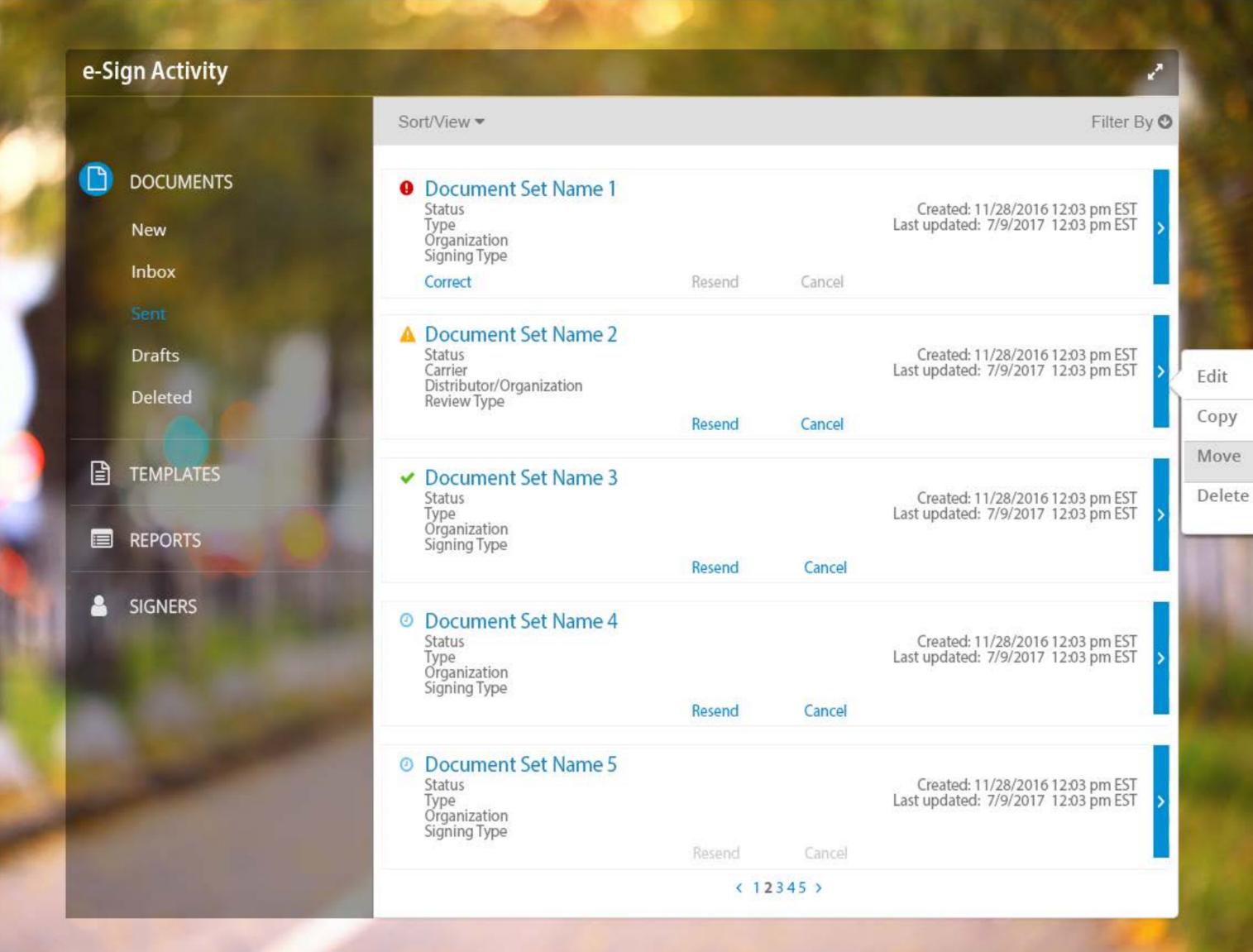
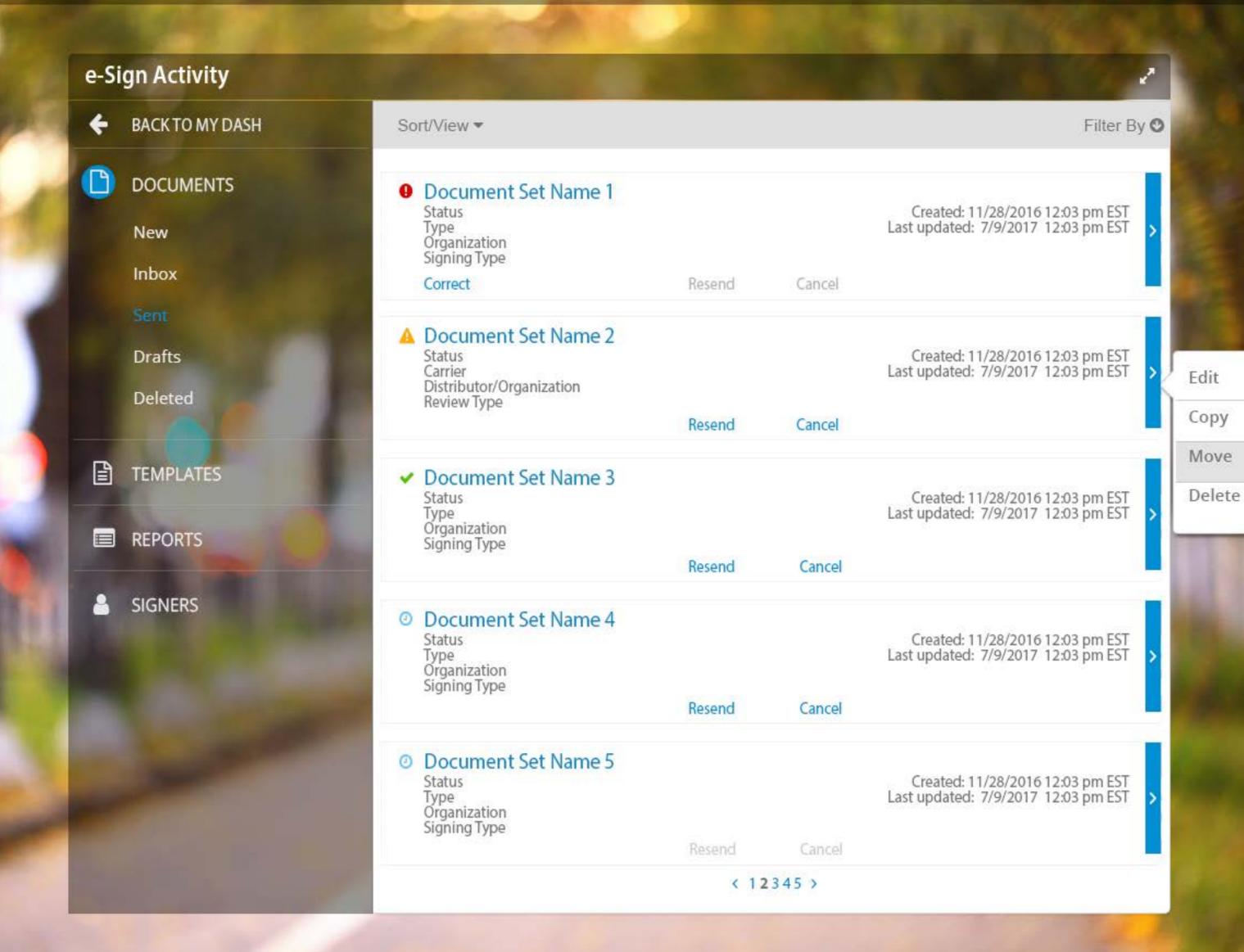
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**2**Sured

