

# **PARTNERING WITH LINCOLN FINANCIAL GROUP®**



## **PRODUCER CONTRACTING APPOINTMENT PACKET FOR GROUP PROTECTION**



Insurance products are issued by insurance affiliates of Lincoln Financial Group.

# Welcome to Lincoln Financial Group

We are pleased that you have chosen to associate with Lincoln National Life Insurance Company and/or Lincoln Life & Annuity Company of New York and affiliates (hereinafter "Lincoln"). The instructions, information and forms on the following pages are designed to make the process of contracting and appointment a smooth and expeditious experience.

Lincoln is focused on offering superior service to Producers. To avoid an unnecessary delay in processing, please be certain that all items on the checklist below have been completed and submitted.

## Instructions for Completing Required Forms

### Producer Section

#### Provide the Following:

- 1. **Application for Producer Appointment (PS10888)**. Completed and signed. An explanation for any "yes" answer(s) must also be signed and dated by Producer. All correspondence regarding background information will be sent to home address.
- 2. **Fair Credit Reporting Act Disclosure & Authorization (LA02298)**. Complete Name and Sign and Date.
- 3. **Business Associate Agreement (GLM10571)**. Complete Name and Date on page one and Sign and Date page three.

#### For firms not previously appointed:

- 4. **W-9**. Must be submitted. [www.irs.gov/pub/irs-pdf/fw9.pdf](http://www.irs.gov/pub/irs-pdf/fw9.pdf).

#### Optional:

- 5. **Electronic Funds Transfer/Direct Deposit Authorization & Agreement for Commissions form (BJ-02059)**. Complete and attach a voided check for EFT deposit.

- Submit completed contracting to (Please select one method of submission.):

Email: [bplicensing@lfg.com](mailto:bplicensing@lfg.com)

**OR** mail to:

Lincoln Financial Group  
Attn: GP Licensing  
PO Box 515  
Concord, NH 03302-0515



# Application for Producer Appointment

The Lincoln National Life Insurance Company  
Lincoln Life & Annuity Company of New York  
Attn: GP Licensing, PO Box 515, Concord, NH 03302-0515

## Personal Information

Distributor ID# \_\_\_\_\_  Male  Female

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Physical Home Address: \_\_\_\_\_  
Street City State Zip  
(All correspondence regarding background information will be sent to home address.)

Business Address: \_\_\_\_\_  
Street City State Zip

Mailing Address (if different from above): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

The Lincoln National Life Insurance Company / Lincoln Life & Annuity Company of New York pays commission to (mark one):  
 Agency  Individual

Name of agency for commissions to firm: \_\_\_\_\_

Federal Tax ID#: \_\_\_\_\_

List state(s) in which you wish to be appointed: \_\_\_\_\_

**Please read and answer each of the following questions: Attach a written explanation, including date of the event and date of discharge, for any YES answers. If anything occurs, which results in a change to any of your answers, you must notify The Lincoln National Life Insurance Company / Lincoln Life & Annuity Company of New York, in writing, within 30 days of the occurrence.**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Are you now or have you ever been the subject of any complaint, investigation, or proceeding by any Insurance Department, the SEC or any federal or state regulatory agency?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been convicted of or pleaded guilty or nolo contendere to a felony or misdemeanor other than a traffic offense?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently, or have you ever been involved in a bankruptcy (personal or any business in which you had control or an ownership interest), pending litigations in which you are a defendant, had a salary garnished or had liens or judgments against you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you currently, or have you ever been the subject of any customer complaint or complaint or proceeding by any securities, insurance or commodities regulatory body or organization?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had your contract, appointment or employment arrangement terminated or have you been permitted to resign from any insurance company or other financial services employer for any reason other than low production?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you currently, or have you ever been refused a license to sell insurance or been refused membership in any securities regulatory body or organization or had a license suspended or revoked by any securities and/or State Insurance Department?            | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you currently a party or in the past ten years, have you been a party to any lawsuit, arbitration or civil litigation?  | <input type="checkbox"/> | <input type="checkbox"/> |

By signing below, I certify that the foregoing answers are true and correct to the best of my knowledge and belief. I also give The Lincoln National Life Insurance Company / Lincoln Life & Annuity Company of New York permission to investigate as necessary to verify this information and to share the information with parties recruiting and recommending my appointment unless I direct you otherwise. This authorization, in original or copy form, is valid now or any time in the future.

