Lincoln Financial Group®

Long Term Disability Claim Form Statement Of Employee

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
disabilityclaims@lfg.com

1. Your Information

Full Name (First) | (M.I.) | (Last Name)

Social Security Number | Date of Date of Birth

Street Address

☐ Male ☐ Female

Phone Number

City | State | Zip Code

Email Address

2. Your Employer

Employer Name

Group ID | Job Title

Policy Number | Billing Location

3. Reason for inability to work

Description of Sickness, Injury or Pregnancy

Date Last Worked

Injury work related? ☐ Yes ☐ No

4. Other Income Being Received

	Amount $	Date Began	Date Will Terminate	Date Applied For
Social Security	_____	__ /__ /____	__ /__ /____	__ /__ /____
Workers' Comp	_____	__ /__ /____	__ /__ /____	__ /__ /____
Salary Continuance	_____	__ /__ /____	__ /__ /____	__ /__ /____
State Disability	_____	__ /__ /____	__ /__ /____	__ /__ /____
Other Disability	_____	__ /__ /____	__ /__ /____	__ /__ /____
Sick Pay	_____	__ /__ /____	__ /__ /____	__ /__ /____

If approved, should Lincoln National Life Insurance Co. withhold Federal Income Taxes from your benefits?

☐ Yes ☐ No If yes, indicate how much? _____

(Minimum: $20 per week Short-Term Disability) (Minimum: $88 per Month Long-Term Disability)

5. Who is your treating health care provider?

This is your primary health care professional. Please have them complete the Attending Physician's Statement. If you have additional health care providers, please also complete the Treating Medical Professional form.

Physician's Full Name

Phone Number | Fax Number

Street Address

City | State | Zip Code

6. Account for Direct Deposit ☐ Checking ☐ Saving

Bank Name

Routing Number

Account Number

The above statements are true and complete to the best of my knowledge and belief. I have read and understand Fraud Warning Statements. I have completed and attached the Authorization for Release of Information.

Signature | Date __ /__ /__

Print Name

(Please see FRAUD NOTICES attached)

Illness or Injury Supplemental Questionnaire

Instructions: Please answer the questions to the best of your ability and sign and date below.

1. Is someone else responsible for your illness/injury? ☐ Yes ☐ No

2. Are you making a claim against anyone or any insurance company other than Lincoln Financial Group? ☐ Yes ☐ No

If you answered yes to either question above, please answer the following questions:

3. Please describe in detail the cause of your illness or injury:

4. Please provide the location and address where the illness or injury occurred:

5. Please provide the Responsible Party's information:

1. Name: _____
2. Address: _____
3. Telephone Number: _____
4. Insurance Company's Name: _____
5. Claim Number: _____

6. If you have hired an attorney to investigate or prosecute a claim related to your illness or injury, please provide your attorney's information:

1. Name: _____
2. Address: _____
3. Telephone Number: _____

7. If you have any documents related to any investigation into how your illness or injury occurred, please attach them.

I have answered the above questions to the best of my ability. I understand that fraudulently answering any of these questions could result in the suspension or termination of my benefits. I further understand that I have an obligation to supplement any of the above responses should any of the above information change in the future.

Print Name: _____

Signature: _____ Date: _____ /_____ /_____

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*Please submit a written job description for the employee's position with this claim form
*Please submit a copy of this employee's enrollment statement with this claim form

1. This claim is for:

Full Name (First) (M.I.) (Last Name)

Social Security Number Coverage Start Date ____ /____ /_____

2. Employee's Coverage & Policy

Organization Name Insurance Class

Group ID Policy Number

Billing Location Claim Location

3. Describe Employee's Role

Job Title

Description of Duties

4. Other Income Being Received

	Amount $	Date Began	Date Will Terminate	Date Applied For
Retirement Income	_____	___ /___ /____	___ /___ /____	___ /___ /____
Workers' Comp	_____	___ /___ /____	___ /___ /____	___ /___ /____
Salary Continuance	_____	___ /___ /____	___ /___ /____	___ /___ /____
State Disability	_____	___ /___ /____	___ /___ /____	___ /___ /____
Other Disability pay	_____	___ /___ /____	___ /___ /____	___ /___ /____

Have you considered job accommodations? ☐ Yes ☐ No

Injury work related? ☐ Yes ☐ No

____ /____ /_____ Date hired

Hours worked in a standard day

____ /____ /_____ Date last worked

Hours worked in a standard week

____ /____ /_____ Date back to work full-time

Hours worked on day last worked

$ Earnings

Frequency (W/M/Y etc.)

5. Employer Contact

Employer Contact Name

Street Address

City State Zip Code

Phone Number Fax Number

Email Address

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. I have completed and attached the Authorization for Release of Information.

