The Lincoln National Life Insurance Company
Group Insurance Service Office, P.O. Box 2616, Omaha, NE 68103-2616
Phone: 800-423-2765 Fax: 603-427-1825
Email: EOIDocuments@lfg.com

EVIDENCE OF INSURABILITY

Based on your Employee benefit selections, we need more information from you. Please complete and return this entire form to THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (the Company). We ("the Company") use this form, known as evidence of insurability, to gather additional medical information. This information helps us evaluate your application for insurance or an increased amount of insurance. The insurance that requires this form will not be effective until we send you a written approval.

Print clearly in ink. An incomplete application will delay processing.

Employer Information	
Group Name: loanDepot.com LLC	Group ID/Number: 09-LF0972
Billing Group or Location:	Sort Group:
Policy #(s):	

Reason for Application: ☐ Annual Enrollment ☐ Initial Enrollment ☐ Change in Family Status
☐ Salary or Pay Increase ☐ Late Entrant (person requesting insurance after initial eligibility)
☐ New Hire (newly eligible) ☐ Updating benefits outside enrollment period ☐ Other_____

A. Applicant Name (Employee) Insurance Information – Required.

First Name _____ MI _____ Last Name _____

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____ Birth State _____ Employee ID _____

Street Address (Include Apt. or Suite Number) _____ City _____ State _____ ZIP Code _____

Cell Phone (____) _____ Home Phone (____) _____ Work Phone (____) _____ Best Time To Call _____AM/PM

Email Address _____ Sex at Birth: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Domestic Partnership ☐ Civil Union

Employment Information: ☐ Full-Time ☐ Part-Time Employee Occupation:_____

Earnings: ☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annual $_____ Date of Hire: _____/_____/_____

Is the Employee Actively at Work? ☐ Yes ☐ No Date of Rehire: _____/_____/_____

Mark the box or boxes for each type of group insurance you are applying for and fill in the amount of insurance you are requesting. Your Employer can help you fill out this section. All insurance amounts are subject to the limitations and exclusions stated in the policy and certificate.

Type of Group Insurance	Current Amount	Additional Amount	Total Amount
☐ Basic Life (Employee)	$_____	$_____	$_____
☐ Dependent Life (Spouse or Domestic Partner)*	$_____	$_____	$_____
☐ Short-Term Disability (STD)	$_____	$_____	$_____
☐ Long-Term Disability (LTD)	$_____	$_____	$_____
☐ Voluntary Life (Employee)	$_____	$_____	$_____
☐ Voluntary Life (Spouse or Domestic Partner)*	$_____	$_____	$_____
☐ Voluntary Short-Term Disability (STD)	$_____	$_____	$_____
☐ Voluntary Long-Term Disability (LTD)	$_____	$_____	$_____
☐ Critical Illness (Employee)	$_____	$_____	$_____
☐ Critical Illness (Spouse or Domestic Partner)*	$_____	$_____	$_____

*Employee insurance is required to have dependent insurance.

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B. Applicant Dependent (Spouse, Domestic Partner, Civil Union Partner) Information. Only complete if applying for Dependent insurance. (Attach additional sheet, if needed.)

	First Name	MI	Last Name	Social Security Number	Date of Birth	Sex at Birth	Birth State
Spouse or Domestic Partner:				___-___-____	__/__/____	☐ M ☐ F	

Provide contact information if different than the Employee information above.

Street Address (Include Apt. or Suite Number) _____ City _____ State _____ ZIP Code _____

Cell Phone (____)_____ Home Phone (____)_____ Work Phone (____)_____ Best Time To Call _____AM/PM

Email Address _____

STATEMENT OF HEALTH

C. Medical Information – Applicants complete if applying for ANY insurance.

	Height	Weight		Height	Weight
Employee:	____ft____in.	_____lbs.	**Spouse or Domestic Partner:**	____ft____in.	_____lbs.

	Employee		Spouse or Domestic Partner	
	Yes	No	Yes	No
1. I understand that the Company is relying on the information that I provide in this form in order to evaluate my application for insurance. I understand that any incorrect information or information not disclosed in this application could result in underwriting delays, loss of benefits, or non-payment of claims.	☐	☐	☐	☐
2. Within the past 12 months, has anyone applying for insurance used any form of tobacco or nicotine products (includes cigarettes, cigars, chewing tobacco, vaping, e-cigarettes, and nicotine supplements like gum and patches)?	☐	☐	☐	☐

D. Medical Information – Applicants complete if applying for Life or Disability insurance. You must answer YES or NO for each question per Applicant to avoid a processing delay. Child refers to all Dependent Children Applicants.

