Lincoln Financial®

Group Critical Illness Claim Form

The Lincoln National Life Insurance Company
PO Box 2609, Omaha, NE 68103-2609
Toll Free (800) 423-2765 Fax (888) 735-7636
LincolnFinancial.com

Please call our Customer Service Center at 1-800-423-2765 if you have any questions about benefits or how to file your claim.

Follow these instructions to complete this form.

1. Complete **Sections A and B** in full.
2. Complete and sign **Section C**.
3. Have your physician complete **Section D** in full and sign.
4. Send the completed form and bills to:

   The Lincoln National Life Insurance Company
   PO Box 2609, Omaha, NE 68103-2609
   Fax: (888) 735-7636 Phone: (800) 423-2765
   Email: fileclaim@lfg.com

Incomplete forms may delay processing of the claim.

Section A – Employee and Patient Information (to be completed by Employee)

Employee Information

Employer Name: _____	Policy Number: _____
Employee's Name: (First, Middle, Last) _____ /_____ /_____	
Employee's Birthdate (MM/DD/YYYY): _____ /_____ /_____	Employee's Work ID or Social Security Number: _____
Employee's Address: ☐ Check if address is new _____	
City/State/Zip: _____ /_____ /_____	
Employee's e-mail: _____	Employee's Telephone Number: _____ - _____- _____
Employee's Gender: ☐ Male ☐ Female	Date Last Worked: (MM/DD/YYYY) _____ /_____ /_____

Patient Information

Patient Name: (First, Middle, Last, if not employee) _____ /_____ /_____	
Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Patient's Birthdate: (MM/DD/YYYY) _____ /_____ /_____
Patient's Gender: (if not employee) ☐ Male ☐ Female	Patient's Telephone Number: _____ - _____- _____

Section B – Claim Details

Please check the illness(es) for which you are requesting benefits:

If claimant is deceased, please provide a copy of the certified death certificate.

Please provide lab reports, radiology reports, pathology reports, clinical diagnosis, and any other medical record documentation to support your claim.

Base Critical Illness Benefit

- ☐ Heart Attack
  - Please submit discharge summary, Cardiology consult report, cardiac catheterization report, history & physical, and ER notes
- ☐ Arterial/Vascular Disease
  - Please submit cardiology, neurology, vascular surgeon notes, office treatment notes, admission/ discharge summaries, operative notes
- ☐ Mitral or Aortic Valve Disease
  - Please submit a copy of the operative report, office treatment notes, diagnostic exams.
- ☐ Stroke
  - Please submit neurologist consultation notes, admission/ discharge summaries, diagnostic exams, confirmation of lasting deficits
- ☐ End Stage Renal Failure
  - Please submit medical evidence report, port placement, confirmation of placement on UNOS list
- ☐ Major Organ Failure/Transplant
  - Please submit a copy of the operative report for the procedure, confirmation of placement on the UNOS list
- ☐ Cancer (invasive, non-invasive, skin)
  - Please submit a copy of the pathology report from which the condition was diagnosed

Base Critical Illness Benefit

- ☐ Heart Attack
- ☐ Sudden Cardiac Arrest
- ☐ Arterial/Vascular Disease
- ☐ Mitral or Aortic Valve Disease
- ☐ Stroke
- ☐ End Stage Renal Failure
- ☐ Major Organ Failure
- ☐ Invasive Cancer
- ☐ Non-Invasive Cancer/Cancer in Situ
- ☐ Skin Cancer

Child Covered Conditions

- ☐ Cerebral Palsy
- ☐ Cleft Lip/Cleft Palate
- ☐ Cystic Fibrosis
- ☐ Down Syndrome
- ☐ Muscular Dystrophy
- ☐ Spina Bifida
- ☐ Type I Diabetes

Supplemental Benefits

- ☐ Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Advanced ALS/Lou Gehrig's Disease

Supplemental Benefits (continued)

- ☐ Advanced Alzheimer's Disease
- ☐ Advanced Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Advanced Parkinson's Disease
- ☐ Advanced Multiple Sclerosis (MS)
- ☐ Advanced Huntington's Disease
- ☐ Benign Brain Tumor
- ☐ Loss of Speech
- ☐ Loss of Sight
- ☐ Loss of Hearing

Occupational Disease Benefit

- ☐ Hepatitis
- ☐ HIV
- ☐ Invasive MRSA Infection
- ☐ Rabies
- ☐ Tetanus
- ☐ Tuberculosis

Accidental Injury Benefit

- ☐ Severe Traumatic Brain Injury
- ☐ Severe Burn
- ☐ Paralysis

Payment Method

Please select a method of payment to receive your benefits. If no method of payment is selected, you will receive a check for your benefits.

