Lincoln Financial Group®

# Long Term Disability Claim Form Statement Of Employee

**Lincoln Life & Annuity Company of New York**
PO Box 2609, Omaha, NE 68103-2609
Toll Free (800) 423-2765 Fax (877) 843-3950
LincolnFinancial.com
disabilityclaims@lfg.com

## 1. Your Information

First Name: _____ M.I.: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Social Security Number: _____ Date of Birth: _____ ☐ Male ☐ Female

Email Address: _____ Phone Number: _____

## 2. Your Employer

Employer Name: _____

Group ID: _____ Job Title: _____

Policy Number: _____

## 3. Reason for inability to work

Description of Sickness, Injury or Pregnancy: _____

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

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.

**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.

**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.**

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**Signature:** _____ **Date:** _____

Print Name: _____

# Long Term Disability Claim Form Statement Of Employer

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disabilityclaims@lfg.com

*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:

First Name: _____ 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 Number: _____

## 3. Describe Employee's Role

Job Title: _____

Description of Sickness, Injury or Pregnancy:

_____

## 4. Other Income Being Received

| | Amount $ | Date Began | Date Will Terminate | Date Applied For |
|---|---|---|---|---|
| Retirement Income | | | | |
| Workers' Comp | | | | |
| Salary Continuance | | | | |
| State Disability | | | | |
| Other Disability | | | | |

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 Fraud Warning Statements.

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**Signature** _____ **Date** _____

Print Name _____

(Please see FRAUD NOTICES attached)

Lincoln Financial Group®

# Long Term Disability Claim Form Physician's Statement

**Lincoln Life & Annuity Company of New York**
PO Box 2609, Omaha, NE 68103-2609
Toll Free (800) 423-2765 Fax (877) 843-3950
LincolnFinancial.com
disabilityclaims@lfg.com

## 1. Patient Information

First Name: _____ 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 diagnostic 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)

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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?

_____

**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: _____

## 5. Treatment

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

Describe ongoing treatment frequency: _____

## 6. Prognosis

Describe the patients prognosis for recovery: _____

_____

Patient able to return to work Full-Time on: _____

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

_____ to _____

## 7. Physician's Information

Physician Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

The above statements are true and complete to the best of my knowledge and belief.

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**Signature** _____ **Date** _____

Print Name _____



(Please see FRAUD NOTICES attached)

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# Authorization For Release Of Information

**Lincoln Life & Annuity Company of New York**
PO Box 2609, Omaha, NE 68103-2609
Toll Free (800) 423-2765 Fax (877) 843-3950
LincolnFinancial.com
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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:** Lincoln Life & Annuity Company of New York ("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.

**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.

**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.

**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.