Lincoln Financial Group®

The Lincoln National Life Insurance Company, PO Box 2609, Omaha, NE 68103-2609
toll free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com

EMPLOYER PLAN - CLAIM FOR BENEFITS
EMPLOYEE STATEMENT

(BENEFITS MAY BE DELAYED IF CLAIM FORM IS NOT FULLY COMPLETED)

Please sign this page and the authorization on page two of this form to avoid delays in processing
(PLEASE see FRAUD NOTICES attached)

1. Full Name **(Last, First, Middle Initial)**
2. Social Security Number
3. Phone Number (*include area code*)
4. Street Address & Mailing Address
5. City
6. State
7. Zip Code
8. Date of Birth
9. I have been unable to work because of my disability since
10. Gender ☐ Male ☐ Female
11. Hospital Confined ☐ Yes ☐ No
12. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced
13. Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If "Yes" provide dates:
14. Is your disability due to a: ☐ Sickness ☐ Injury ☐ Other

14a. Please describe your Sickness or how your injury occurred:

Height:

Weight:

15. I returned to work part-time on:

    I returned to work full-time on:

16. Is your accident or illness due to your occupation? ☐ Yes ☐ No If "Yes" explain:

    Have you or do you intend to file a Workers Compensation Claim? ☐ Yes ☐ No

17. Treated by: (on another piece of paper, provide names & addresses of all doctors who have treated you for this disability)

    Doctor: ____________________

    Address: ____________________

18. Describe other income you are receiving, have applied for, or will be applying for:

	Amount	Date Began	Date Will Terminate	Date Applied For
Social Security (Disability Retirement)	$			
Salary Continuance or State Disability Benefits	$			
Workers' Compensation	$			
Other income related to your disability	$			

19. The above statements are true and complete to the best of my knowledge and belief. **I have completed and attached the Authorization for Release of Information.**

    The above Statements are true and complete to the best of my knowledge and belief. I have read and understand the attached Fraud Warning Statements.

    ____________________ ____________________
    Signature of Employee Date

20. Please provide us with your e-mail address:

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AUTHORIZATION FOR RELEASE OF INFORMATION

1. **I (the undersigned) authorize** any physician, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; insurance or reinsurance company; government agency; department of labor; acquaintance; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

   Claimant/Patient Name: ____
   (Last) (First) (Middle)

   Date of Birth: ______________________ Social Security Number: ______________________

2. Information to be released:
   - data or records regarding my medical history, treatment, prescriptions, consultations [including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition I may now have or have had];
   - any information regarding insurance coverage; and
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, Retirement Income, financial, earnings and employment history).

3. Information to be released to: The Lincoln National Life Insurance Company
   PO Box 2609
   Omaha, NE 68103-2609

4. I understand the information obtained by use of this Authorization will be used by The Lincoln National Life Insurance Company ("Company") to evaluate my claim for disability benefits. The Company will only release such information:
   - to its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
   - to a vendor, approved by the company, which specializes in the application for Social Security Disability Benefits
   - to vendors/consultants providing the claimant with wellness, disability or leave related services as part of an employer sponsored benefit plan
   - to the employer for self-insured disability plans; or
   - as otherwise may be required by law or as I may further authorize.

   I further understand that refusal to sign this Authorization may result in the denial of benefits.

5. I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. For Colorado claims, the disclosed information may not be redisclosed or reused by the recipient under Colorado law.

6. I understand that I may revoke this Authorization in writing at any time, except to the extent:
   1. the Company has taken action in reliance on this Authorization; or
   2. the Company is using this Authorization in connection with a contestable claim.

   If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of my signature below. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.