By signing this application you:

- I certify that I have and will maintain, either individually or through the brokerage/firm with whom I am acting as a producer/benefits counselor, E&O insurance coverage in a minimum amount of \$1,000,000.
- I agree that I will comply with all applicable local, state and federal laws; all rules and regulations of regulatory agencies having jurisdiction with respect to the solicitation, negotiation and sale of insurance policies. I also agree to abide by any Lincoln rules and guidelines as may be published, or contained on the Company's website, from time to time.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**Disclosure Of Use Of Consumer Reports**

As part of the appointing and/or contracting process, The Lincoln National Life Insurance Company and its affiliates (hereinafter, Lincoln), request consumer reports on prospective producers. From time to time after appointing and/or contracting, Lincoln reserves the right to request consumer reports on its producers in connection with their contracts or new appointments. Occasionally, Lincoln requests investigative consumer reports, which include personal interviews with sources such as your neighbors, friends, associates and/or former employers. Consumer reports and investigatory consumer reports may include information about any or all of the following: your character, general reputation, personal characteristics, mode of living, education, past employment, credit report, professional credentials or driving and criminal record. If we request an investigative report, we are required by the Fair Credit Reporting Act to notify you within three days after the report is requested, and if you make a written request, we are obligated to disclose to you within five days the nature and scope of the investigation requested. Consumer reports and investigative consumer reports, as well as other information in your file, may be shared among Lincoln Financial Group and its affiliates and parties recruiting and recommending your appointment unless you direct otherwise.

**California, Minnesota and Oklahoma applicants and residents:** I have the right to request a copy of any report obtained by Lincoln from a consumer reporting agency by initialing here \_\_\_\_\_ (initial only if you wish to receive a copy)

**Minnesota applicants only:** I understand that I may request a complete and accurate disclosure of the nature of any report obtained by Lincoln.

**New York applicants only:** I acknowledge that I have received the attached copy of Article 23A of New York's Correction Law. I further understand that upon request I will be advised if any investigative consumer reports are requested and provided the name and address of the consumer reporting agency, and I may receive a copy of any report by contacting said agency.

**Massachusetts and New Jersey applicants only:** I have the right to request an investigative consumer report from a consumer reporting agency.

**Washington state applicants only:** I understand I have the right to request from the consumer reporting agency a written summary of my rights and remedies under the Washington Fair Credit Reporting Act.

**Authorization**

I authorize The Lincoln National Life Insurance Company and its affiliates to request and obtain one or more consumer reports and/or investigative consumer reports about me for appointing and/or contracting purposes, and to share such information within Lincoln Financial Group and its affiliates as well as with parties recruiting and recommending my appointment unless I direct you otherwise.

Name (Sign): \_\_\_\_\_ Date: \_\_\_\_\_

Name (Print): \_\_\_\_\_

# NEW YORK CORRECTION LAW ARTICLE 23-A

## A COPY OF THIS LAW IS BEING PROVIDED TO YOU IN CONJUNCTION WITH OUR ORDERING BACKGROUND REPORTS ON YOU.

### New York Bus Code §380-c(b)(2) and 380-g(d)

**§750. Definitions.** For the purposes of this article, the following terms shall have the following meanings:

- (1) "Public agency" means the state or any local subdivision thereof, or any state or local department, agency, board or commission.
- (2) "Private employer" means any person, company, corporation, labor organization or association which employs ten or more persons.
- (3) "Direct relationship" means that the nature of criminal conduct for which the person was convicted has a direct bearing on his fitness or ability to perform one or more of the duties or responsibilities necessarily related to the license, opportunity, or job in question.
- (4) "License" means any certificate, license, permit or grant of permission required by the laws of this state, its political subdivisions or instrumentalities as a condition for the lawful practice of any occupation, employment, trade, vocation, business, or profession. Provided, however, that "license" shall not, for the purposes of this article, include any license or permit to own, possess, carry, or fire any explosive, pistol, handgun, rifle, shotgun, or other firearm.
- (5) "Employment" means any occupation, vocation or employment, or any form of vocational or educational training. Provided, however, that "employment" shall not, for the purposes of this article, include membership in any law enforcement agency.