1. **Within the past 5 years,** to the best of your knowledge and belief, has anyone applying for insurance been diagnosed with or treated by a licensed member of the medical profession for any of the following diseases, illnesses, or conditions:	Employee		Spouse or Domestic Partner	
	Yes	No	Yes	No
a. Coronary artery disease, angina, ischemia, heart attack or myocardial infarction, cardiac angioplasty, bypass surgery or stent placement, cardiomyopathy, congestive heart failure, heart failure, aortic or cardiac aneurysm, congenital heart disease, left ventricular hypertrophy (LVH), abnormal electrocardiogram (EKG), vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve, pulmonary stenosis, valve replacement/repair, atrial fibrillation/flutter, abnormal heart rhythm, implantation of pacemaker, hypertension/high blood pressure, history of stroke, mini-stroke, or transient ischemic attack (TIA)?	☐	☐	☐	☐
b. Cancer or tumor (exclude basal cell carcinoma), chronic obstructive pulmonary disease (COPD), chronic pulmonary disease, cardio-pulmonary disease requiring oxygen, chronic bronchitis, asthma, sarcoidosis, emphysema, tuberculosis, respiratory failure, pulmonary embolism, pulmonary fibrosis, pulmonary hypertension, liver disease, hepatitis, autoimmune hepatitis, alcohol related liver disease, cirrhosis, fatty liver, Wilson's Disease, primary biliary cholangitis, primary sclerosis cholangitis, ulcerative colitis, Crohn's disease, chronic kidney disease, kidney failure, kidney disease requiring dialysis, kidney stones, polycystic kidney disease, nephritis, nephropathy, congenital kidney disorder, glomerulonephritis, pre-eclampsia, or diabetes?	☐	☐	☐	☐
c. Multiple sclerosis, Parkinson's disease, Alzheimer's Disease, epilepsy, neuropathy, amyotrophic lateral sclerosis (ALS), Huntington's, neuromuscular disease, cerebral palsy, cerebral vascular accident (CVA), encephalopathy, or dementia?	☐	☐	☐	☐
d. Lupus, antiphospholipid syndrome, autoimmune hemolytic anemias, scleroderma, sickle cell anemia, Factor V Leiden, aplastic anemia, hemochromatosis, idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenic purpura (TTP), or polycythemia vera?	☐	☐	☐	☐

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	Employee		Spouse or Domestic Partner	
	Yes	No	Yes	No
e. Mental disease requiring treatment (including hospital confinement) by a physician, psychiatrist, psychologist, counselor or therapist. (Examples include, but are not limited to, schizophrenia, schizoaffective disorder, obsessive compulsive disorder (OCD), autism, post-traumatic stress disorder (PTSD), personality disorders, psychosis, eating disorders, dissociative disorders, bipolar affective disorder, and Tourette's disorder.); depression, anxiety, or alcohol or drug abuse?	☐	☐	☐	☐
f. Fracture, spondylosis, spondylolysis, spondylolisthesis, intervertebral rupture, herniation or protrusion of a disc (slipped disc), herniated disc, degenerative disc disease (DDD), degenerative joint disease (DJD), back surgery, scoliosis, congenial disorders of the spine, sciatica, osteoarthritis, rheumatoid arthritis, psoriatic arthritis, degenerative joint disease, injury to or damage to the ligaments, cartilage, or meniscus of the knee, surgery of a joint, joint replacement, carpal tunnel syndrome, bunion, plantar fasciitis, hammer toe, epicondylitis, chronic pain?	☐	☐	☐	☐
g. Currently pregnant?	☐	☐	☐	☐
h. Missed work or school for more than 7 consecutive days due to any disease, illness, or condition?	☐	☐	☐	☐
2. Within the past 5 years, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed by a medical professional as having Acquired Immunodeficiency Syndrome (AIDS)? **Note: CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.**	☐	☐	☐	☐

If a question was answered YES in SECTION D, then you must complete SECTION E below.

E. Additional Details

Provide details for any questions answered YES in SECTION D. (Attach additional sheet, if needed.)

Question Number	Applicant Name	Condition/Diagnosis	Treatment/Names of Medication	Date of Diagnosis & Medication Prescribed Date(s)	Are You Currently Being Treated?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

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F. Medical Information – Applicants complete if applying for Critical Illness insurance. You must answer YES or NO for each question per Applicant to avoid a processing delay.