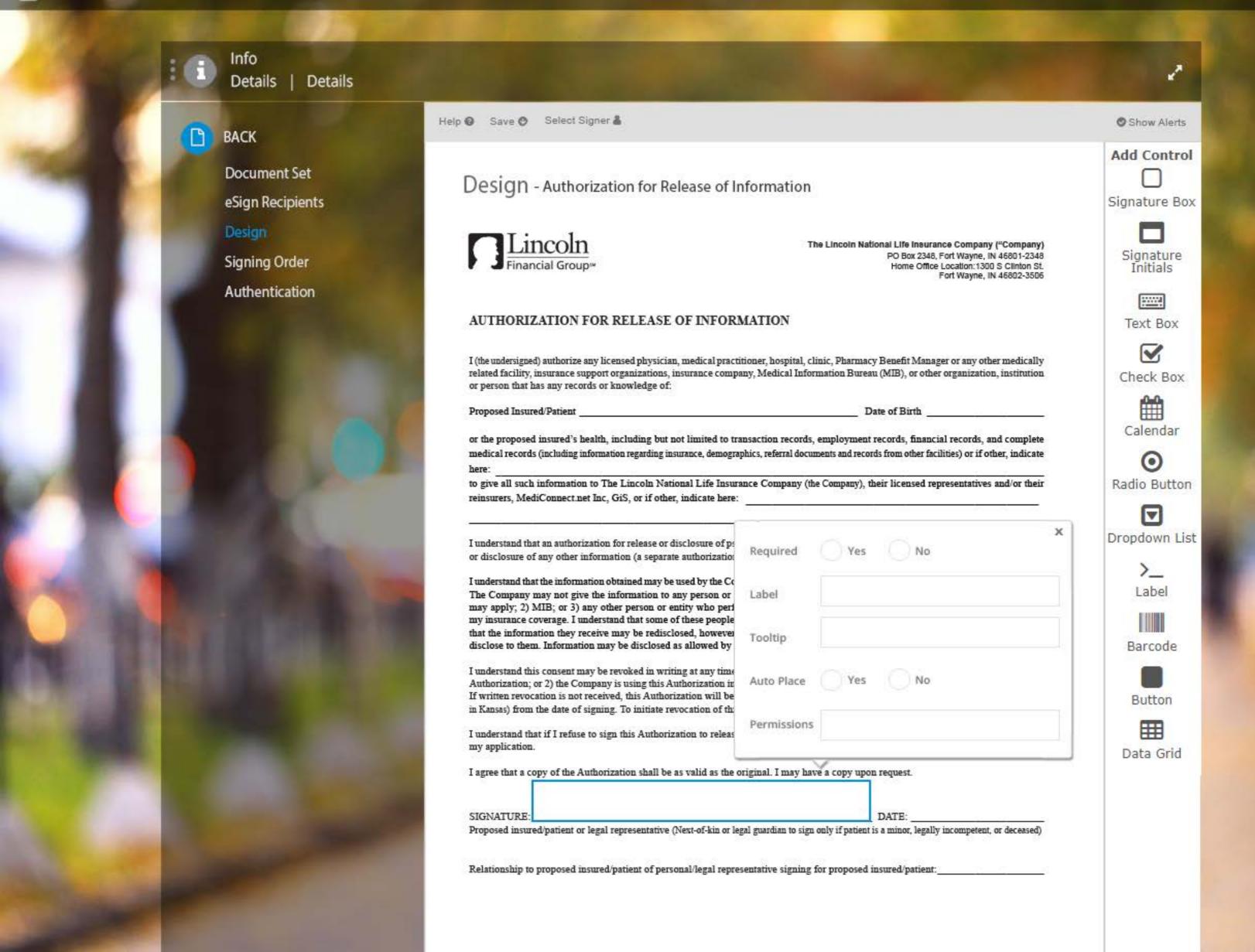
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