**§751. Applicability.** The provisions of this article shall apply to any application by any person for a license or employment at any public or private employer, who has previously been convicted of one or more criminal offenses in this state or in any other jurisdiction, and to any license or employment held by any person whose conviction of one or more criminal offenses in this state or in any other jurisdiction preceded such employment or granting of a license, except where a mandatory forfeiture, disability or bar to employment is imposed by law, and has not been removed by an executive pardon, certificate of relief from disabilities or certificate of good conduct. Nothing in this article shall be construed to affect any right an employer may have with respect to an intentional misrepresentation in connection with an application for employment made by a prospective employee or previously made by a current employee.

**§752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited.** No application for any license or employment, and no employment or license held by an individual, to which the provisions of this article are applicable, shall be denied or acted upon adversely by reason of the individuals having been previously convicted of one or more criminal offenses, or by reason of a finding of lack of 'good moral character' when such finding is based upon the fact that the individual has previously been convicted of one or more criminal offenses, unless:

- (1) There is a direct relationship between one or more of the previous criminal offenses and the specific license or employment sought or held by the individual; or
- (2) the issuance or continuation of the license or the granting or continuation of the employment would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public.

**§753. Factors to be considered concerning a previous criminal conviction; presumption.** 1. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall consider the following factors:

- (a) The public policy of this state, as expressed in this act, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses.
- (b) The specific duties and responsibilities necessarily related to the license or employment sought or held by the person.
- (c) The bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his fitness or ability to perform one or more such duties or responsibilities.
- (d) The time which has elapsed since the occurrence of the criminal offense or offenses.
- (e) The age of the person at the time of occurrence of the criminal offense or offenses.
- (f) The seriousness of the offense or offenses.
- (g) Any information produced by the person, or produced on his behalf, in regard to his rehabilitation and good conduct.
- (h) The legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public.

2. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall also give consideration to a certificate of relief from disabilities or a certificate of good conduct issued to the applicant, which certificate shall create a presumption of rehabilitation in regard to the offense or offenses specified therein.

**§754. Written statement upon denial of license or employment.** At the request of any person previously convicted of one or more criminal offenses who has been denied a license or employment, a public agency or private employer shall provide, within thirty days of a request, a written statement setting forth the reasons for such denial.

**§755. Enforcement.** 1. In relation to actions by public agencies, the provisions of this article shall be enforceable by a proceeding brought pursuant to article seventy-eight of the civil practice law and rules.

2. In relation to actions by private employers, the provisions of this article shall be enforceable by the division of human rights pursuant to the powers and procedures set forth in article fifteen of the executive law, and, concurrently, by the New York city commission on human rights.

Attn: Licensing  
PO Box 2616, Omaha, NE 68114  
Fax: (877) 573-6177  
Phone: (800) 423-2765  
E-mail: BPLicensing@lfg.com

This Business Associate Agreement (“Agreement”) is made and entered into by and between The Lincoln National Life Insurance Company and/or Lincoln Life & Annuity Company of New York (the “Covered Entity”) and \_\_\_\_\_ (“Business Associate”), and is effective this \_\_\_\_ day of \_\_\_\_\_, 201\_\_ (“Effective Date”).

### Recitals

- A. Covered Entity and Business Associate are parties to an arrangement pursuant to which Business Associate provides certain services relating to the marketing, sale and/or administration of Covered Entity’s insurance products and services (the “Services”) which may involve the use and/or disclosure of individually identifiable health information (“Protected Health Information”).
- B. The parties acknowledge and agree that in order to perform the Services, Business Associate may be required to create, receive, transmit, access, maintain, or otherwise hold, use or disclose Protected Health Information.
- C. Business Associate desires to protect the privacy and provide for the security of Protected Health Information in accordance with the terms and conditions set forth below:

#### 1. Definitions

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms by HIPAA, HITECH, and the regulations promulgated under these Privacy Laws.

