Lincoln Financial Group®

Request For Living Benefit (Accelerated Death Benefit)

The Lincoln National Life Insurance Company
PO Box 2649, Omaha, NE 68103-2649
toll free (800) 423-2765 Fax (800) 462-4660
www.LincolnFinancial.com

To avoid a delay or denial of benefits, please complete all questions and submit medical records from all attending physicians documenting the disabling condition from the claimant's date last worked to present.

EMPLOYEE'S STATEMENT (To Be Completed By The Employee)

A. Information about you

Employee's Name: _____

Address: _____
City State Zip Code

Phone Number: _____ Social Security No.: _____ Date of Birth: _____

Occupation: _____ Email Address: _____

Spouse Name (if Living Benefit is for Spouse)_____ Date of Birth: _____

Amount of Group life Insurance $_____ Amount of Living benefit Requested $ _____

I understand that my group life insurance coverage will be reduced by the Living Benefit amount.

PAYMENT OPTIONS: Please select one of the following options (One Single Check or Direct Deposit)

☐ One Single Check - This is the default payment option if no option is selected.

☐ Direct Deposit - Complete the following information to allow the benefit amount to be directed deposited to your account.

Bank Name_____

Address _____

Routing # _____ Bank Account #_____

Type of Account (Select One):

☐ Checking
☐ Savings

I (we) authorize and request The Lincoln National Life Insurance Company, and its subsidiaries, to make payment of any amounts owing to me (either of us) by initiating credit entries or adjustment entries to my account indicated above in the bank named above, hereinafter called BANK, and I (we) authorize and request BANK to accept any credit entries or adjustment entries initiated by Lincoln Financial Group to such account without responsibility for the correctness thereof It is understood that this agreement may be terminated by me (either of us) at any time by written notification to The Lincoln National Life Insurance Company or BANK. Any such notification to The Lincoln National Life Insurance Company shall be effective only with respect to entries initiated by The Lincoln National Life Insurance Company after receipt of such notification and a reasonable opportunity to act on it. I understand that The Lincoln National Life Insurance Company is required to send a notification and a reasonable opportunity to act on it. I understand that The Lincoln National Life Insurance Company is required to send a notification to BANK before the first transaction .Any such notification to BANK shall be effective only with respect to entries credited to my (our) account by BANK after receipt of such notification and a reasonable time to act on it. It is also understood that this agreement shall not modify or alter the other provisions of the policy(ies) or supplementary contract which provides for any payment due me.

B. Information about the disability

What is your Terminal condition? _____

First medical attention for the current disability was given by (complete below):

Doctor's Name	Telephone: Fax:	Specialty
Address (Street, City, State, Zip)	Dates Seen From	Dates Seen To

List all other physicians and hospitals you have seen for this condition:

Doctor's Name	Telephone: Fax:	Specialty
Address (Street, City, State, Zip)	Dates Seen From	Dates Seen To
Doctor's Name	Telephone: Fax:	Specialty
Address (Street, City, State, Zip)	Dates Seen From	Dates Seen To
Hospital		
Address (Street, City, State, Zip)	Dates of Hospitalization From	Dates of Hospitalization To

	Yes	No
1. Was this terminal condition caused by self-inflected injury or suicide attempt?	☐	☐
2. Have you made an Assignment of Proceeds for this Group Life Insurance?	☐	☐
3. Have you filed for relief in Bankruptcy court?	☐	☐
4. Does any part of your insurance have to be paid to your child, spouse or former spouse pursuant to a Legal Separation Agreement, Divorce Decree, Child Support Order or other Court Order?	☐	☐

AUTHORIZATION: The above statements are true and complete to the best of my knowledge and belief. **I have completed and attached the Authorization for release of Information.** A photostatic copy of this form will be as valid as the original.

Signature of Insured Person_____ Date_____

Signature of Witness _____ Date_____

C. EMPLOYER'S Statement (To Be Completed By The Employer)

Group Name_____ Group Policy Number _____

Phone Number_____ Fax Number _____ Email Address_____

Employee's Certificate Number _____ Effective Date of Policy _____

Effective Date of Employee's Insurance_____ Hire Date_____

Insurance Class _____ Average Hours Worked Per Week _____

Date last worked (Month-Day-Year)_____ Salary $_____ per_____

Reason for Date Last Worked _____

PLEASE INCLUDE A COPY OF THE INSURED PERSON'S ENROLLMENT FORM

Signature _____ Title _____ Date _____

******* ATTENDING PHYSICIAN'S STATEMENT *******

Your patient has applied for a LIVING BENEFIT (Accelerated Death Benefit) under his/her Group Term Life Insurance policy. To determine eligibility for this benefit, we need answers to the questions below, along with copies of his/her medical records.

Please be sure to sign and date this form. Your patient's signed authorization is on the other side of this form. Thank you for your prompt attention to this matter.

Patient's Name _____

Please identify the TERMINAL CONDITION by name _____

I have diagnosed the above named patient as having a TERMINAL CONDITION. It is my medical opinion that this patient has a life expectancy of approximately _____ months

1. HISTORY

a) When did the symptoms first appear or the accident happen? _____

b) Has the patient been hospital confined for the condition? ☐ Yes ☐ No

-If YES, please identify the hospital: _____
and the hospital address: _____

-Date Admitted _____ Date Released _____

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

- If YES, please state when and briefly describe _____
_____

2. CONDITION

a) Diagnosis (including any complications): _____
_____

b) Subjective symptoms: _____
_____

c) Objective findings (including X-ray, EKG, lab data and clinical findings): _____
_____

3. TREATMENT

a) Date of first visit _____ Date of last visit _____

b) Nature of treatment (including any surgery and/or prescribed medication): _____
_____

c) Treatment Frequency: ☐ Daily - ☐ Weekly - ☐ Monthly - ☐ Every _____ months - ☐ Other _____

4. PROGRESS AND PROGNOSIS

a) Is patient TOTALLY DISABLED from his/her present occupation? ☐ Yes ☐ No

b) Is patient TOTALLY DISABLED from any other occupation? ☐ Yes ☐ No

5. PHYSICIAN

After you have fully completed this form, attach copies of the following materials:

– Office notes for the period of treatment to the present
– Test results showing objective findings
– Hospital discharge summaries
– Consulting physician reports

Name _____ Phone _____

Address _____

Specialty/Degree _____ Date _____

Signature _____

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.

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; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

   Claimant/Insured Name: _____
   (Last) (First) (Middle)

   Date of Birth: _____ Social Security Number: _____

2. Information to be released:
   - 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; 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 2649
   Omaha, NE 68103-2649

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 a living benefit (accelerated death benefit). 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
   - 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 federal law. 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.

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 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 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.