The Lincoln National Life Insurance Company
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PRODUCER FEE/OVERRIDE DISCLOSURE FORM

GROUP INFORMATION

Group Name:_____

Group ID: _____

PRODUCER TYPE - Please check each typeof producer that will be receiving compensation in connection with this group.

☐ Writing Broker ☐ Third Party Adminstrator (TPA) ☐ Enroller/Enrollment Firm ☐ General Agent ☐ Broker's Broker

Writing Producer complete and sign this form for each group in which an override or fee will be assessed. Please return the form to your Regional Group Office.

FEES

☐ Yes, fees apply for the above group. Fees are payment(s) for specific services performed for the group as indicated below. Please mark all that apply below.

Service Fees	Fee Percentage	Coverage (mark all that apply)				
Enrollment Services	_____ %	☐ Life ☐ Vol. Life	☐ STD ☐ Vol. STD	☐ LTD ☐ Vol. LTD	☐ Dental ☐ Vol. Dental	☐ Vision ☐ Vol. Vision
TPA Services	_____ %	☐ Life ☐ Vol. Life	☐ STD ☐ Vol. STD	☐ LTD ☐ Vol. LTD	☐ Dental ☐ Vol. Dental	☐ Vision ☐ Vol. Vision
Mailing Costs	_____ %	☐ Life ☐ Vol. Life	☐ STD ☐ Vol. STD	☐ LTD ☐ Vol. LTD	☐ Dental ☐ Vol. Dental	☐ Vision ☐ Vol. Vision
Printing Costs	_____ %	☐ Life ☐ Vol. Life	☐ STD ☐ Vol. STD	☐ LTD ☐ Vol. LTD	☐ Dental ☐ Vol. Dental	☐ Vision ☐ Vol. Vision
Human Resource Services	_____ %	☐ Life ☐ Vol. Life	☐ STD ☐ Vol. STD	☐ LTD ☐ Vol. LTD	☐ Dental ☐ Vol. Dental	☐ Vision ☐ Vol. Vision
IT/Systems Costs	_____ %	☐ Life ☐ Vol. Life	☐ STD ☐ Vol. STD	☐ LTD ☐ Vol. LTD	☐ Dental ☐ Vol. Dental	☐ Vision ☐ Vol. Vision
Finders Fees	_____ %	☐ Life ☐ Vol. Life	☐ STD ☐ Vol. STD	☐ LTD ☐ Vol. LTD	☐ Dental ☐ Vol. Dental	☐ Vision ☐ Vol. Vision
Consulting Fees	_____ %	☐ Life ☐ Vol. Life	☐ STD ☐ Vol. STD	☐ LTD ☐ Vol. LTD	☐ Dental ☐ Vol. Dental	☐ Vision ☐ Vol. Vision

Fees will be paid: ☐ 1year ☐ 2 year ☐ date the policy terminates ☐ Other

Fee Recipient Name:_____

Fee Recipient Address: _____

Fee Recipient Tax ID#: _____

Group ID: _____

OVERRIDE COMMSION

☐ Yes, Overrides apply to the above group. Overrides are payment(s) to a general agent or manager for managing an agency or for performing adminstration functions only (for example a broker's broker). Overrides for the above policy to be paid as follows (complete for all coverages that apply):

Coverage	Override Percentage	Coverage	Override Percentage
Life		Vol. Life	
STD		Vol. STD	
LTD		Vol. LTD	
Dental		Vol. Dental	
Vision		Vol. Vision	

Override will be paid: ☐ 1year ☐ 2 year ☐ date the policy terminates ☐ Other

Override Recipient Name: _____

Override Recipient Address: _____

Override Recipient Tax ID#: _____

I hereby represent that all information provided on this form is true and correct to the best of my knowledge and belief. I understand that The Lincoln National Life Insurance Company will rely on this information to comply with certain record-keeping and disclosure requirements. I further understand that I may be required to disclose the information provided on this form to the customer.

Writing Producer Name: _____

Writing Producer Address: _____

Writing Producer Tax ID#: _____ Date: _____

Writing Producer Signature: _____