#### 2. Obligations and Activities of Business Associate

- (a) Use or Disclosure of Protected Health Information - Business Associate agrees not to use or disclose Protected Health Information, other than as permitted or required by the Agreement or as required by law.
- (b) Safeguards - Business Associate agrees to develop, implement, maintain, and use appropriate and effective administrative, technical, and physical safeguards and to comply with the HIPAA Security Rules set forth in Subpart C of 45 CFR Part 164 with respect to Electronic Protected Health Information, in order to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement. Business Associate agrees to keep these safeguards current and document them in written policies, standards, procedures or guidelines, which Business Associate will provide to Covered Entity upon Covered Entity’s request.
- (c) Breach Notification - Business Associate agrees to notify Covered Entity promptly following the discovery of a breach or suspected breach of unsecured Protected Health Information, Security Incident or other Use or Disclosure of Protected Health Information which is not permitted under the terms of this Agreement (collectively, the “Breach”). Such notification shall comply with 45 CFR § 164.410 and shall:
  - (i) Be made via email to Lincoln’s Corporate Privacy Office at [privacy@lfg.com](mailto:privacy@lfg.com).
  - (ii) Be made within one (1) day after discovery.
  - (iii) Include the names of the Individuals whose information was breached, the circumstances surrounding the Breach, the date of the Breach and date of discovery, a brief description of the types of information breached including the full name, social security number, date of birth, diagnosis or other types of information, any steps the Individuals should take to protect themselves from potential harm resulting from the Breach, the steps Business Associate (or its agent or subcontractor) is taking to investigate the Breach, mitigate losses, and protect against future breaches; any other relevant information; and a contact person for more information.

Covered Entity shall have sole control over the timing and method of providing notification of the Breach to the affected individual(s) or others. Business Associate shall be financially responsible and reimburse Covered Entity for any costs associated with the Breach.

- (d) Duty to Mitigate - Business Associate agrees to act promptly to mitigate, to the extent practicable, any harmful effect that is known to Business Associate relating to a Breach. If requested by Covered Entity, Business Associate will be financially responsible for Covered Entity’s provision of credit monitoring services and/or other reasonable services to individuals as part of mitigating harm under this Section. Business Associate shall be responsible for all costs of mitigation under this Section.
- (e) Agents - In accordance with 45 CFR 164.502 (e)(1)(ii) and 164.308 (b)(2), if applicable, Business Associate agrees to ensure that any agent, including a subcontractor, that receives, creates, maintains or transmits Protected Health Information on behalf of Business Associate or on behalf of Covered Entity agrees to the same restrictions and conditions that apply to Business Associate with respect to such information.

- (f) Access to Secretary – Business Associate agrees to make its internal practices, books, and records, including policies and procedures relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary of Health and Human Services and the Covered Entity, for purposes of the Secretary determining Covered Entity's compliance with HIPAA within 10 days after the Business Associate's receipt of such request.
- (g) Access to Individuals - Business Associate agrees to make available to the Covered Entity, or, if directed by Covered Entity, to make available to an Individual Protected Health Information in a Designated Record Set, in order to meet the requirements under 45 CFR 164.524. Except as provided for in this Agreement, in the event Business Associate receives an access request directly from an Individual, Business Associate will redirect the Individual to the Covered Entity within ten (10) business days after the Business Associate's receipt of such request.
- (h) Amendment of Protected Health Information - Business Associate agrees to make any amendment(s) to Protected Health Information it holds in a Designated Record Set, as directed, or agreed to, by the Covered Entity pursuant to 45 CFR 164.526, and in the time and manner reasonably requested by Covered Entity. Except as provided for in this Agreement, in the event Business Associate receives an amendment request directly from an Individual, Business Associate will redirect the Individual to the Covered Entity within ten (10) business days after the Business Associate's receipt of such request.
- (i) Accounting of Disclosures - Business Associate agrees to document and provide a description of any disclosures of Protected Health Information and information related to such disclosures during the six (6) years prior to the date on which an accounting is requested, as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528. Business Associate agrees to provide such information to Covered Entity, or to an Individual at the direction of the Covered Entity, in order for Covered Entity to comply with the accounting requirements in 45 CFR 164.528. Except as provided for in this Agreement, in the event Business Associate receives a request for an accounting of disclosure or other similar request directly from an Individual, Business Associate will redirect the Individual to the Covered Entity within ten (10) business days after the Business Associate's receipt of such request.
- (j) Accounting of Certain Disclosures Through An Electronic Health Record. Business Associate agrees to document and provide a description of any disclosures of Protected Health Information through an electronic health record and information related to such disclosures during the three (3) years prior to the date on which an accounting is requested, as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures to carry out treatment, payment, and health care operations as provided in 45 CFR 164.506.
- (k) Covered Entity's Right to Restrict – Business Associate agrees to comply, upon receipt of a communication by Covered Entity, with any restrictions to the use or disclosure of Protected Health Information that Covered Entity has agreed to or is required to abide by in accordance with 45 CFR 164.522. To the extent the Business Associate is to carry out any other of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, Business Associate agrees to comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s).
- (l) Retention – Except as otherwise provided herein, Business Associate shall retain complete and accurate records of any Protected Health Information of Covered Entity for a period of no less than six (6) years after Business Associates creates or receives the Protected Health Information on behalf of Covered Entity. Business Associate shall not directly or indirectly receive remuneration in exchange for any of Covered Entity's Protected Health Information without the prior authorization of Covered Entity.

