



The Lincoln National Life Insurance Company
PO Box 82087, Lincoln, NE 68501-2087
toll free (877) 815-9256 Fax (877) 668-5331
www.LincolnFinancial.com

ACCIDENT INSURANCE PLAN CLAIM FORM

POLICY HOLDER INFORMATION

Policyholder Name: (Last, First, Middle Initial)
Policy Number*:
Date of Birth: Social Security Number:
Mailing Address:
City: State: Zip:
Email Address:
Employer Name:
Employer Address:
City: State: Zip:

CLAIMANT INFORMATION

Claimant Name: (Last, First, Middle Initial)
Relationship to Policyholder: Date of Birth: Employer/School:

CLAIM INFORMATION

Date of Accident: Location of Accident:

Explain the injuries and how the accident happened:

[Blank lines for accident explanation]

Was patient hospitalized? Yes No

Admission Date: Discharge Date:

Name of Hospital: City: State:

* To obtain your policy number please call 1-877-815-9256

ATTENDING PHYSICIAN'S STATEMENT

Physician Name: _____ IRS Identification Number: _____

Phone Number: _____ Fax Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of Service Procedure Code (CPT) Place where service was performed: _____

Diagnosis Description: _____

Date of Service Procedure Code (CPT) Place where service was performed: _____

Diagnosis Description: _____

Date of Service Procedure Code (CPT) Place where service was performed: _____

Diagnosis Description: _____

Please describe how the accident occurred: _____

Date of Accident: _____

Description: _____

Hospital Name: _____

Dates patient was confined to hospital: _____

Hospital Name: _____

City: _____ State: _____ Zip: _____

PHYSICIAN'S DISABILITY STATEMENT

Is this condition the result of an accidental injury? _____

First date of total disability: _____ Date person can return to work: _____

Physician's Signature (No Stamps Please) _____ Date

EMPLOYER'S DISABILITY STATEMENT

Off the Job Accident Disability Benefit

Employer's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of first absence: _____ Return to work (RTW) date or estimated RTW Date: _____

Did this accident occur at work? _____

Employer's Signature _____ Date Signed

Title

FAMILY CARE BENEFIT

Dependent Name: (Last, First, Middle Initial) _____

Dates of Service: _____ Date of Birth: _____

Name of Provider: _____ Provider Tax ID Number: _____

Provider Address: _____

City: _____ State: _____ Zip: _____

WELLNESS BENEFIT

Note: Please be sure to attach a copy of the bill including the diagnosis.

Claimant Name: (Last, First, Middle Initial) _____

Dates of Service: _____ Name of Provider: _____

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 82087
Lincoln, NE 68501-2087

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
- 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 federal law. 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)

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.

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.

Louisiana and Rhode Island. 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.

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 who 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.

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.

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.

Tennessee 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.

FOR ALL OTHER STATES EXCLUDING CONNECTICUT, KANSAS, AND VIRGINIA. 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.

ACCIDENT INSURANCE PLAN - HOW TO FILE A CLAIM

General Information

1. Contact your employer or call 1-877-815-9256 to obtain a claim form.
2. FULLY COMPLETE the Claimant's portion, including your signature and date on the Authorization to Obtain Information.

Disability Benefit

1. Have your Employer FULLY COMPLETE and SIGN the Employer's Section.
2. Have your doctor FULLY COMPLETE the Attending Physician's Portion of the claim form.
3. Send the fully completed claim form to our office.
4. Do not complete and/or submit your claim prior to your disability.

Wellness Benefit

1. Attach copies of the following with the claim form: UB-92 forms (Hospital Bills), HCFA forms (Physician Bills), or itemized bills that provide Dates of Service, Type of Service, Diagnosis and Charges. You can ask your Doctor and/or hospital to provide these to you.

Family Care Benefit

1. Written verification that the covered Dependent Child is receiving ongoing monthly Child Care.