Lincoln Financial Group®

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

LIFE CLAIM FORM

TO AVOID DELAY OR DENIAL OF BENEFITS, PLEASE COMPLETE ALL QUESTIONS.

TO BE COMPLETED BY THE EMPLOYER OR PLAN ADMINISTRATOR

Group Name _____

Address _____ City _____ State _____ Zip _____

Group Policy Number _____ - _____ - _____

Billing Location _____

Certificate Holder _____
(Employee Name or Member Name)

The Deceased is insured as: Employee ☐ Spouse ☐ Child ☐ Member ☐

1. Name of Deceased _____ State of Residence _____
2. Date of Death _____ Date of Birth _____ Age _____
3. Social Security Number or Certificate # _____ Insurance Class _____
(Employee's SSN) (Refer to policy schedule of insurance)
4. Amount of Benefit: Life $ _____ AD&D $ _____ Opt. Life $ _____ Opt. AD&D $ _____
Vol Life $ _____ Vol AD&D $ _____ Dep Life $ _____
Seat Belt $ _____ Airbag $ _____
Repatriation (attach bill) $ _____ Repatriation: miles from residence _____
5. Date Employed: Full Time _____ Part Time _____
Annual Salary (if salary based) $ _____ Date Of Last Salary Increase _____
6. Effective Date of Insurance with Lincoln Financial Group _____
(Certificate Holder)
7. Date on which the Employee was last present at Work?_____
8. REASON FOR CEASING WORK
☐ Illness (including disability leave of absence) ☐ Leave of Absence (other than disability) ☐ Accident
☐ Quit ☐ Dismissed ☐ Vacation ☐ Temporary Layoff ☐ Retired ☐ Deceased
9. Employee Was: (Check All That Apply)
☐ Full-time ☐ Union ☐ Hourly ☐ Exempt ☐ Commissioned
☐ Part-time ☐ Non-Union ☐ Salaried ☐ Non-Exempt
☐ Other (Explain) _____
10. Average Hours Worked Per Week: _____ Occupation _____
(Certificate Holder)

Completed by _____ Date _____

Title _____ Phone Number (_____) _____

E-mail Address _____ FAX Number (_____) _____

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TO BE COMPLETED BY THE BENEFICIARY

Please type or print legibly—name and address as stated will appear on checks

Name _____ Sex: ☐ Male ☐ Female
First Middle Initial Last

Relationship to Deceased _____

Address _____
Street Apartment No.

Home Phone (_____) _____

_____ Daytime Phone (_____) _____
City State Zip

Date of Birth _____
Month Day Year

Beneficiary's Social Security Number or
Taxpayer Identification Number _____ E-mail Address _____

You have the right to choose how you will receive the payment of life proceeds. If the amount payable to you is $5,000 or more, our usual method of payment is to open a SecureLine Account, which gives you complete control of your funds. If the amount is below $5,000, you will be paid with a single check. Please choose your method of payment as listed below:

☐ **I elect my proceeds to be paid into a SecureLine Account for my immediate use.** A SecureLine Account is a personal, interest-bearing account, designed specifically for flexibility and security for your Life Insurance Benefits. A SecureLine Account can be incredibly useful to you during this particularly stressful period. Determining what to do with insurance proceeds is an important decision that should not be rushed. So, instead of receiving a lump sum of money through the mail, you will receive a checkbook and the peace of mind that comes with knowing your benefit is secure and earning interest while you evaluate your options.

Additional Benefits of the SecureLine Account:

Safe All amounts of Life Insurance Benefits including interest earned, are fully protected and guaranteed by The Lincoln National Life Insurance Company.

Free You will receive unlimited free checks as long as your SecureLine Account is open. You may write checks for any amount over $250 and up to your full balance at any time. There are no fees for withdrawing any amount from your SecureLine Account.
There are no annual or monthly fees associated with your account. The SecureLine Account is completely free to have and use.
You will receive free monthly statements showing your account balance, interest earned, and transactions for the month.

Interest Your SecureLine account starts earning Interest the day the account is opened. Interest is compounded daily and credited to your account on the last day of each month.

Current Interest Rate The interest rate is established for each calendar month three business days prior to the first of the month based on the current Bloomberg checking account rate. The current rate will be effective on the first day of each calendar month using the index indicated. An account established at the end of the month will be credited with the current month's rate through month-end and the new month's rate will be credited beginning the first of the next month.

