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

CRITICAL ILLNESS CLAIM FORM

Policyholder Information

Policyholder Name (Last, First, Middle Initial): _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

email address: _____ Telephone Number: _____

Employer Name: Transport Workers Union Local 556 Employment Date (MM/DD/YY): _____

Occupation: _____ Policy Number: 00405004245-00000

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) n/a

☐ Permanent and Total Disability Benefit
Date Disability began (Provide attachments A&B) n/a

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

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

*** 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

☐ **Please check this box if you or your authorized representative would like to receive a copy of this form.**

I (the undersigned) authorize any physician, medical professional, or other provider of health care services, hospital, clinic, other medical or medically related facility, or insurance or reinsurance company to release information to The Lincoln National Life Insurance Company (Lincoln) in connection with a claim for benefits.

Patient Information: (Name of Claimant Whose Information Will Be Released)

Patient Name: (Last, First, Middle) _____ Date of Birth: _____

Other Names Used: _____ Social Security Number: _____

Description of the information to be disclosed:

☐ Entire Medical Record, including but not limited to patient histories, office notes (EXCEPT psychotherapy notes), test results, radiology studies, films, prescriptions, referrals, consults, billing records, insurance records, and other related records sent to you by other health care providers.

☐ Other: _____

Expiration: This Authorization will be considered valid until the happening of the earliest following event:

1. The term of the coverage of the policy if the claim is for a health insurance benefit;
2. The duration of the claim if the claim is not for a health insurance benefit; or
3. Twelve (12) months from the date of the signature below.

Right to Revoke: I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that Lincoln has taken action in reliance on this authorization. To initiate revocation of this Authorization, direct all correspondence to Lincoln at the above address.

Claimant Rights:

1. I understand that the information used or disclosed 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 redisclosed or reused by the recipient under Colorado law.
2. I understand that a photocopy of this Authorization is to be considered as valid as the original.
3. I understand that I am entitled to receive a copy of this Authorization.
4. I understand that this information may be released to my employer for self-insured plans only.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this Authorization.

Authorized Representative Information: Complete this section if a personal representative is authorizing disclosure of the claimant's information. A copy of a power of attorney or other court-initiated document will be required, unless parent signing for patient under 18.

Name: (Last, First, Middle) _____ Relationship to claimant: _____

Address: _____ Phone: _____

Signature/Date: The Claimant whose information will be released or the claimant's authorized representative must sign and date this form in order to process.

Sign: _____ Date: _____

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.

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: _____

Tax ID Number: _____

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