

# Lincoln TermAccel<sup>®</sup>

Get ready for your Tele-App phone interview

With 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 A skilled Lincoln professional will call you to schedule your phone interview. Choose a time that's convenient for you.
- 2 Because the interview questions concern your health history and financial situation, 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 following worksheet 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 20 to 30 minutes; 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.



## Preinterview worksheet

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

Your Social Security number

### Financial information

Your annual earned income

Your total household income

Your net worth (assets minus liabilities)

Beneficiary(ies)	Primary beneficiary (1)	Primary beneficiary (2)	Contingent beneficiary
Name			
Date of birth			
Address			
Phone number			
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
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

### Physical stature

Height

Weight

### Social habits

Tobacco use (types, including e-cigarettes )

Alcohol use (number of drinks per week)

**Hobbies/avocations (Include activities such as racing, scuba diving, skydiving, hang gliding, mountain climbing.)**

Activity	Amateur or professional	Certifications/club affiliations/licenses	Location of activity	Maximum speeds, depths, heights attained	Frequency of activity

**Aviation**

Type of aircraft flown	Are you a student pilot? <input type="checkbox"/> Yes <input type="checkbox"/> No	License(s) held	Total hours flown solo	Total hours expected to fly in the next 12 months	Are you instrument flight rated (IFR)? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Medical history**

List any medical conditions you have or have ever been diagnosed with.

Condition	Date of diagnosis	Symptoms	Type and date of treatment	Tests done and results	Date of last doctor visit
1					
2					
3					

**Doctors visits**

Provide the following information about any doctors you've seen in the last 10 years for a medical condition or follow up.

Doctor's name					
City and state			Specialty		
Date of visit	Reason for last visit		Testing or treatment received		
Doctor's name					
City and state			Specialty		
Date of visit	Reason for last visit		Testing or treatment received		

**Hospital and medical facilities**

Provide the following information about your hospital or medical facility admissions.

Hospital/medical facility name and complete mailing address	Name of doctor consulted	Admission date(s)	Reason for admission(s)	Treatment date(s)

## Family medical history

Have any of your parents or siblings died due to coronary disease, heart attack or stroke before age 65?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, what was the age of death?
----------------------------------------------------------------------------------------------------------	----------------------------------------------------------	-----------------------------------

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency of symptoms	Do you require oral steroids? <input type="checkbox"/> Yes <input type="checkbox"/> No
Crohn's disease	Date of diagnosis	Did you require surgical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did you require hospitalization for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did you require steroids or immunosuppressants? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Complications from high blood pressure?	Type of treatment
Multiple sclerosis	Date of diagnosis	Do you have limitations on activities of daily living? <input type="checkbox"/> Yes <input type="checkbox"/> No	Complications from multiple sclerosis?	Type of treatment
Seizure disorder	Date of diagnosis	Did you require hospitalization for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency of seizures/date of last seizure	Type of treatment
Sleep apnea	Date of diagnosis	Did you require surgical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If CPAP is required? <input type="checkbox"/> Yes <input type="checkbox"/> No How often?	Did you have follow-up sleep studies? <input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcerative colitis	Date of diagnosis	Did you require surgical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dates of colonoscopies	Did you require steroids or immunosuppressants? <input type="checkbox"/> Yes <input type="checkbox"/> 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

**Thanks again for choosing Lincoln.**

**If you have any questions regarding the Tele-App process, call us toll free at 866-TELL-ABE (866-835-5223).**

©2016 Lincoln National Corporation

[LincolnFinancial.com](http://LincolnFinancial.com)

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

LCN-1462529-040516  
POD 5/16 Z02

Order code: TO-PHI-FL1001



### Important information:

*Lincoln TermAcce*<sup>®</sup> Level Term is issued on policy form TRM5065/ICC15TRM5065 with endorsement END7013, data pages TA5165, and state variations by The Lincoln National Life Insurance Company, Fort Wayne, IN, and distributed by Lincoln Financial Distributors, Inc., a broker-dealer. **The Lincoln National Life Insurance Company does not solicit business in the state of New York, nor is it authorized to do so.**

**All guarantees and benefits of the insurance policy are subject to the claims-paying ability of the issuing insurance company.** They are not backed by the broker-dealer and/or insurance agency selling the policy, or any affiliates of those entities other than the issuing company affiliates, and none makes any representations or guarantees regarding the claims-paying ability of the issuer.

Products, riders and features are subject to state availability. Limitations and exclusions may apply. Not available in New York.