

1. Your Information

Full Name (First)	(M.I.)	(Last Name)
Street Address		
City	State	Zip Code

	___ / ___ / ___
Social Security Number	Date of Birth
	<input type="checkbox"/> Male <input type="checkbox"/> Female
Phone Number	
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	
	Injury work related? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date Last Worked	

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: ____ / ____ / ____

*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)

1. Patient Information

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Full Name (First)	(M.I.)	(Last Name)	Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Height	Weight	Blood Pressure	Employer Name

2. Diagnosis

<input type="text"/>	<input type="text"/>
Primary ICD diagnostic Code (Required)	Primary ICD diagnosis Description
<input type="text"/>	<input type="text"/>
Secondary ICD Diagnosis Code	Secondary ICD Diagnosis Description

Pregnancy

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Vaginal	<input type="checkbox"/> C-Section
First Treated	Estimated Delivery	Date of Delivery		

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:

<input type="text"/>	<input type="text"/>	<input type="text"/>
Symptoms first Appeared	Reduced Ability to work	Advised to stop work
<input type="text"/>	<input type="text"/>	<input type="text"/>
Initial Treatment	Most Recent Treatment	Next Treatment
Dates hospital confined:	<input type="text"/>	to <input type="text"/>

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.

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

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 _____	

Reaching

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: _____ / _____ / _____

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

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

7. Physician's Information

Name

Street Address

City

State

Zip Code



Authorization For Release Of Information

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. 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.