Select Payment Type: ☐ Direct deposit into my account
☐ Send me a check

9-Digit Routing Number: _____

Account Number: _____

Financial Institution Name: _____

Banking Type: ☐ Personal ☐ Business

Account Type: ☐ Checking ☐ Savings

Lincoln Financial®

Authorization For Release of Information

The Lincoln National Life Insurance Company
PO Box 2609, Omaha, NE 68103-2609
Toll Free (800) 423-2765 Fax (888) 735-7636
LincolnFinancial.com

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 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 pursuant to this Authorization and that information, once disclosed, 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 or the Company is using this Authorization in connection with a contestable claim regarding my policy. 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 24 months from the date of my signature below, or the duration of my claim for benefits, whichever is greater.
7. I agree that a copy of this Authorization shall be considered as valid as the original. I am entitled to receive a copy of this Authorization.
8. I understand that if I refuse to sign this Authorization, or subsequently revoke this Authorization, it may impair Lincoln's ability to process my application or evaluate claims and may be a basis for denying an application or claim for benefits.
9. If I do not sign this Authorization, it will not affect my ability to receive health care services.

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 NUMBER: _____

Section D – Physician Statement (to be completed by Physician)

Employee Name: (First, Middle, Last)

_____ /_____ /_____

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

_____ /_____ /_____

Patient's Address:

_____

City/State/Zip:

_____ /_____ /_____

Patient's Birthdate: (MM/DD/YYYY)	Patient's Gender:	Patient's relationship to employee:
_____ /_____ /_____	☐ Male ☐ Female	☐ Self ☐ Spouse ☐ Life Partner ☐ Child

Primary Diagnosis with ICD10 code:	Date of Diagnosis: (MM/DD/YYYY)
_____	_____ /_____ /_____

Reported date of first symptoms: (MM/DD/YYYY)	Secondary Diagnoses with ICD10 codes:
_____ /_____ /_____	_____

Has the patient ever had same or similar condition? ☐ Yes ☐ No	If Yes, please provide dates: (MM/DD/YYYY)
	_____ /_____ /_____ _____ /_____ /_____

Predisposing risk factors or conditions related to the diagnoses, with dates: (MM/DD/YYYY)

_____

_____

_____ / _____/_____ _____ /_____ / _____ _____ /_____ /_____

Was this patient referred to you by another physician? ☐ Yes ☐ No

If Yes, please provide the name and address of referring physician:

Physician's Name:_____ /_____

Address:_____

City/State/Zip: _____ /_____ /_____

Name of Hospital:

_____

Hospital Address:

_____

City/State/Zip:

_____ /_____ /_____

Hospital Telephone Number:	Dates Confined: (MM/DD/YYYY)
_____ - _____- _____	_____ /_____ /_____ _____ /_____ /_____
Hospital Fax Number:	
_____ - _____- _____	_____ /_____ /_____ _____ /_____ /_____

Hospital Stay Type: (if applicable)

☐ Inpatient ☐ Outpatient ☐ Observation

Nature of Surgical Procedure: (Describe fully, and provide CPTS and/or operative report)

Physician Verification

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

Print Full Name: (First, Middle, Last) _____ /_____ /_____	
Medical Specialty: _____	
Phone Number: _____ - _____- _____	Fax Number: _____ - _____- _____
Address: _____	
City/State/Zip: _____ /_____ /_____	
Signature of Physician: _____	Date: (MM/DD/YYYY) _____ /_____ /_____
Tax ID Number: _____	NPI Number: _____
Are you, the physician, related to the patient? ☐ Yes ☐ No If Yes, what is the relationship?_____	