MUST BE COVERED FOR MEDICAL, HOSPITAL, AND SURGICAL COVERAGE TO APPLY.*	Employee		Spouse or Domestic Partner	
	Yes	No	Yes	No
1. **Within the past 5 years**, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed or treated by a licensed member of the medical profession Systemic Lupus, Type I or II Diabetes, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or sarcoidosis? **Note: CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.**	☐	☐	☐	☐
2. **Within the past 5 years,** to the best of your knowledge and belief, has anyone applying for insurance been diagnosed or treated by a licensed member of the medical profession for a condition for which a Pacemaker has been installed, or been diagnosed with or received treatment for any type of fibrillation, coronary artery disease, atherectomy or any type of heart surgery, heart attack, congestive heart failure, cardiomyopathy, stroke, transient ischemic attack, congenital heart disease, chronic anticoagulation therapy?	☐	☐	☐	☐
3. To the best of your knowledge and belief, is anyone applying for insurance currently taking three or more high blood pressure (HBP) medications or had HBP medications changed or increased within the past six months?	☐	☐	☐	☐
4. **Within the past 5 years,** to the best of your knowledge and belief, has anyone applying for insurance been diagnosed or treated by a licensed member of the medical profession for internal cancer, lymphoma, leukemia or melanoma?	☐	☐	☐	☐
5. **Within the past 5 years,** to the best of your knowledge and belief, has anyone applying for insurance been diagnosed or treated by a licensed member of the medical profession for Cystic fibrosis, renal hypertension or any kidney disease or disorder (examples include, but are not limited to, chronic kidney disease, kidney disease requiring dialysis, kidney failure, kidney stones, polycystic kidney disease, nephritis, nephropathy, and glomerulonephritis), chronic obstructive pulmonary disease, emphysema, pulmonary fibrosis, Hepatitis (not including Hepatitis A), liver disease or disorder (examples include, but are not limited to, liver disease, autoimmune hepatitis, alcohol related liver disease, cirrhosis of the liver, fatty liver, Wilson's disease, primary biliary cholangitis, and primary sclerosis cholangitis), any organ transplant, or donor?	☐	☐	☐	☐
6. **Within the past 5 years**, to the best of your knowledge and belief, has anyone applying for insurance been diagnosed or treated by a licensed member of the medical profession for glaucoma or retinitis pigmentosa?	☐	☐	☐	☐

Is each Applicant covered by an individual or group insurance policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans?

☐ **Yes** ☐ **No (If No, Critical Illness insurance shall not be issued.)**

***FOR CRITICAL ILLNESS INSURANCE: A PERSON MUST BE COVERED BY AN INDIVIDUAL OR GROUP POLICY OR CONTRACT THAT ARRANGES OR PROVIDES MEDICAL, HOSPITAL, AND SURGICAL COVERAGE NOT DESIGNED TO SUPPLEMENT OTHER PRIVATE OR GOVERNMENTAL PLANS. BOTH THE EMPLOYEE AND SPOUSE MUST BE COVERED BY SUCH A PLAN IF APPLYING FOR CRITICAL ILLNESS FOR DEPENDENT SPOUSE.**

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G. Fraud Warning/State Disclosure(s)

FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM:

ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

H. Acknowledgements and Declarations (Initial each item and sign where indicated.)

1. I request the insurance for which I am (or may become) or my Spouse or Domestic Partner is (or may become) eligible under group policies issued by the Company; _____ (initials)
2. I represent to the best of my knowledge and belief that the above Statement of Health is true and complete, and that each item answered yes is fully disclosed; _____ (initials)
3. I represent that if the above Statement of Health has been completed to obtain insurance for my Spouse or Domestic Partner, I have discussed and reviewed with my Spouse or Domestic Partner the responses and information supplied on behalf of my Spouse or Domestic Partner in the Statement of Health, and to the best of our knowledge and belief, the Spouse or Domestic Partner portion of the Statement of Health is true and complete, and each item answered yes is fully disclosed; _____(initials)
4. I acknowledge that I have read the **Fraud Warning/State Disclosure(s)**; ____ (initials)
5. I understand that for continued eligibility I must remain an active employee working at least the minimum hours or otherwise continue insurance as outlined in the contract; and _____ (initials)
6. **The attached AUTHORIZATION FOR RELEASE OF INFORMATION has been completed and signed by me (Employee Applicant). A separate AUTHORIZATION FOR RELEASE OF INFORMATION has been completed and signed by the (Spouse or Domestic Partner) Applicant, if required.** _____ (initials)

Signature of (Employee) Applicant: **X**_____ Date: ____/____/____

Signature of (Spouse or Domestic Partner) Applicant: **X**_____ Date: ____/____/____

PAYROLL DEDUCTION AUTHORIZATION (Sign where indicated):
I authorize any required deductions from my earnings.

