Lincoln Financial Group®

Group Accident 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. Please provide an itemized bill or form from the hospital. Retain copies for your records. 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	

Please check the box(es) that best describes your claim.

☐ Accident Hospital Admission	☐ Ground Ambulance	☐ Physician Follow up Visits #_____ of visits
☐ Accident Hospital Daily Confinement	☐ Hemiplegia	☐ Prosthesis
☐ Accident Intensive Care Admission	☐ Initial Care Visit	☐ Quadriplegia
☐ Accident Intensive Care Daily Confinement	☐ Laceration	☐ Safe Driver Injury/Death: Air Bag
☐ Accidental Death	☐ Lodging	☐ Safe Driver Injury/Death: Seat Belt
☐ Air Ambulance Transportation	☐ Loss of Arm and Leg	☐ Safe Driver: Air Bag
☐ Alternative Care/Rehab Facility Daily Confinement	☐ Loss of Both Arms	☐ Safe Driver: Seatbelt
☐ Blood, plasma, platelets	☐ Loss of Both Arms and Both Legs	☐ Safe Rider Injury/Death: Motor Vehicle Helmet
☐ Burns	☐ Loss of Both Legs	☐ Safe Rider: Other Helmet (bicycle, scooter, skateboard, etc.)
☐ Common Carrier Death	☐ Loss of Finger, Thumb, Toe	☐ Safe Rider: Helmet
☐ Concussion	☐ Loss of Hand, Foot, Arm, Eye, or Hearing in One Ear	☐ Severe Traumatic Brain Injury
☐ Dental Crown	☐ Loss of Hearing in Both Ears	☐ Skin Grafts
☐ Dental Extraction	☐ Loss of Sight in Both Eyes	☐ Spouse Training
☐ Dislocations	☐ Loss of Speech	☐ Surgical Benefits
☐ Education	☐ Major Diagnostic Exam	☐ Transportation
☐ Emergency Care Treatment	☐ Medical Mobility Devices	☐ Transportation of Remains
☐ Epidural/Cortisone Pain Management	☐ Modification to Home/Auto	☐ Wheelchair - Expected <1 year
☐ Eye - Removal of foreign object	☐ Motor Vehicle Death	☐ Wheelchair - Expected >1 year
☐ Eye - Surgical repair	☐ Motor Vehicle Injury	☐ X-Ray
☐ Family Care	☐ Paraplegia	
☐ Fractures	☐ Physical, Occupational, and Chiropractic Therapy #_____ of appointments	

Section B - Accident Details

Date of Accident: (MM/DD/YYYY) _____/_____/_____	Where did the accident happen? _____
Is Accident related to employment? ☐ Yes ☐ No Is Accident an auto accident? ☐ Yes ☐ No	Were you driving? ☐ Yes ☐ No If yes, please provide a police report.
Explain the injuries and how the accident happened:	

If patient is deceased, please provide a copy of the certified death certificate. Please provide an itemized bill from the hospital, lab reports radiology reports, pathology reports, clinical diagnosis, and any other medical record documentation to support your claim.

Were you hospitalized? ☐ Yes ☐ No	Admission Date: (MM/DD/YYYY) _____/_____/_____	Discharge Date: (MM/DD/YYYY) _____/_____/_____

Name of Hospital: _____	City/State/Zip: _____	Hospital Telephone Number: _____-_____-_____

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 Group®

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

Section C - Authorization For Release of Information

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:

Patient's Name: (First, Middle, Last) _____/_____/_____
Patient's Birthdate: (MM/DD/YYYY) _____/_____/_____ 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 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.

PATIENT SIGNATURE: _____ **DATE:** (MM/DD/YYYY) _____/_____/_____ Legal representative (nearest relative, legal guardian, or appointed representative) to sign only if patient is a minor, legally incompetent, or deceased. Power of attorney or guardianship must be attached.
PRINT NAME: (First, Middle, Last) _____/_____/_____
Relationship to Patient: (if legal representative signing)
ADDRESS: Street: _____
City/State/Zip: _____/_____/_____
TELEPHONE NUMBER: _____-_____ - _____

Section D - Physician's Statement (to be completed by Physician)

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

Patient's Birthdate: (MM/DD/YYYY)
_____/_____/_____

Patient's relationship to employee:
☐ Self ☐ Spouse ☐ Life Partner ☐ Child

Patient's Address:
_____

City/State/Zip:
_____/_____/_____

Primary Diagnosis with ICD10 code:
_____

Secondary Diagnosis with ICD10 code:
_____

Is this condition the result of an accidental injury? ☐ Yes ☐ No Date of Accident/Injury:_____/_____/_____
If Yes, please describe how the accident occurred: _____

Is this condition the result of an illness? ☐ Yes ☐ No Date symptoms first appeared:_____/_____/_____

Is the patient's condition work related? ☐ Yes ☐ No If Yes, explain: _____

Have assistive medical devices been recommended for the claimant? ☐ Yes ☐ No
If Yes, give details: _____

Was the patient treated in the ER? ☐ Yes ☐ No If Yes, date seen in ER:_____/_____/_____
If Yes, name of hospital: _____

Were x-rays performed? ☐ Yes ☐ No Date:_____/_____/_____ Results:_____

MRI/CT performed? ☐ Yes ☐ No Date:_____/_____/_____ Results:_____

Additional treatment date(s) for this condition: (MM/DD/YYYY) _____/_____/_____ _____/_____/_____
_____/_____/_____ _____/_____/_____

Date first consulted for this condition: (MM/DD/YYYY)
_____/_____/_____

Reported date of first symptoms: (MM/DD/YYYY)
_____/_____/_____

Has the patient ever had same or similar condition? ☐ Yes ☐ No

If Yes, please provide dates: (MM/DD/YYYY)
_____/_____/_____ _____/_____/_____

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

If Yes, please provide the name and address of the referring physician:
Physician's Name: _____/_____
Address: _____
City/State/Zip: _____/_____/_____

Name of Hospital:
_____

Address/City/State/Zip:
_____

Hospital Telephone Number:
_____-_____-_____

Hospital Fax Number:
_____-_____-_____

Dates Confined: (MM/DD/YYYY)
_____/_____/_____ _____/_____/_____
_____/_____/_____ _____/_____/_____

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? _____	

Section E

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.