Lincoln LifeGuaranteesM SUL

A Life Insurance Illustration Flexible Premium Adjustable Life Policy



Presented by: Richard Denmark

Signature Page

\$7.500,000

Level

ABR

Annual

 For:
 Dennis Shasha
 Karen Shasha
 Initial Death Benefit:

 Age:
 53
 54
 Initial Death Benefit Opt:

 Sex:
 Male
 Female
 Initial Payment Mode:

 Class:
 Standard Non-Tobacco
 Standard Non-Tobacco
 Riders:

Numeric Summary

	Guaranteed	Midpoint	Current
Description	Values	Values	Values
Lapse Year	n/a	n/a	n/a
End of Year 5, Age 58			
Total Premium Paid	202,975	202,975	202,975
Surrender Value	0	0	0
Death Benefit	7.500,000	7,500,000	7,500,000
End of Year 10, Age 63	, ,	.,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Total Premium Paid	345,950	345,950	345,950
Surrender Value	44,259	59,396	74,503
Death Benefit	7,500,000	7.500.000	7,500,000
End of Year 20, Age 73	.,,	1,000,000	7,000,000
Total Premium Paid	983,220	983,220	983.220
Surrender Value	452,423	597,395	739,713
Death Benefit	7.500,000	7,500,000	7,500,000
End of Year 30, Age 83	,,	,,000,000	1,000,000
Total Premium Paid	1,971,810	1,971,810	1,971,810
Surrender Value	0	363.152	1,144,202
Death Benefit	7.500,000	7,500,000	7,500,000
End of Year 17, Age 70	-,500,000	,,000,000	7,500,000
Total Premium Paid	686.643	686,643	686,643
Surrender Value	285,035	365,512	445,170
Death Benefit	7,500,000	7,500,000	7,500,000

NOTE: Non-guaranteed benefits and values are not guaranteed. The assumptions on which they are based are subject to change by the company. Actual results may be more or less favorable. Guaranteed Values are based on maximum cost of insurance charges and guaranteed minimum interest crediting rate.

Signature Section

Date

I/We have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The licensed agent/representative has told me/us they are not guaranteed. I understand that this illustration is not a contract and that the terms of the policy constitute the actual agreement of coverage.

I have been advised to consult with my own tax advisors regarding the tax effects of the illustrated policy and also with respect to its valuation.

It is my intention to replace existing coverage with the coverage represented by this illustration. My insurance agent has explained the advantages and disadvantages of this exchange.

The information above is NOT intended as legal or tax advice.

Proposed Owner/Applicant Signature

For such advice, the taxpayer should consult his or her attorney or tax advisor.

I certify that this illustration has been presented to the applicant/owner and that I have explained that any non-guaranteed elements illustrated are subject to change. I have made no statements that are inconsistent with the illustration. I have advised the applicant/owner to consult with tax advisors regarding the tax effects of the illustrated policy.

TRUST	X	JFD	III	CA	TI	M	Ĵ
	•						•

I/WE hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me/us or my/our physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I/We authorize the Company to disclose information related to my insurability to MIB, Inc., and to other insurers to whom I/we may apply for coverage.

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

I hereby authorize the Company to obtain an Investigative Consumer Report.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken

prior to notification will not be affected.	C				
life policy.	: Company to c	determine eligibility for life coverage or a claim for be	enefits under a		
\Box I elect to be interviewed if an Investigative Con	sumer Report i	s prepared.			
SIGNATORY SECTION					
Signed in	, this	day of			
(state)		(month)	(year)		
Signature of Proposed Insured A (Parent or Guardian if under 14 years and 6 months of age)		Signature of Proposed Insured B (If coverage applied for) (Parent or Guardian if under 14 years and 6 months of age)			
Signature of Applicant/Owner/Trustee (If other than Propo (Provide Officer's Title if policy is owned by a Corporation)	sed Insured)	Signature of Applicant/Owner/Trustee (If other than Proposed Insured) (Provide Officer's Title if policy is owned by a Corporation)			
TO BE COMPLETED BY AGENT ONLY					
(i) Does the applicant have any existing life insura					
(ii) Do you know or have you any reason to believ If a replacement is involved, I certify that only materials were left with the applicant.	e that replacem company appro	ent of insurance is involved? $\square Y \square N$ oved sales materials were used in this sale and that copie	es of all sales		
I declare that I have accurately answered all questi	ons contained i	n this section.			
I declare that I have provided each Proposed Insured	and Owner(s) w	ith the Important Notice as well as a copy of the Privacy Pra	actices Notice.		
Signature of Licensed Agent, Broker or Registered Repres	entative	Name of Licensed Agent, Broker or Registered Representati (Please Print)	ive		
APPLICABLE TO VARIABLE LIFE ONLY	P				
I have reviewed the Application, Supplements, New	Account Form	and allocation forms and find the transaction suitable.	here is a second of the second		
Signature of Registered Principal of Broker/Dealer		Name of Registered Principal of Broker/Dealer (Please Print)	}		
			Page 5 of 5		

LFF06321-18 7/08