Signature of (Employee) Applicant: **X**_____ Date: ____/____/____

PLEASE COMPLETE THE ATTACHED AUTHORIZATION FOR RELEASE OF INFORMATION (EACH APPLICANT IS REQUIRED TO COMPLETE AND SIGN AN "AUTHORIZATION FOR RELEASE OF INFORMATION" FORM)

Return all pages to avoid processing delays.

AUTHORIZATION FOR RELEASE OF INFORMATION

AUTHORIZATION: I (the undersigned) authorize any physician, medical professional, medical facility, pharmacy benefit manager, insurer, reinsurer, consumer reporting agency or MIB, Inc. ("MIB") to release information from the records of:

1. Applicant/Patient Name:_____
   (Last) (First) (Middle)

   Date of Birth: ____/____/____ Social Security Number: ____-_____-_____

This Authorization covers any periods of medical treatment during the last seven years.

2. Information to be released: My complete medical records including:
   - information about the diagnosis, treatment or prognosis of my medical condition (including referral documents from other facilities); and
   - prescription drug records and related information maintained by physicians, pharmacy benefit managers, and other sources.

3. Information is to be released to: EMSI (Examination Management Services Incorporated), The Lincoln National Life Insurance Company (the Company) or its reinsurers.

4. I understand that the purpose of disclosing this information is to evaluate my application for insurance. The Company will use the information obtained with this Authorization to determine eligibility for insurance; and will only release such information:
   - to reinsurance companies, the MIB or providers of a business or legal service concerned with my application; and
   - as otherwise may be required by law or may be further authorized by me.

5. I authorize The Lincoln National Life Insurance Company, or its reinsurers, to disclose Protected Health Information or personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

   I further understand that refusal to sign this Authorization may result in denial of eligibility for this insurance.

6. I understand the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law, however, the Company contractually requires the recipient to protect the information.

7. I understand that I may revoke this Authorization 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 insurance with the 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 Company at the above address.

8. A photocopy of this Authorization is to be considered as valid as the original.

9. I acknowledge that I have received the attached Notice of Information Practices.

10. I understand that I am entitled to receive a copy of this Authorization.

Signature of Applicant: X_____ **Date:** ____/____/____

NOTICE OF INSURANCE INFORMATION PRACTICES

COLLECTION OF INFORMATION
This NOTICE is provided in compliance with your state's Insurance Information and Privacy Protection Act.

In order to provide insurance on a fair and equitable basis, we must collect information about you and others for whom insurance may be provided. This information may include age, occupation, physical condition, health history, prescription drug records, general reputation, mode of living and other personal characteristics.

You will provide much of the information. We may collect or verify information by personal interviews and by otherwise contacting Medical professionals and institutions, pharmacy benefit managers, employers, business associates, friends, neighbors and other insurance companies. We may ask insurance support organizations to collect information and submit an investigative consumer report. That organization may disclose the contents of the report to others for which it performs such services. You may request a copy of the report or a personal interview in connection with it.

DISCLOSURE OF INFORMATION
The law allows disclosure of certain information without your authorization in response to a valid administration or judicial order, as permitted or required by law, or to:

1. Persons or organizations performing professional, business or insurance functions for us;
2. Our agents, insurance support organizations or consumer reporting agencies;
3. Medical professionals and medical-care institutions;
4. Persons or organizations conducting bonafide actuarial or scientific research studies, audits or evaluations;
5. Insurance regulatory, law enforcement or other governmental authorities;
6. Persons or organizations involved in any sale, transfer, merger or consolidation of our business; and
7. Group Policyholders, certificate holders, professional peer review organizations, or persons having legal or beneficial interest in a policy of insurance.

We do NOT disclose to our affiliates any information we receive about you from a consumer reporting agency. We do NOT disclose your nonpublic personal information to third parties except as necessary to provide you our products and services.

We, or our reinsurers, may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

MIB, Inc.
Information regarding your insurability will be treated as confidential. The Lincoln National Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901. If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Information for consumers about MIB may be obtained on its website at www.mib.com.

PERSONAL DISCLOSURE
Also, you have a right to access personal information about you in our files. You may request that we correct, amend or delete information you believe is inaccurate or irrelevant. A description of the appropriate procedures will be sent to you upon written request.

TELEPHONE PERSONAL HISTORY REVIEW
After your application has been received in the Group Insurance Service Office, you may receive a telephone call from a specially trained Group Insurance Service Office Interviewer who will ask you some questions to obtain verification or additional information.

If you have questions about the terms discussed in the NOTICE, please write to:
The Lincoln National Life Insurance Company
Group Insurance Service Office
P. O. Box 2616
Omaha, Nebraska 68103-2616

DETACH THIS COPY AND KEEP FOR YOUR RECORDS