Interest Rate effective 8/1/10 The interest rate is established for each calendar month three business days prior to the first of the month based on the current LIBOR 3 month rate. The current rate will be effective on the first day of each calendar month using the index indicated. An account established at the end of the month will be credited with the current month's rate through month-end and the new month's rate will be credited beginning the first of the next month.

Convenient If, at any month-end after your account is established, the balance in the account falls below $1,000.00, it will be closed automatically. The balance in the account will be sent to you, together with any interest due, at the end of the following month.

Personalized Service Toll free number to speak with your personal SecureLine Account Specialist for assistance with your account.

☐ **I elect my proceeds to be paid by a lump sum check.**

I understand that The Lincoln National Life Insurance Company furnishes this form without waiving any defense the Company may have or admitting that any insurance is in force. I agree to furnish statements by physicians who attended or treated the deceased and all other documents requested by the Company as proof of death.
I have completed and attached the Authorization for Release of Information. A photocopy of this authorization shall be as valid as the original.
I certify, under penalty of perjury, that the Social Security Number or other Taxpayer Identification Number information listed above is correct. I understand that my signature may be used for signature verification for my SecureLine Account and other purposes.

Signature _____ **Date** _____
(Sign as you would a check as signature may be used for check verification)

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; coroner's office; insurance or reinsurance company; government agency; department of labor; law enforcement or public safety department; 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. Claimant/Insured Information to be released:
   - data or records regarding medical history, treatment, prescriptions, consultations, autopsy [including medical and psychological reports, records, charts, notes (excluding psychotherapy notes), x-rays, films or correspondence, and any medical condition(s)];
   - any information regarding insurance coverage; and
   - accident report or any official investigative reports (such as police, fire, FAA, OSHA, or toxicology report).

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 death benefits. 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)

IMPORTANT CLAIM PROCESS INFORMATION

In order to expedite the claim process, please see the following important claim process information when submitting a claim:

- Proof of Loss:

  All Life Claims must be accompanied by a Certified Death Certificate, unless the claim qualifies for JET processing.

- Accidental Death Benefits:

  If death resulted from anything other than Natural Causes (i.e. accident, homicide), a copy of the official investigative report (i.e. police, accident, fire, FAA, OSHA) must accompany or follow the claim. AD&D benefits cannot be paid on any claim without an investigative report regarding the Insured Person's /Dependent's death. If your Group Contract contains an Alcohol/Drug Exclusion, a Toxicology Report will be required.

- Payment Verification:

  Groups should include the enrollment form, copies of any beneficiary changes, absolute assignments or funeral assignments when submitting a claim.

- Beneficiary is Deceased:

  If the Primary Beneficiary is no longer living - a Certified Death Certificate must accompany the claim before payment can be made to the Contingent (secondary) Beneficiary. If the Contingent (secondary) Beneficiary is also deceased, a Certified Death Certificate will also be required in order to pay certain relatives or the Estate, according to the contract.

- Beneficiary is an Estate:

  Court documents of appointment must be forwarded to The Lincoln National Life Insurance Company before payment can be made to an Estate. The documents of appointment must name the Personal Representative of the Estate (also called the Executor, Executrix, Administrator or other similar title) to whom benefits can be paid.

- Beneficiary is a Trust:

  If payment is to be made to a Trust, a copy of the Trust Document must be provided with the claim. Such documents must designate the Trustee to whom proceeds will be paid.

- Beneficiary is a Minor:

  According to state law, a minor lacks capacity to sign a binding release of an insurance contract.

  For this reason, life insurance benefits are not directly payable to a minor beneficiary. The following are options available when the beneficiary is a minor:

  1. SecureLine Account – The insurance proceeds are placed into an interest bearing account until the minor child reaches the age of majority for the state in which he/she resides. (Not all states apply)
  2. UTMA (Uniform Transfer to Minors Act) – UTMA payment can be utilized providing that the benefit amount including interest is under the amount allowed for the minor beneficiary's state of residence.
  3. Guardianship papers – The minor's custodian may obtain formal guardianship papers for the minor's estate. These legal guardianship documents must be obtained prior to the release of the benefit.

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.

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.

Louisiana and Rhode Island. 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.

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.

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.

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.

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.