Lincoln Financial Group®

Accident Plan Claim Form

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 occured: _____

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:

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

	1	2	3	4	5	6	7	8
Sit	☐	☐	☐	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐	☐	☐	☐

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

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

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: _____

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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
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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:** 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.