Lincoln Financial Group℠

The Lincoln National Life Insurance Company, PO Box 82087, Lincoln, NE 68501-2087
toll free (877) 815-9256 Fax (877) 843-3950
www.LincolnFinancial.com

CRITICAL ILLNESS CLAIM FORM

To Be Completed by the Employee

Policyholder Name: _____

Policy Number(s): _____ Social Security Number: _____

Employee's Name (First, Middle, Last): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home/Cell Phone Number: _____ Work Phone Number: _____

email Address: _____ Employment Date (MM/DD/YY): _____

Work Schedule at time of claim: _____ Days per Week: _____ Hours per Day: _____

Did CI coverage exist under a prior policy? ☐ Yes ☐ No If Yes, Effective date of prior plan: _____

Termination date of prior plan: _____

Effective date of this coverage: _____

Claimants Name (if not employee): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Claimant's relationship to Employee: ☐ Self ☐ Spouse ☐ Child Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

This claim is being submitted for (check all that apply)

☐ Critical Illness Category (Provide attached Physicians Statement page 5)
☐ Organ ☐ Cancer ☐ Heart ☐ Child ☐ Quality of Life

☐ Critical Illness Assessment Benefit (see policy for listing)
Date assessment was performed (Attach supporting documentation/provider invoice) _____

☐ Child Care Expense Benefit*
Dates requesting benefits for (Attach supporting documentation/provider invoice) _____

☐ Permanent and Total Disability Benefit
Date Disability began (Provide attachments A&B) _____

☐ Treatment Care Benefit* (see policy for listing)
Date treatment was provided (Attach supporting documentation/provider invoice) _____

☐ Occupational HIV/Hepatitis Benefit
Date testing provided (Attach supporting documentation/provider invoice) _____

*** For Services related to a hospitalization please provide the information below.**

Name of Hospital: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Hospital Phone Number: _____ Hospital Fax Number: _____

Date admitted: _____ Date discharged: _____

Signature: _____ Date: _____

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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, consultation [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 68501-3950

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 critical illness 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
   - to a vendor, approved by the company, which specializes in the application for Social Security Disability Benefits
   - to vendors/consultants providing the claimant with wellness, critical illness or leave related services as part of an employer sponsored benefit plan
   - to the employer for self-insured critical illness plans; 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 the federal HIPAA Privacy Rule. 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/insured is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

PRINT NAME: _____

Relationship to Claimant/Insured of personal/legal representative signing for Claimant/Insured: _____

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.

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 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.

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 with the penalty of 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 are 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 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, 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.

Attending Physician's Statement - Critical Illness

Employee (Patient) Information (to be completed by Employee)

Policyholder Name: _____

Patient's Name (First, Middle, Last): _____

Patient Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Patient's relationship to Employee: ☐ Self ☐ Spouse ☐ Child Patient's Gender: ☐ Male ☐ Female

Patient's or Authorized Person's Signature: _____ Date: _____

Physician or Supplier Statement

Primary Diagnosis: _____

Date of Diagnosis: _____

Date first consulted for this condition: _____ Reported date of first symptoms: _____

Secondary Diagnoses: _____

Has the patient ever had same or similar condition? ☐ Yes ☐ No If so, please provide dates: _____

Other providers to whom you have referred the patient: _____

Predisposing risk factors or conditions related to the diagnoses, with dates:

_____

_____

Please check the condition(s) that apply to this patient, and provide for each diagnosis the test results, operative reports, pathology reports, or other detailed rationale as required below for the condition:

Quality of Life Category

☐ Amyotrophic Lateral Sclerosis (diagnostic criteria)
☐ Advanced Multiple Sclerosis (neurological exam, imaging, CSF)
☐ Advanced Parkinson's Disease (disease progressed to Stage 4)
☐ Loss of Hearing (diagnosis by otolaryngologist and permanent)
☐ Advanced Alzheimer's Disease (FAST scale rating)
☐ Muscular Dystrophy (diagnosed during childhood)
☐ Loss of Sight (diagnosis by ophthalmologist and permanent)
☐ Loss of Speech (unintelligible for at least 12 months)

Organ Category

☐ End-Stage Renal Failure (irreversible, permanent dialysis/transplant required)
☐ Required Major Organ Transplant (end stage (major) organ disease)
☐ Acute Respiratory Distress Syndrome (inadequate oxygenation due to aspiration or infection)

Heart Category

☐ Myocardial Infarction (Heart Attack) (death of heart muscle, based on EKG)
☐ Required Heart Transplant (as determined by physician and placed on UNOS list)
☐ Stroke (permanent, demonstrated by CT/MRI)
☐ Arteriosclerosis (severity requires angioplasty, stent place, therectomy or bypass)
☐ Aneurysm due to Arteriosclerosis (surgical intervention required)

Cancer Category

☐ Cancer (diagnosis by oncologist based on biopsy)
☐ Cancer in Situ (diagnosis by oncologist, no spread to lymph nodes or tissues)
☐ Benign Brain Tumor (non-malignant, results in neurological deficit)
☐ Required Bone Marrow Transplant (inability to produce blood cells)

Child Category

☐ Structural Congenital Defect (during childhood, by pediatrician)
☐ Genetic Disorders (during childhood, by Physician)
☐ Congenital Metabolic Disorder (during childhood based on blood test, physical exam, or genetic testing)
☐ Type I Diabetes (during childhood by endocrinologist)

Fraud Notice: The Statements on the previous page are true and complete to the best of my knowledge and belief.

Print or Type Name: _____

Degree: _____

Medical Specialty: _____

Address: _____

City:_____ State:_____ Zip Code: _____

Phone Number: _____ Fax Number:_____

Signature of Physician: _____ Date: _____

SSN or Employer ID Number: _____

Are you, the physician, related to the patient? ☐ Yes ☐ No If yes, what is the relationship?_____