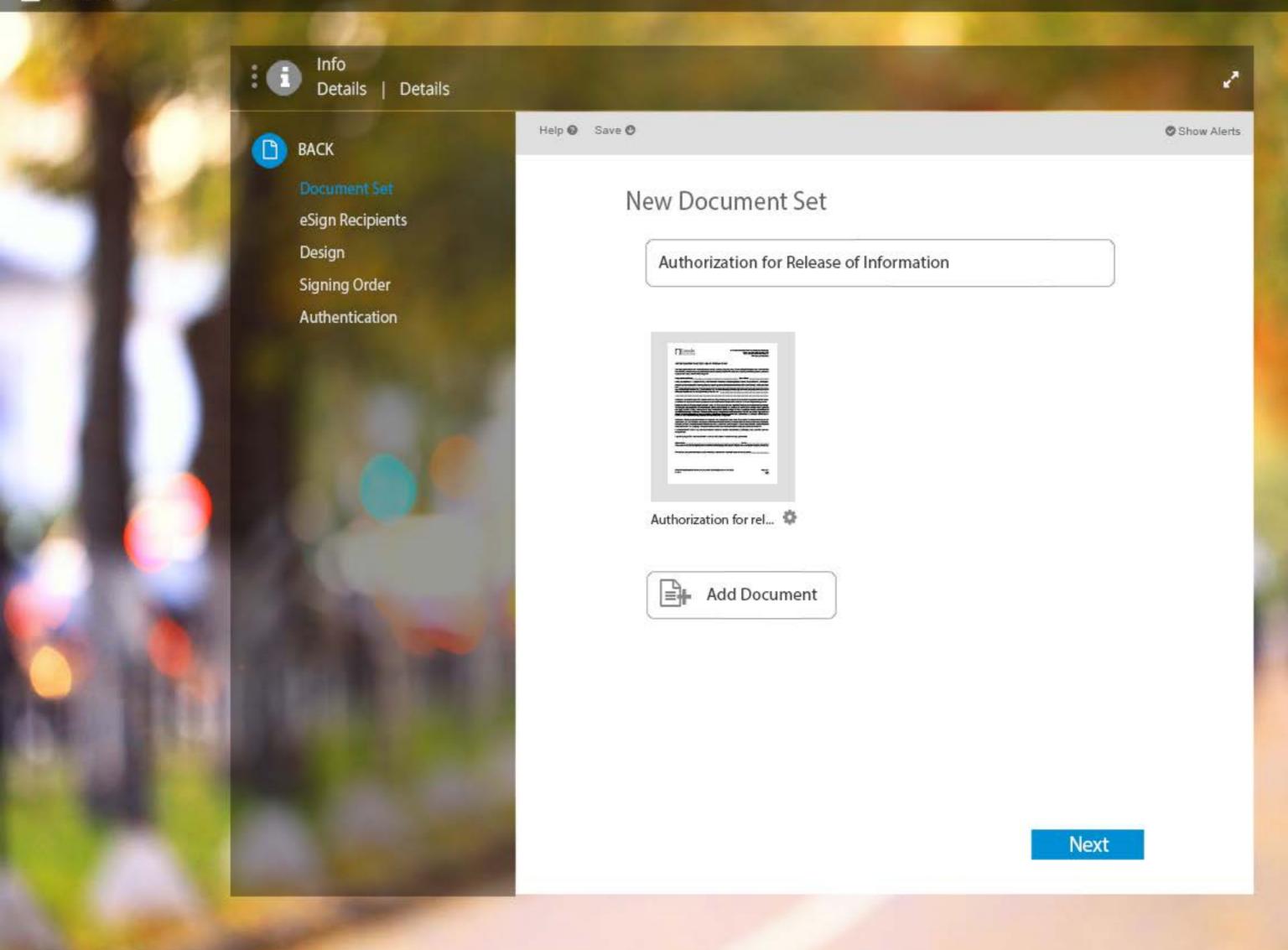


