Lincoln Financial Group®
You're In Charge®

Lincoln's Tele-App preparation guide

Get ready for your life insurance application phone interview

With Lincoln's Tele-App, providing the important information needed to complete your life insurance application is just a phone call away.

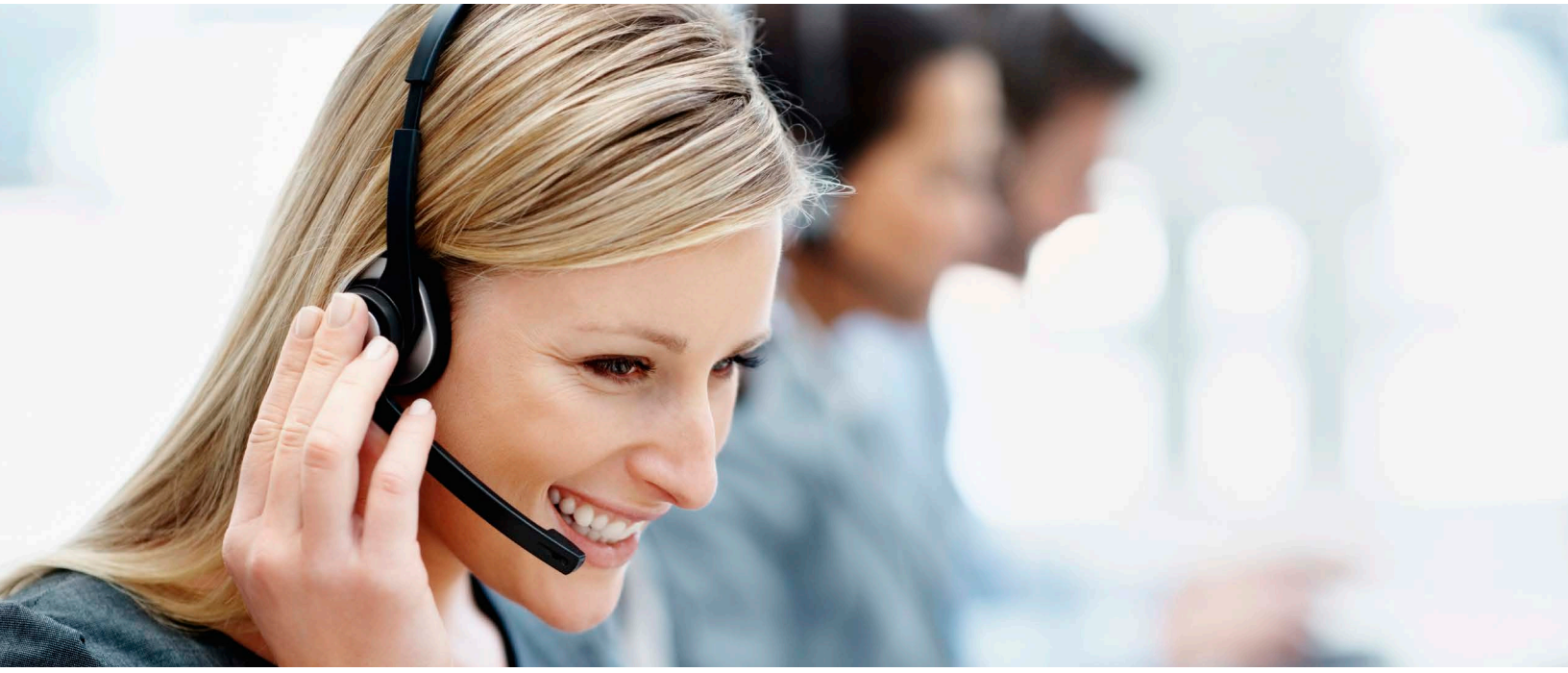
You can make your phone interview even smoother and simpler by completing the worksheet on the next few pages before your call. It ensures you'll have easy access to the detailed health and financial information you'll need during your interview.

Here's how the Tele-App process works

1. You will receive an email from Lincoln with a link to schedule your Tele-App interview. Choose a time that's convenient for you. If no appointment is scheduled within 24–48 hours, a skilled Lincoln professional will call you to schedule your phone interview. An appointment reminder is available upon request, via text message or email.
2. Because the interview questions relate to your health history and financial information, schedule the call for a time and place that give you the privacy you need. No need to worry! We will keep your personal information confidential and secure.
3. Complete the worksheet that follows to ensure interview accuracy. It's for your use only.
4. Our Lincoln associate will call you at your scheduled time. The interview will take about 20 to 40 minutes and is conducted in English only. Have your completed worksheet ready.
5. After your interview, a paramed service will contact you to schedule labs, if required.

Take charge with a fast, convenient phone interview process.

Complete the worksheet — it can save you time and promotes accuracy.



