APPLICATION FOR PORTABLE GROUP TERM LIFE INSURANCE

Lincoln Life Assurance
Company of Boston

How to Apply: This form completed by the applicant, together with a check made payable to Lincoln Life Assurance company of Boston for the first premium must be received within 31 days after termination of group coverage at:

LINCOLN LIFE ASSURANCE COMPANY OF BOSTON c/o JHA Service Center   P.O. Box 7146 Portland, ME 04112

TO BE COMPLETED BY APPLICANT

I have the right to apply for a Portable Group Life Insurance Certificate under the terms of Group Life Insurance Policy Number:

1. Name (Last, First, Middle Initial)	2. Sex [ ] Male [ ] Female	3. Social Security Number
4. Home Address (Street, City, Street, Zip)		5. Date of Birth
[6. Dependent Spouse Name (Last, First, Middle Initial)]	[7. Dependent Spouse Sex [ ] Male [ ] Female]	[8. SS# and Date of Birth]
9. Date you were no longer eligible for the group life insurance:	10. What was your job with the above Employer?	11. Plan of Insurance **PORTABLE GROUP TERM LIFE**
12. Amount of insurance requested? (Must be less than or equal to the optional coverage terminated under the Group Life plan) Applicant Amount $ [Dependent Amount $]		13. How will premiums be paid? [ ] Annually [ ] Quarterly
14. Amount of premium submitted with the application? $ (See Instructions, page 3, line 13)	15. Primary Beneficiary of the Applicant (See the reverse side of this form)	16. Contingent Beneficiary of the Applicant
17. Additional Instructions:		

THE STATEMENTS ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND I AGREE THAT THEY SHALL FORM A PART OF THE CONTRACT OF INSURANCE APPLIED FOR. I UNDERSTAND THAT ANY PERSON WHO KNOWINGLY OR WITH INTNENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY , FILES A STATEMENT CONTAINING ANY FALSE, INCOMPLETE , OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

_____   _____
Signature of Applicant   Date

Upon approval of this application, a certificate of coverage will be sent directly to you at the address provided.

NOTE: Employer **MUST** complete information required on reverse side.

TO BE COMPLETED BY EMPLOYER

1. Employer (Firm Name and Division)	2. Employer's Address (Street, City, Street, Zip)	
3. Group Life Policy Number	4. Name of Person Eligible for Portable Group Term Life Insurance	5. Date of Birth (mm/dd/yy)
6. Sex [ ] Male [ ] Female	7. Date Eligibility for Group Life Insurance Ceased*	8. Amount of Optional Group Life Insurance which is terminated Applicant Amount $ [Dependent Amount $]
9. Date this Person was first Insured under the Group Life Insurance Policy	10. Reason for Termination of Person's Group Life Insurance [ ] Employment terminated or membership in an eligible class terminated [ ] Class of eligible persons terminated	
11. Employer Representative Signature		Date:

INFORMATION ABOUT BENEFICIARIES

The person(s) designated as Beneficiary on the application will receive the amount of insurance upon the death of the Applicant. The Beneficiary for Dependent Spouse coverage is the applicant listed on the reverse side of this form.

You may name more than one Primary Beneficiary if you wish. All Primary Beneficiaries who survive the applicant, will share equally in the insurance benefits.

You may name more than one Contingent Beneficiary who will receive the benefits if the Primary Beneficiary should die before you. If more than one contingent Beneficiary is named, all Contingent Beneficiaries who survive the Applicant will share equally.

When naming Beneficiaries, please follow this example:

a.	PRIMARY BENEFICIARY:	Mary	J.	Doe,	Wife
b.	CONTINGENT BENEFICIARY:	John	P.	Doe,	Son

NOTE: If a Beneficiary is a married woman, use her given name, for example "Mary J. Doe" and not "Mrs. John Doe".

If a beneficiary is not related to you, use the term "no relation" and enter the Beneficiary's address in Question 17.

NOTE: BOTH SIDES OF THIS APPLICATION MUST BE COMPLETED.