Lincoln Financial Group®

**The Lincoln National Life Insurance Company**
Service Office: PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as "the Company")

# DRUG USAGE SUPPLEMENT

Proposed Insured: _____ Date of Birth *(mm/dd/yy)*: _____

1A. Are you now using or have you used during the last ten (10) years any of the following drugs:

a) Opium derivatives: Heroin, Morphine, Demerol, Methadone, Codeine, Percocet, Dilaudid or Oxycontin. ☐ Yes ☐ No
b) Barbiturates: Amytal, Phenobarbital, Seconal, Nembutal, Pentobarbital ☐ Yes ☐ No
c) Marijuana: Hashish, Cannabis ☐ Yes ☐ No
d) Amphetamines: Benzedrine, Dexedrine, Methedrine, Preludin ☐ Yes ☐ No
e) Cocaine, Crack ☐ Yes ☐ No
f) Hallucinogens: LSD, HMT, Mescaline, Peyote, Psilocybin, PCP ☐ Yes ☐ No
g) Sedatives and Tranquilizers: Librium, Valium, Quaalude, Dalmane, Placidyl ☐ Yes ☐ No

1B. Were any of the above prescribed by a physician: ☐ Yes ☐ No
If "Yes", which?

2. If "Yes" answers in 1A or 1B, please give details.

| Type | Usual Quantity | Frequency of Use | How Taken (Oral, Injection, Inhaled, Smoked, Etc.) | Date: From - To |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

3. Except those prescribed by a physician, are you now using or have you used during the last ten (10) years any other drugs not listed in numbers 1 or 2 above ? ☐ Yes ☐ No If "Yes", explain:

4. Have you ever sought medical treatment because of drug usage? ☐ Yes ☐ No
If "Yes". state dates and names of doctors and institutions consulted:

5. Please indicate any additional relevant information:

I have read or have had read to me the completed Drug Usage Supplement before signing below. All statements and answers in this Supplement are correctly recorded and are full, complete and true to the best of my knowledge and belief. I agree that this Drug Usage Supplement constitutes a part of my application for insurance. I understand that any false statements or material misrepresentations may result in the loss of coverage under the policy.

Signed in _____, this _____ day of _____ _____
(state) (month) (year)

**Signature of Proposed Insured** (Parent or Guardian if under 14 years of age) **Witness**