7. A photocopy of this Authorization is to be considered as valid as the original.

8. I understand I am entitled to receive a copy of this Authorization.

SIGNATURE: ______________________________________ **DATE:** ________________

Claimant/legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/patient is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

PRINT NAME: ______________________________________

Relationship to Claimant/Patient of personal/legal representative signing for Claimant/Patient: ____________________

ADDRESS: ______________________________________ PHONE NO: ________________
(Street)

____
(City) (State) (Zip Code)

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EMPLOYER'S REPORT OF CLAIM (TO BE COMPLETED BY EMPLOYER)

Please submit a copy of this employee's complete Job Description with this claim form.
(PLEASE see FRAUD NOTICES attached)

1. Name of Employee **(last, first, middle initial)**		2. Employee Social Security No.
3. Occupation of Employee	4. Class	5. Employee Date of Hire
6. Number of Hours Worked Per Week	7. Date Effective	
8. Date Employee was Last Present at Work	9. Employee's Basic Weekly Earnings	10. Returned To Work? ☐ Full-time ☐ Part-time Date:
11. Percent of premium paid by: Employee: % ☐ pre-tax ☐ post-tax Employer: %	12. Is the Claim due to your employee's occupation? ☐ Yes ☐ No 13. Has a Workers' Compensation claim been filed? ☐ Yes ☐ No	
14. Has Employee received any other income since the date last worked? ☐ Yes ☐ No Please specify the type of income (Sick Pay, Vacation, Salary Continuation, Paid Time Off, Etc.) ____________ Weekly Amount Paid $ Date Began: Date Ended:		
Employer's Name & Address (or name of policyholder, if other)	Telephone No. (Include Area Code and Extension)	Group ID or Billing Number
E-mail address		Fax Number (Include Area Code)

The above Statements are true and complete to the best of my knowledge and belief. I have read and understand the attached Fraud Warning Statements.

______________________________ ______________________________
Signature of Person Completing this form and Title Date

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ATTENDING PHYSICIAN'S STATEMENT

1. Name of Patient
2. Social Security Number
3. Employer Name
4. When did symptoms first appear or accident happen?
5. Date you believe patient was unable to work?
6. **Diagnosis** (including complications)
7. Subjective symptoms
8. **Medical findings** (Including current x-rays, EKG's, laboratory data and any clinical findings)
9. List of Restrictions & Limitations
10. Nature of treatment (Including surgery and medications prescribed, if any.)
11. **Names, specialty and addresses of other treating physicians**
12. Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes" provide dates.
13. Do you consider this condition to be due to your patient's employment? ☐ Yes ☐ No
14. If pregnancy, estimated date of delivery:
    Actual date of delivery:
15. Date first treated
16. Date of last visit/treatment
17. Frequency ☐ Weekly ☐ Monthly ☐ Other (specify)
18. Has patient: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed
19. Is patient: ☐ Ambulatory ☐ House Confined ☐ House Confined ☐ Hospital Confined
20. Has patient been hospital confined? ☐ Yes ☐ No Confined from: to
    If "Yes" give name of hospital.
21. Has surgery been scheduled or performed? ☐ Yes ☐ No If "Yes" date of surgery:
    Type of surgery scheduled:
22. Prognosis and Rehabilitation:

    a. When do you think your patient will be able to return to work?
    PRESENT occupation? ALL OTHER occupations?
    b. Can present job be modified to allow patient to handle with his/her impairment? ☐ Yes ☐ No
    c. **When could trial employment commence?** ☐ Full-time ☐ Part-time

Please submit clinical documentation to support your decision.

Print Name (Attending Physician)	Specialty	Telephone (Include Area Code)

Street Address/City or Town/State or Province/Zip Code

The above Statements are true and complete to the best of my knowledge and belief. I have read and understand the attached Fraud Warning Statements.

Signature (Attending Physician) **No stamps please**	Date	Fax Number (Include Area Code)

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY IS NOT RESPONSIBLE FOR CHARGES INCURRED DUE TO COMPLETION OF THIS FORM. THE PATIENT IS RESPONSIBLE FOR ANY CHARGES ASSOCIATED WITH FORM COMPLETION.

FRAUD NOTICES. For your protection, certain states require that the following notices appear on this form.

Alaska. A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona. For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island and West Virginia. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California. For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware. Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia. It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho. Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete or misleading information is guilty of a felony.

Indiana. A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky. Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland. Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota. A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire. Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.