

PRODUCER FEE/OVERRIDE DISCLOSURE FORM

Group Information:
Group Name: _____
Group ID: _____

PRODUCER TYPE: Please check each type of producer that will be receiving compensation in connection with this group.

Writing Broker Third Party Administrator (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	_____ %	<input type="checkbox"/> Life	<input type="checkbox"/> STD	<input type="checkbox"/> LTD	<input type="checkbox"/> Dental
		<input type="checkbox"/> Vol. Life	<input type="checkbox"/> Vol. STD	<input type="checkbox"/> Vol. LTD	<input type="checkbox"/> Vol. Dental
TPA Services	_____ %	<input type="checkbox"/> Life	<input type="checkbox"/> STD	<input type="checkbox"/> LTD	<input type="checkbox"/> Dental
		<input type="checkbox"/> Vol. Life	<input type="checkbox"/> Vol. STD	<input type="checkbox"/> Vol. LTD	<input type="checkbox"/> Vol. Dental
Mailing Costs	_____ %	<input type="checkbox"/> Life	<input type="checkbox"/> STD	<input type="checkbox"/> LTD	<input type="checkbox"/> Dental
		<input type="checkbox"/> Vol. Life	<input type="checkbox"/> Vol. STD	<input type="checkbox"/> Vol. LTD	<input type="checkbox"/> Vol. Dental
Printing Costs	_____ %	<input type="checkbox"/> Life	<input type="checkbox"/> STD	<input type="checkbox"/> LTD	<input type="checkbox"/> Dental
		<input type="checkbox"/> Vol. Life	<input type="checkbox"/> Vol. STD	<input type="checkbox"/> Vol. LTD	<input type="checkbox"/> Vol. Dental
Human Resource Services	_____ %	<input type="checkbox"/> Life	<input type="checkbox"/> STD	<input type="checkbox"/> LTD	<input type="checkbox"/> Dental
		<input type="checkbox"/> Vol. Life	<input type="checkbox"/> Vol. STD	<input type="checkbox"/> Vol. LTD	<input type="checkbox"/> Vol. Dental
IT/Systems Costs	_____ %	<input type="checkbox"/> Life	<input type="checkbox"/> STD	<input type="checkbox"/> LTD	<input type="checkbox"/> Dental
		<input type="checkbox"/> Vol. Life	<input type="checkbox"/> Vol. STD	<input type="checkbox"/> Vol. LTD	<input type="checkbox"/> Vol. Dental
Finders Fees	_____ %	<input type="checkbox"/> Life	<input type="checkbox"/> STD	<input type="checkbox"/> LTD	<input type="checkbox"/> Dental
		<input type="checkbox"/> Vol. Life	<input type="checkbox"/> Vol. STD	<input type="checkbox"/> Vol. LTD	<input type="checkbox"/> Vol. Dental
Consulting Fees	_____ %	<input type="checkbox"/> Life	<input type="checkbox"/> STD	<input type="checkbox"/> LTD	<input type="checkbox"/> Dental
		<input type="checkbox"/> Vol. Life	<input type="checkbox"/> Vol. STD	<input type="checkbox"/> Vol. LTD	<input type="checkbox"/> Vol. Dental

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

Fee Recipient Name: _____

Fee Recipient Address: _____

Fee Recipient Tax ID#: _____

Group ID: _____

OVERRIDE COMMISSION:

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

<u>Coverage</u>	<u>Override %</u>	<u>Coverage</u>	<u>Override %</u>
Life	_____	Vol. Life	_____
STD	_____	Vol. STD	_____
LTD	_____	Vol. LTD	_____
Dental	_____	Vol. Dental	_____

Override will be paid 1 year 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: _____