

The Lincoln National Life Insurance Company  
PO Box 2609, Omaha, NE 68103-2609  
toll free (877) 815-9256 Fax (877) 668-5331  
www.LincolnFinancial.com

**How To Use this Form to File A Claim**

Lincoln Accident includes support services for emotional, legal, or financial issues related to your accident. If you need assistance, call 1-800-327-2950, 24 hours a day, 7 days a week.

You may qualify for additional benefits under Lincoln Accident. Please review your benefit information.

For an Accidental Injury Claim: Please complete sections I, II, III (Part A and C). Return this form along with an itemized bill from the doctor (HCFA 1500) or hospital (UB92) as well as a copy of the medical records related to the accident.

For a Dismemberment Claim: Please complete sections I, II, III (Part A and C), and IV.

For a Death Claim: Please complete sections I, II and V.

For a Hospital Sickness (Rider) Claim: Please complete sections I, II and III (Parts A and C)

For a Motor Vehicle Accident (Rider) Claim: Please complete sections I, II and III (Parts A and C) and IV if applicable. Please include a copy of the Police Report related to the Accident.

For a Disability (Rider) Claim: Please complete sections I, II and III (Part A, B and C)

**SECTION I - IDENTIFYING INFORMATION**

**Policyholder Information**

Policyholder Name (Last, First, Middle Initial): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

e-mail address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Claimant Information**

Claimant Name (Last, First, Middle Initial): \_\_\_\_\_

Relationship to Policyholder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer/School: \_\_\_\_\_

**SECTION II - CLAIM INFORMATION**

Date of Accident: \_\_\_\_\_ Location of Accident: \_\_\_\_\_

Date of start of illness: \_\_\_\_\_ Symptoms of your illness: \_\_\_\_\_

Explain the injuries and how the accident happened:

\_\_\_\_\_  
\_\_\_\_\_

Were you treated in the ER?  Yes  No If Yes, date treated in ER: \_\_\_\_\_

Were you hospitalized?  Yes  No Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Name of Hospital: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**SECTION III - ATTENDING PHYSICIAN'S STATEMENT**

Part A

To Be Completed By The Attending Physician

This claim is for (Patient's Name): \_\_\_\_\_

Patient's Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Primary Diagnosis (including ICD or DSM code): \_\_\_\_\_

Is this condition the result of an accidental injury?  Yes  No Date of Accident: \_\_\_\_\_

Is this condition the result of an illness?  Yes  No Date symptoms first appeared: \_\_\_\_\_

Please describe how the accident occurred: \_\_\_\_\_

Date of Service: \_\_\_\_\_ Procedure Code: \_\_\_\_\_

Was the patient treated in the ER?  Yes  No

If Yes, date seen in ER: \_\_\_\_\_

Has the patient been hospital confined?  Yes  No If Yes, complete the following:

Give Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Has the patient undergone surgery?  Yes  No

If Yes, give date, procedure and result: \_\_\_\_\_

If No, do you expect surgery to be performed in the future?  Yes  No

If Yes, give date and type of surgery: \_\_\_\_\_

Have assistive medical devices been recommended for the claimant?  Yes  No

If Yes, give details: \_\_\_\_\_

Part B (for Disability Only)

Symptoms: \_\_\_\_\_

Objective Findings: \_\_\_\_\_

Are there secondary conditions contributing to the disability?  Yes  No If Yes, what are they? (Please include ICD or DSM Code)

If this is a cardiac condition, what is the functional capacity?  Class 1 - No Limitation  Class 2 - Slight Limitation  
 Class 3 - Marked Limitation  Class 4 - Complete Limitation

When did the symptoms first appear? \_\_\_\_\_ Date of the patient's first visit: \_\_\_\_\_

Date you believe the patient was first unable to work: \_\_\_\_\_ Date of patient's last visit: \_\_\_\_\_

How often do you see the patient? \_\_\_\_\_

Is the patient's condition work related?  Yes  No

If Yes, explain: \_\_\_\_\_

What medication is the patient currently taking? \_\_\_\_\_

Please indicate other types and frequencies or treatment: \_\_\_\_\_

Has the patient been referred to a medical rehabilitation or therapy program?  Yes  No

If Yes, give details: \_\_\_\_\_

Have you referred the patient for other types of consultations?  Yes  No

If Yes, give details: \_\_\_\_\_

Restrictions (What the patient SHOULD NOT do): \_\_\_\_\_

Limitations (What the patient CANNOT do): \_\_\_\_\_

What is your prognosis for recovery? \_\_\_\_\_

**SECTION III - ATTENDING PHYSICIAN'S STATEMENT (cont'd)**

Has patient achieved maximum medical improvement?  Yes  No If No, complete the following:

How soon do you expect fundamental changes in the patient's medical condition?  1-2 months  3 - 4 months  5 - 6 months  
 6 - 12 months  1 - 1½ year  more than 1½ years

Give details concerning expected improvement or deterioration:

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In an eight hour workday, claimant can: (Check full hourly capacity for each activity)

	1	2	3	4	5	6	7	8
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are the restrictions in:	Yes	No	Comments
Lifting/Carrying	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use of hands in repetitive actions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use of feet in repetitive movements	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bending	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reaching above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

When do you expect the claimant to return to prior level of functioning? \_\_\_\_\_

Would you recommend vocational rehabilitation for this patient?  Yes  No

Is patient now TOTALLY disabled from PRESENT occupation?  Yes  No

Is patient now TOTALLY disabled from ANY OTHER occupation?  Yes  No

After you have fully completed this form, attach copies of the following materials:

- Office notes for the period of treatment for the last two years
- Test results showing objective findings
- Hospital discharge summaries
- Consulting physician reports

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Part C

Your Name: \_\_\_\_\_ Degree: \_\_\_\_\_

Specialty: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Signature of Attending Physician (No Stamp) \_\_\_\_\_ Date \_\_\_\_\_

**SECTION IV - DISMEMBERMENT**

Date of Dismemberment: \_\_\_\_\_

**SECTION V - DEATH**

Name of Deceased: \_\_\_\_\_ Date Last Worked: \_\_\_\_\_

Reason for Ceasing Work: \_\_\_\_\_

Date of Death: \_\_\_\_\_ Cause of Death: \_\_\_\_\_



# Authorization For Release Of Information

The Lincoln National Life Insurance Company  
PO Box 2609, Omaha, NE 68103-2609  
Toll free (877) 815-9256 Fax (877) 668-5331  
www.LincolnFinancial.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 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:** \_\_\_\_\_

**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.

**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.