### **3. Permitted Uses and Disclosures by Business Associate**

- (a) Business Associate agrees that it shall keep confidential all Protected Health Information as required by HIPAA, that Business Associate receives, creates, or maintains under and/or in connection with this Agreement, and shall not use or disclose Protected Health Information except as permitted or required by this Agreement, or by law. Business Associate may not use or disclose Protected Health Information in a manner that would violate HIPAA if done by Covered Entity.
- (b) Business Associate shall determine the amount of Protected Health Information necessary for its purposes and shall limit its requests, uses, and disclosures to the minimum necessary Protected Health Information required to accomplish the intended purpose. Business Associate shall follow any minimum necessary policies and procedures provided by Covered Entity.
- (c) Business Associate is authorized to use Protected Health Information if necessary for the proper management and administration of the Business Associate and to carry out any of the Business Associate's legal responsibilities. Business Associate is authorized to disclose Protected Health Information if necessary for the proper management and administration of the Business Associate and to carry out any of Business Associate's legal responsibilities if (i) the disclosure is required by law; or (ii) Business Associate shall obtain reasonable assurances from the third-party recipient of Protected Health Information that: (x) the Protected Health Information will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the third party; and (y) the third party will notify Business Associate of any instances of which the third party is aware in which the confidentiality of the Protected Health Information has been breached.
- (d) Business Associate may use Protected Health Information to provide data aggregation services to Covered Entity relating to Covered Entity's health care operations.
- (e) All other uses or disclosures by Business Associate not authorized by this Agreement are prohibited.



**4. Amendment**

The parties agree to take such action as is necessary to comply with the requirements of HIPAA and any other privacy laws and regulations applicable to the Services or the relationship between the parties ("Privacy Laws"). Covered Entity shall have the right to amend this Agreement at any time upon written notice through the addition or modification of addendums or amendments to this Agreement in order to comply with Privacy Laws. In the event Covered Entity does not exercise this right and this Agreement no longer complies with Privacy Laws, this Agreement will automatically be amended to the minimum extent necessary such that both parties remain in compliance with such Privacy Laws.

**5. Term and Termination**

- (a) Term. The term of this Agreement shall commence as of the Effective Date and terminate when all Protected Health Information created by or received by Business Associate on behalf of Covered Entity is either returned to Covered Entity or destroyed, except as otherwise provided herein. Upon termination of the relationship between the parties, Business Associate will destroy or return to Covered Entity any Protected Health Information it holds in any form. This provision also applies to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate will retain no copies of the Protected Health Information. If Business Associate reasonably can show that it is infeasible to return or destroy Protected Health Information, and the Covered Entity agrees, Business Associate must extend the protections under this Agreement to such Protected Health Information and only may further use or disclose such information for those purposes that make the return or destruction infeasible.
- (b) Termination for Cause. Upon Covered Entity's knowledge of a breach of this Agreement by Business Associate, Covered Entity and/or its affiliate, as applicable, is authorized to terminate this Agreement.