Insurance products issued by:
The Lincoln National Life Insurance Company

Preinterview worksheet

Use a separate sheet of paper if there is not enough room in the space provided.

Important numbers

Your Social Security number		Your driver's license number	

Financial information

Your annual earned income	Other recurring income	Your net worth (assets minus liabilities)

Beneficiary(ies)	Primary beneficiary (1)	Primary beneficiary (2)	Contingent beneficiary
Name			
Date of birth			
Address			
Phone number			
Email address			
SSN or TIN			
Relationship			
Trust name			
Trustee name			
Date of trust			
Share percentage (total must equal 100%)			

Third party designation (We will notify this person about a policy lapse grace period.)

Name	Address	Phone number

Existing insurance information

List every life insurance policy and annuity contract you currently have in-force, and any life insurance or annuity you've applied for, but have not yet been issued.

Company name	Policy number	Issue date	Face amount	Replacing
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Additional owner information

If you are not the owner of the policy, provide the SSN or TIN of the individual, entity or trust that will own the policy.	Number
If the owner of the policy is a trust, provide the name and date of the trust.	Name
	Date
Policyowner email address	

Physical stature

Height		Weight	

Medical information

Provide the following information about any doctors you have seen.

Name of your primary care physician	Complete mailing address	Phone number	Date of last visit	Reason(s) for visit

Names of other doctors you've seen	Complete mailing address	Phone number	Date of last visit	Reason(s) for visit

Medical tests

List any medical tests you've had, along with the following supporting information.

Name/type of test	Date of test	Result of test (if known)	Who has the results?

Hospitals and medical facilities

Provide the following information about hospital or medical facility admissions.

Name and complete mailing address of the hospital/medical facility	Phone number	Date of admission(s)	Reason for admission(s)	Name of doctor (attending MD) who may have the records

Family medical history

Have any of your parents or siblings died due to coronary disease, heart attack or stroke before age 65?	☐ Yes ☐ No	If so, what was the age of death?	

Medications and/or supplements

Provide the following information about prescription medication and/or supplements you are currently taking.

Prescription name	Dosage and frequency	Who prescribed this medication?	Reason prescribed
1.			
2.			
3.			
4.			

If you have any of the conditions listed, please be prepared to provide the following information.

Asthma			
Date of diagnosis	Have you been diagnosed with status asthmaticus? ☐ Yes ☐ No	Frequency of symptoms	Do you require oral steroids? ☐ Yes ☐ No
Crohn's disease			
Date of diagnosis	Did you require surgical treatment? ☐ Yes ☐ No	Did you require hospitalization for this condition? ☐ Yes ☐ No	Did you require steroids or immunosuppressants? ☐ Yes ☐ No
Diabetes			
Date of diagnosis	Provide most recent A1C result.	Complications from diabetes?	Type of treatment
Hypertension (high blood pressure)			
Date of diagnosis	Did you require hospitalization for this condition? ☐ Yes ☐ No	Complications from high blood pressure?	Type of treatment
Multiple sclerosis			
Date of diagnosis	Do you have limitations on activities of daily living? ☐ Yes ☐ No	Complications from multiple sclerosis?	Type of treatment
Seizure disorder			
Date of diagnosis	Did you require hospitalization for this condition? ☐ Yes ☐ No	Frequency of seizures/date of last seizure	Type of treatment
Sleep apnea			
Date of diagnosis	Did you require surgical treatment? ☐ Yes ☐ No	If CPAP is required? ☐ Yes ☐ No / How often?	Did you have follow-up sleep studies? ☐ Yes ☐ No
Ulcerative colitis			
Date of diagnosis	Did you require surgical treatment? ☐ Yes ☐ No	Dates of colonoscopies	Did you require steroids or immunosuppressants? ☐ Yes ☐ No

Hobbies, avocations, and aviation activity
We will be asking you for details on your hobbies and other avocations (including aviation activities). Provide the following details for each hobby or avocation you engage in. After reviewing your responses, we may have some follow-up questions.

Hobbies/avocations (any type of racing, scuba diving, skydiving, hang gliding, etc.)

Activity		
Number of hours performed in the last 12 months		
Number of hours expected in the next 12 months		
Certifications/licenses held		
Location of activity performed		
Speeds, depths,heights attained		

Aviation

Type of aircraft flown		License(s) held	
Are you a student pilot?	Total hours flown solo	Total hours expected to fly in the next 12 months	Are you qualified under Instrument Flight Rules (IFR)?
☐ Yes ☐ No			☐ Yes ☐ No

Not a deposit
Not FDIC-insured
Not insured by any federal government agency
Not guaranteed by any bank or savings association
May go down in value

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LCN-2346262-121118
POD 2/19 **Z07**
Order code: UW-TELE-FLI003

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Tele-App is not available in the state of New York.