Signature __ /__ /___ Date

Print Name

(Please see FRAUD NOTICES attached)

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Long Term Disability Claim Form Physician's Statement

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disabilityclaims@lfg.com

1. Patient Information

Full Name (First) | (M.I.) | (Last Name) | Social Security Number

Height | Weight | Blood Pressure | Employer Name

2. Diagnosis

Primary ICD diagnostic Code **(Required)** | Primary ICD diagnosis Description

Secondary ICD Diagnosis Code | Secondary ICD Diagnosis Description

Pregnancy ___ /___ /_____ First Treated | ___ /___ /_____ Estimated Delivery | ___ /___ /_____ Date of Delivery | ☐ Vaginal ☐ C-Section

Symptoms

Objective Findings (Include copies of any x-rays, laboratory data, EKG's, MRI's, scans and any clinical findings)

3. Disability Circumstances - *Check if applicable*

☐ Illness ☐ Injury ☐ Work Related

If work related or injury, summarize circumstances

Date of:

___ /___ /_____ Symptoms first Appeared | ___ /___ /_____ Reduced Ability to work | ___ /___ /_____ Advised to stop work

___ /___ /_____ Initial Treatment | ___ /___ /_____ Most Recent Treatment | ___ /___ /_____ Next Treatment

Dates hospital confined: ___ /___ /_____ to ___ /___ /_____

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.

(Please see FRAUD NOTICES attached)

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

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4. Limitations and Restrictions

Restrictions (what the patient SHOULD NOT do)

Limitations (what the patient CANNOT do)

Indicate frequency per day the listed activities below can be used performed using:
N= Never 0% O= Occasionally <33% F= Frequently 34%-66% C= Continuously 67% - 100%

Lifting/Carrying						**Reaching**	
1-5 lbs.	_____	Standing	____	Crouching	_____	Overhead	_____
6-10 lbs.	_____	Walking	____	Crawling	_____	Desk Level	_____
11-25 lbs.	_____	Sitting	____	Grasping	_____	Below Waist	_____
26-50 lbs.	_____	Balancing	____	Climbing	_____		
51-100 lbs.	_____	Stooping	____	Pushing	_____		
100 + lbs.	_____	Kneeling	____	Pulling	_____		
		Fingering	____	Bending	_____		

What job modifications would allow the patient to return to work?

5. Treatment

Describe current and recommended treatment plans including any completed or future surgeries. (Include dates)

6. Prognosis

Describe the patients prognosis for recovery

7. Physician's Information

Name

Street Address

City State Zip Code

Activities of Daily Living

If patient cannot complete these activities of Daily living indicate, when they were first unable to do so. (M/D/Y)

Continence _____ /_____ /_____

Dressing _____ /_____ /_____

Transferring _____ /_____ /_____

Bathing _____ /_____ /_____

Toileting _____ /_____ /_____

Eating _____ /_____ /_____

Date patient experienced loss of

Cognitive Functioning: _____ /_____ /_____

Describe ongoing treatment frequency

Patient able to return to work Full-Time on:

_____ /____ /_____ to ____ /____ /_____

If a specific date is unavailable, please provide a date range you expect a fundamental or marked change.

Phone Number Fax Number

Signature **Date** __ /__ /___

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Authorization For Release Of Information

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1. In connection with a claim for benefits, 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:

Name of Insured: _____
(Last) (First) (Middle)

Date of Birth: ____ /____ /_____ Social Security Number: XXX-XX-_____

2. **Information to be released (hereinafter referred to as "My Information"):**
   - 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, claims or benefits; and/or
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history).

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

4. **I understand My Information will be used by Lincoln to evaluate and administer my claim for benefits. I also authorize Lincoln to release My Information as follows:**
   - 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 Lincoln, which specializes in the application for Social Security Disability Benefits
   - to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
   - for self-insured disability plans only, to my employer; or
   - for fully insured plans, I understand the information obtained with this Authorization may be used in discussions between Lincoln and my employer regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
   - as otherwise may be required by law or as I may further authorize.
5. I understand My Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. For Colorado claims, the disclosed information may not be re-disclosed 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 Lincoln has taken action in reliance on this Authorization. To initiate revocation of this Authorization, direct all correspondence to Lincoln at the above address. 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, or the duration of my claim for benefits, whichever is shorter.
7. A photocopy of this Authorization is to be considered as valid as the original. 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: _____
(Street)

_____
(City) (State) (Zip Code)

PHONE NO: _____

(Please see FRAUD NOTICES attached)

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

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

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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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.

New Jersey. Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico. 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 civil fines and criminal penalties.

New York. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma. Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon. Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or, (2) conceals for the purpose of misleading, information concerning any material fact, may have committed a fraudulent insurance act.

Pennsylvania. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

Puerto Rico. Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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

Texas. 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.

FOR ALL OTHER STATES EXCLUDING CONNECTICUT AND KANSAS. A person may be committing insurance fraud, if he or she submits an application or claim containing a false or deceptive statement with intent to defraud (or knowing that he or she is helping to defraud) an insurance company.