

**REQUEST FOR LIVING BENEFIT (ACCELERATED DEATH BENEFIT)**

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.

<b>EMPLOYEE'S STATEMENT (To Be Completed By The Employee)</b>			
<b>A. Information about you</b>			
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.			
<b>B. Information about the disability</b>			
What is your Terminal condition? _____			
First medical attention for the current disability was given by (complete below):			
Doctor's Name	Telephone:	Specialty	
	Fax:		
Address (Street, City, State, Zip)		Dates Seen	To
List all other physicians and hospitals you have seen for this condition:			
Doctor's Name	Telephone:	Specialty	
	Fax:		
Address (Street, City, State, Zip)		Dates Seen	To
Doctor's Name	Telephone:	Specialty	
	Fax:		
Address (Street, City, State, Zip)		Dates Seen	To
Hospital			
Address (Street, City, State, Zip)		Dates of Hospitalization	
		To	
		Yes	No
1. Was this terminal condition caused by self-inflicted injury or suicide attempt?		<input type="checkbox"/>	<input type="checkbox"/>
2. Have you made an Assignment of Proceeds for this Group Life Insurance?		<input type="checkbox"/>	<input type="checkbox"/>
3. Have you filed for relief in Bankruptcy court?		<input type="checkbox"/>	<input type="checkbox"/>
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?		<input type="checkbox"/>	<input type="checkbox"/>
AUTHORIZATION: The above statements are true and complete to the best of my knowledge and belief. <b>I have completed and attached the Authorization for release of Information.</b> A photostatic copy of this form will be as valid as the original.			
Signature of Insured Person _____		Date _____	
Signature of Witness _____		Date _____	
<b>EMPLOYER'S STATEMENT (To Be Completed By The Employer)</b>			
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 _____		
<b>PLEASE INCLUDE A COPY OF THE INSURED PERSON'S ENROLLMENT FORM</b>			
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
- Hospital discharge summaries
- Test results showing objective findings
- 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.



**FRAUD NOTICES. For your protection, certain states require that the following notices appear on this form.**

**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 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.