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**

Basic Accident Insurance Life Insurance Company of North America - Policy No. OK-964798

Employee's Primary Beneficiary(ies):	Relationship to Employee	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**

Note: This form is not complete without your signature. Please sign on the second page where indicated.

Voluntary Accident Insurance, Life Insurance Company of North America - Policy No. OK-964798				
Employee's Primary Beneficiary(ies):	Relationship to Employee	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship to Employee	Social Security Number	Date of Birth	% (total must equal 100%)

If you need additional space using the above format, attach a separate piece of paper with the appropriate policy number, the date, and your signature.

Community Property Laws - If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature _____ Date _____/_____/_____

Owner Signature _____ Date _____/_____/_____

GUIDELINES FOR DESIGNATION OF BENEFICIARIES

General - Please be sure to include the beneficiary's full name, social security number and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.

Minors - While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child's estate. You may want to obtain the assistance of an attorney in drafting your beneficiary designation.

Trust as Beneficiary - You may designate a trust as beneficiary, using the following form: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]."

If you wish to designate a testamentary trust as beneficiary (i.e., one created by will), you should recognize the possibility that your will which was intended to create this trust may not be admitted to probate (because it is lost, contested, or superseded by a later will). Claim payment delays can result if the beneficiary designation doesn't provide for this situation.

Life Status Changes - We recommend that you review your beneficiary designation when significant life status events occur, such as marriage, divorce, or birth of a child.

See an Attorney! The above guidelines are general and are not intended to be relied on as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation. A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous, and meets legal requirements.

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Supplementary Contact Information

This information is requested to assist us in identifying and contacting your beneficiary(ies) in the event of a claim/distribution and ensure benefits are paid out appropriately. State regulations may require benefits be paid to the State if the beneficiary cannot be located in a timely manner.

This information is in connection with the Application/Ticket dated _____

made on the life of: _____
Name(s) of Proposed Insured(s)

Owner Information

Name: Washtenaw Community College Phone: 7349733497

Name: _____ Phone: _____

Insured Information

Name: _____ Phone: _____

Name: _____ Phone: _____

Child Rider Information

Name: _____ Phone: _____
Address: _____ Social Security No.: _____

Name: _____ Phone: _____
Address: _____ Social Security No.: _____

Name: _____ Phone: _____
Address: _____ Social Security No.: _____

Name: _____ Phone: _____
Address: _____ Social Security No.: _____

Beneficiary Information

Name: _____ Date of Birth: _____ Phone: _____
Address: _____ Social Security No.: _____

Name: _____ Date of Birth: _____ Phone: _____
Address: _____ Social Security No.: _____

Name: _____ Date of Birth: _____ Phone: _____
Address: _____ Social Security No.: _____

Name: _____ Date of Birth: _____ Phone: _____
Address: _____ Social Security No.: _____