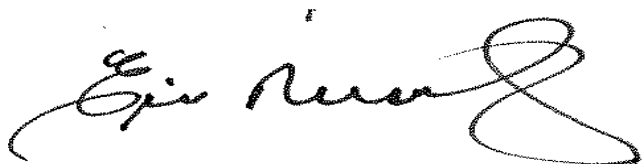
**6. Miscellaneous**

- (a) Indemnification. Business Associate agrees to indemnify, defend, and hold harmless Covered Entity from and against any action, claim, demand, loss, liability, fine, penalty or expense (including attorneys' and witnesses' fees and expenses) arising out of or resulting, directly or indirectly, in any way from any breach by Business Associate of any term hereof or from any act or omission of its agents, employees or subcontractors.
- (b) Regulatory References. A reference in this Agreement to a section in the Privacy Laws means the section as in effect or as amended.
- (c) Survival. Business Associate's obligations in respect of the use, disclosure and protection of Protected Health Information shall survive any termination of this Agreement.
- (d) Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with HIPAA.

**IN WITNESS WHEREOF**, the parties execute this Agreement by their duly authorized representatives.

Covered Entity

Business Associate



\_\_\_\_\_  
Signature

SVP- Group Underwriting, Product, and Operations

Title \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

## Electronic Funds Transfer Authorization Form

This form is used for new direct deposit setup and revision to existing direct deposit of producer or corporate commission earnings. Please complete all applicable sections and fax or mail the completed form to the address/fax number indicated below.

To avoid processing delays, please verify the following:

1. Voided check or a letter from the bank verifying account information.
2. Fields are filled in completely and form is signed.
3. The account you have chosen for deposit is associated with your SSN/Tax ID.

Completed Forms may be sent to:  
Distribution Compensation  
P.O. Box 2348, Fort Wayne, IN 46802  
Fax: 260-455-1587

### IMPORTANT NOTICE(S):

- **If you would like your personal commission earnings paid to a corporation, the corporation must be licensed and appointed** with The Lincoln National Life Insurance Company and/or Lincoln Life & Annuity Company of New York and affiliates ("Lincoln"). These requests can be accommodated by completing the Financial Owner Assignment Form. For questions regarding the Financial Ownership process or requirements, please contact us at 800-238-6252, option 1.
- **Registered Representatives with LFA or LFS:** You must have a personal bank account under your SSN to direct deposit your commissions. Registered commission earnings cannot be paid to a Corporate Account per U.S. Securities and Exchange Commission guidelines.
- **Statement Access:** Once set up for direct deposit, Life & Annuity as well as all business placed through Lincoln Financial Advisors or Lincoln Financial Securities commission statements will be available online. Statements for Group business are available online and will continue to be provided as previously requested.
- Compensation can only be paid to an entity properly licensed and appointed with the company. EFT Transfers must be deposited into a bank account registered under the Tax ID/SSN noted above or properly financially owned.

## Demographic Information

Full Legal Name of Producer OR Full Corporate Name: \_\_\_\_\_

Social Security Number (Last 4 Digits): \_\_\_\_\_ OR Complete Corporate TIN: \_\_\_\_\_

Producer Codes/Agent Number (List one or more): \_\_\_\_\_

**PLEASE NOTE: Commissions on group business will only be set to direct deposit for producer codes identified.**

Email Address: \_\_\_\_\_ Upline Email Address: \_\_\_\_\_

## Account Information

I hereby authorize and request Lincoln (hereinafter called "the Company") to make payment of any amount(s) owed to me by initiating credit or adjustment entries to my bank(s) as indicated below. I authorize and request my bank(s) to accept credit or adjustment entries initiated by the Company and its affiliates and to enter same into the following account(s):

Account Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

ABA (Routing) Number: \_\_\_\_\_  Checking  Savings

## Authorization & Signature

**Upon election of EFT, you must register and use your Lincoln website to access your commission statement online.**

The only negative adjustment the Company will make to your bank account would be to reverse a credit made in error. This type of transaction is rare, would only occur within 5 days of the initial credit and the Company would notify you of this transaction. It is understood that this agreement may be terminated by me or the Company at any time by written notification. Any such notification shall be effective only after receipt and processing by the Company. Compensation for registered insurance products can only be paid to broker dealers with effective selling agreements. Corporations applying for EFT must include signature and title of either the Corporation President, Vice President, or Principal. Corporations must be licensed and appointed with Lincoln.

\_\_\_\_\_  
Signature (Written Signature Required)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date