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

GROUP SHORT-TERM DISABILITY STATEMENT OF EMPLOYEE

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. Please provide us with your e-mail address: May we contact you via e-mail? ☐ Yes ☐ No	9. Date of Birth

10. Date Last Worked: Date of Disability:	11. Gender ☐ Male ☐ Female	12. Hospital Confined ☐ Yes ☐ No Dates of confinement:

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 Date of Injury:

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 disability due to your occupation? ☐ Yes ☐ No If "Yes" explain in 14a
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: _____

Phone Number: _____ Specialty: _____

Address: _____

18. If approved, should Lincoln National Life Insurance Co withhold Federal Income Taxes from your Benefits? ☐ Yes ☐ No
If yes, how much should be withheld each week? (minimum is $20.00 per week) _____

19. Describe other income you are receiving, have applied for, or will be applying for **(check all that apply)**:

	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	$_____	_____	_____	_____

20. 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 of Employee _____ Date _____

21. Payment Method
☐ Direct Deposit
Financial Institution's Name: _____
Type of Account ☐ Checking
Bank/Routing Number: _____
Checking Account Number: _____

(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)

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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
   - 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.

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: _____ **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 submit a copy of this employee's enrollment statement with this claim.
(PLEASE see FRAUD NOTICES attached)

1. Full Name **(last, first, middle initial)**		2. Social Security Number
3. Occupation of Employee/Claimant	4. Insurance Class 01	5. Employee Date of Hire
6. Date Insured	7. Date Employee was last present at work On that day, did employee work a full day? ☐ Yes ☐ No	
8. Employee's Basic Weekly Earnings	9. Returned to Work? ☐ Full-time ☐ Part-time Date:	

10. Information needed for withholding and reporting taxes
Does employee contribute post-tax dollars toward the premium? ☐ Yes ☐ No
If yes, what percent is paid by the employee? _____%
If you leave this section blank, we will assume it is 100% employer contribution and calculate FICA taxes accordingly.

11. What was the employee's regular scheduled work week? _____ hours per week _____ hours per day

12. Is the claim due to your employee's occupation: ☐ Yes ☐ No

13. Has a claim been filed with Workers' Compensation? ☐ Yes ☐ No
If yes, send initial report of illness or injury and award/**denial** notice.
Name, address and telephone number of your compensation carrier _____
Name, address and telephone number of your medical insurance carrier _____

14. Is the employee receiving or has he/she received continued pay? ☐ Yes ☒ No
If yes, complete the following:
Pay Period: Amount: Source of Income:

15. Can job be modified to fit accommodations?

16. Physical Requirements (Include Job Description)

Employer's Name & Address (or name of policyholder, if other)	Telephone Number (Include Area Code and Extension)	Group Policy Number & Division Number 01-0133892

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

_____ _____
Print Name of Person Completing this form and Title E-mail address

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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. **Objective findings** (Including current x-rays, EKG's, laboratory data and any clinical findings)	Height Weight	
9. List of Restrictions & Limitations		
10. Nature of treatment (Including surgery and medications prescribed, if any).		
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. Has patient been hospital confined? ☐ Yes ☐ No Confined from: to If "Yes" give name of hospital.		
18. Has surgery been scheduled or performed? ☐ Yes ☐ No If "Yes" date of surgery: Type of surgery scheduled:		
19. Prognosis and Rehabilitation: a. When do you think your patient will be able to return to work in their occupation? b. **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 Providence/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.

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. 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 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.