**2**Sured

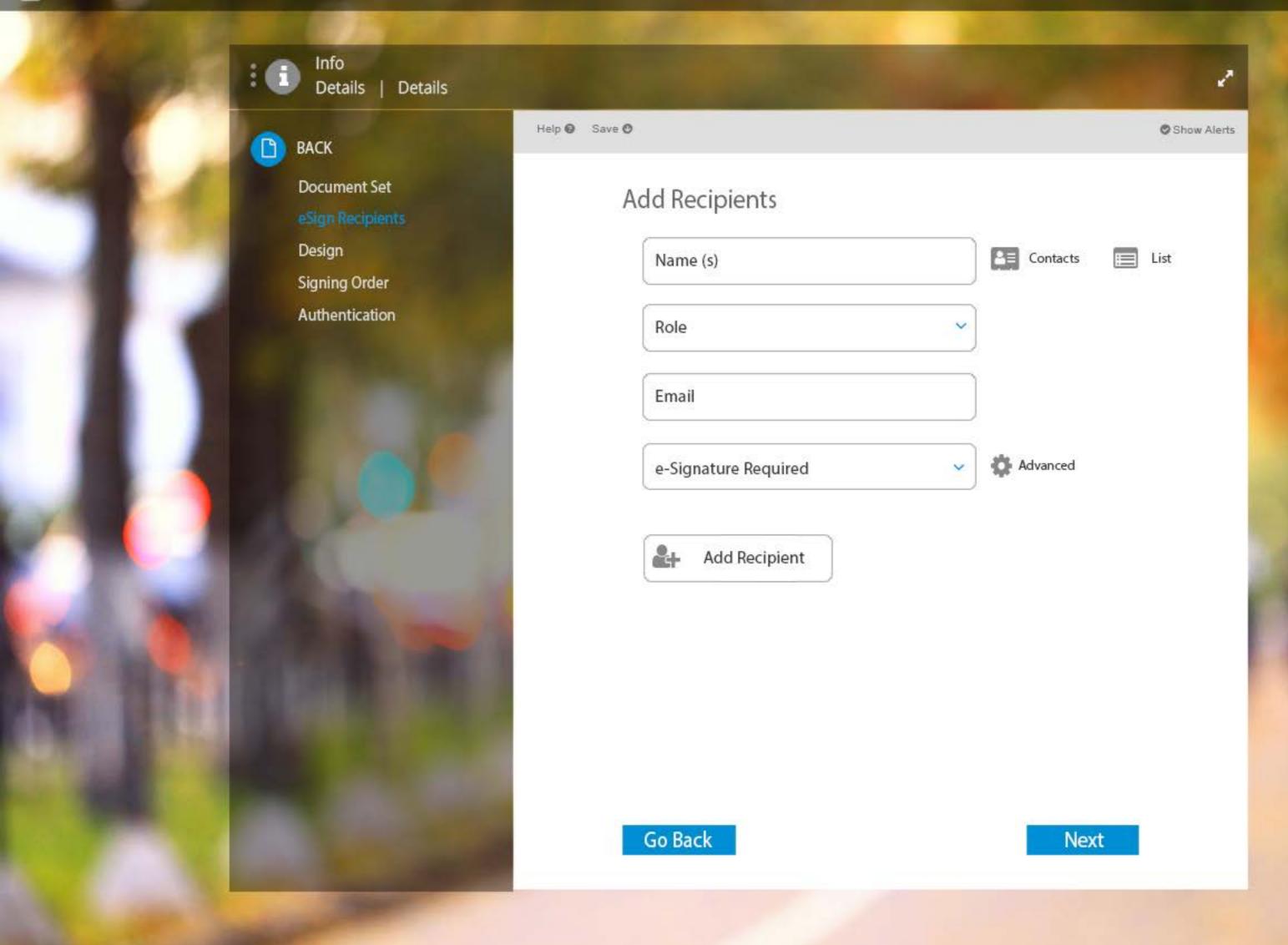


















The Lincoln National Life Insurance Company ("Company)
PO Box 2348, Fort Wayne, IN 46801-2348
Home Office Location: 1300 S Clinton St.
Fort Wayne, IN 46802-3506

	ATION FOR RELI	EASE OF INFOR	MATION		
related facility, it		ations, insurance compa			Manager or any other medical or other organization, institution
Proposed Insured/Patient Date of I				Date of Bir	th
시설하다 이 경험 위원으로 없다고	얼마 하는 이렇게 하게 하나 이렇게 어디를 하게 하는 다른데	경우 그 아이는 사람들이 없는 것 같아 있다면 하는 것이 없다.	기자는 이 이 없이 때 가장이 이상을 하지 않아야다. () []	10 <sup>7</sup> . 100 1.20 1.20 1.20 1.20 1.20 1.20 1.20	financial records, and comple her facilities) or if other, indica
to give all such i	information to The Linco Connect net Inc, GiS, or			npany), their licen	sed representatives and/or the
		100 100 100 000 000 100			with an authorization for relea ure of psychotherapy notes).
The Company m may apply; 2) M my insurance co that the informat disclose to them. I understand this Authorization; o If written revoca in Kansas) from t I understand that	nay not give the information (IB; or 3) any other personance I understand that tion they receive may be information may be disconsent may be revoked (2) the Company is using the date of signing. To in	stion to any person or en- son or entity who perfor t some of these people of e redisclosed, however to sclosed as allowed by land d in writing at any time, ag this Authorization in of Authorization will be continued in the interpretation of this	ntity except: 1) a reinst rms business or legal s or entities may not be co the Company contractu aw or regulation. except to the extent: 1) connection with a conte considered valid for a p Authorization direct al	arer, or other insurervices in connectored by federal ally requires then the Company has estable claim unde eriod of time not all correspondence	te, or to administer my coverage rers to whom I have applied ation with the administration or state privacy regulations at a to protect the information who taken action in reliance on the rmy policy with that Comparto exceed 24 months (12 months to the address above.
my application.  I agree that a cop	py of the Authorization s	shall be as valid as the o	original. I may have a c	opy upon request	
SIGNATURE:	Sign			DATE:	⊞ Date
Proposed insured	l/patient or legal represe	ntative (Next-of-kin or le	gal guardian to sign only i	if patient is a minor,	legally incompetent, or decease
	proposed insured/patient	of personal/legal repre	sentative signing for pr	oposed insured/p	stient:
Relationship to p					
Relationship to p					



## **Adopt Signature**

Full Name

Initials

John Smith

JS

Select Styling

Draw Signature

Preview

John Snith

15

By selecting Adopt and Sign, I agree that the signature and initials will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts - just the same as a pen and paper signature or initial.

Go Back

Adopt and Sign

Relationship to proposed insured/patient of personal/legal representative signing for proposed insured/patient:

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Page 1 of 1

12/11







## 2 Sured

## Adopt Signature

Full Name		Initials
John Smith		JS
Select Styling	Draw Signature	

Preview

John Snith

15

By selecting Adopt and Sign, I agree that the signature and initials will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts - just the same as a pen and paper signature or initial.

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