Lincoln Financial Group®

Lincoln Life & Annuity Company of New York, PO Box 2609, Omaha, NE 68103-2609
Toll Free: (855) 546-1445 Fax: (855) 398-7387
www.Lincoln4Benefits.com
NYNJClaims@lfg.com

STATUTORY CLAIM

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Steps to file your claim:

- Part A and Authorization for Release of Information - To be completed by you.
- Part B - To be completed by your Health Care Provider.
- Part C - To be completed by your Employer.

Your completed claim should be submitted within (30) days after you become sick or disabled. In order to expedite your claim, please have all portions completed in their entirety.

Completed Claim forms can be sent to:
Lincoln Life & Annuity Company of New York
PO Box 2609, Omaha, NE 68103-2609
Toll Free: (855) 546-1445
Fax: (855) 398-7387
NYNJClaims@lfg.com

PART A - CLAIMANT'S STATEMENT (Please Print or Type) Answer All Questions

1. Name (First/Middle/Last): _____

2. Social Security Number: _____ 3. Age: _____

4. Address: _____

City: _____ State: _____ Zip Code: _____

5. Date of Birth: _____ 6. Married (Check One): ☐ Yes ☐ No ☐ Male ☐ Female

7. My disability is (if injury, state how, when and where it occurred): ☐ Illness ☐ Accident ☐ Workers Compensation

_____

_____

8. Date Disabled (Month/Day/Year): _____ 8a. I worked on that day: ☐ Yes ☐ No

8b. I have since worked for wages or profit: ☐ Yes ☐ No If Yes, when: _____

9. Give name of last employer. If more than one employer during last eight (8) weeks, name all employers.

Employer's			Date of Employment		Average Weekly Wages Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.
Business Name	Business Address	Telephone Number	From (Mo/Day/Yr)	Through (Mo/Day/Yr)	

10. Occupation (Describe Job): _____

10a. Name of Union and Local Number, if member: _____

11. For the period of disability covered by this claim

	Yes	No
a. Are you receiving wages,salary or separation pay:	☐	☐
b. Are you receiving or claiming:		
i. Workers compensation for work connected disability	☐	☐
ii. Unemployment Insurance Benefits	☐	☐
iii. Damages for personal injury	☐	☐
iv. Benefits under the Federal Social Security Act for long term disability	☐	☐

c. If "Yes" is checked in any of the items 11a or 11b, complete the following:
I have ☐received ☐ claimed from for the period Date:_____ to Date: _____.

12. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began. ☐ Yes ☐ No

If "Yes", fill in the following: I have been paid by:_____
from Date: _____ to Date: _____.

13. I have read the instructions on page 1. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

Any persons who knowingly and with intent to defraud any insurance company 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 and shall also be subject to a civil penalty not to exceed five thousand dollars and stated value of the claim for such violation.

_____ _____
Claimant's Signature Date

Phone Number: _____ E-mail Address:_____

If signed by other than claimant, print below: name, address, and relationship of representative:

Name: _____

Address: _____

City:_____ State: _____ Zip Code: _____

Relationship: _____

If you have any questions about claiming disability benefits, contact the nearest office of the NYS Workers' Compensation Board, or write: Workers' Compensation Board, Disability Benefits Bureau, 100 Broadway-Menands, Albany, NY 12241.

Health Care Provider must complete Part B on page 3.

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

   Claimant/Patient 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: Lincoln Life & Annuity Company of New York
   PO Box 2609
   Omaha, NE 68103-2609

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 disability 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
   - to a vendor, approved by the company, which specializes in the application for Social Security Disability Benefits
   - to vendors/consultants providing the claimant with wellness, disability or leave related services as part of an employer sponsored benefit plan
   - to the employer for self-insured disability plans; 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 the federal HIPAA Privacy Rule. 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/patient is a minor, legally incompetent, or deceased.) Power of attorney or guardianship must be attached.

PRINT NAME: _____

Relationship to Claimant/Patient of personal/legal representative signing for Claimant/Patient: _____

ADDRESS: _____ PHONE NO: _____
(Street)

_____
(City) (State) (Zip Code)

Important: Use this form only when the claimant becomes sick or disabled while employed or becomes sick or disabled within four (4) weeks after termination of employment.

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

The health care provider's statement must be filled in completely and the form mailed to the insurance carrier or self-insured employer, or returned to the claimant within seven days of the receipt of the form. For item 7d, give approximate date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks".

1. Claimant's Name (First/Middle/Last): _____

2. Date of Birth: _____ 3. Sex: ☐ Male ☐ Female

4. Diagnosis/Analysis: _____ Diagnosis Code: _____

   a. Claimant's Symptoms: _____

   b. Objective Findings: _____

   c. If disability is pregnancy related: Enter delivery date: _____ ☐ Estimated ☐ Actual

   Type: ☐ Vaginal ☐ C-Section

5. Claimant Hospitalized? ☐ Yes ☐ No From: _____ To: _____

6. Operation Indicated? ☐ Yes ☐ No a. Type: _____ b. Date: _____

   List of Restrictions and Limitations: _____

   Nature of treatment: _____

7. Enter Dates for the Following:	Month	Day	Year
a. Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date claimant was unable to work because of this disability			
d. Date claimant will be able to perform usual work			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐ Yes ☐ No

   Remarks (Attached additional sheet , if necessary) _____

   Name(s), address and specialty of other treating physicians:

   _____

   _____

I affirm that I am a: ☐ Chiropractor ☐ Physician ☐ Psychologist ☐ Dentist ☐ Podiatrist ☐ Nurse-Midwife

Licensed in the State of: _____ License Number: _____

_____ _____

Health Care Provider's Signature Date

_____ _____

Health Care Provider's Name (Please Print) Telephone Number

Office Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ E-mail Address: _____

PART C - EMPLOYER'S STATEMENT

1. Employee's Name: _____

2. Employee's Address: _____

   City: _____ State: _____ Zip Code: _____

3. Employee's Occupation: _____

4. Date Employed: _____ 5. Employee Work State: _____

6. Social Security Number: _____ 7. State Disability Policy Number: _____

8. Employee works: ☐ Full time ☐ Part time Number of Hours Per Week: _____
   Check usual days worked: ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

9. Is claimant an: ☐ Employee ☐ Owner ☐ Partner ☐ High School Student 10. Date employee last worked: _____

11. Date employee's wage ceased: _____ 12. Date employee returned to work: _____

13. Required Statutory Benefit Tax Information:
    Important - Indicate percentage Employer contributes to premium _____% (if blank or not a percentage we will tax at 100%)
    ☐ Post Tax ☐ Pre Tax

14. Are wages being continued during disability? ☐ Yes ☐ No If Yes ☐ Salary Continuance ☐ Sick Pay ☐ Vacation ☐ PTO
    Beginning Date: _____ Ending Date: _____ Weekly Amount Paid: _____

15. Is reimbursement requested for the State Disability Benefit? ☐ Yes ☐ No

16. Date you received the completed claim form: _____

17. Did the disability occur as a result of employment? ☐ Yes ☐ No
    Has a Worker's Compensation claim been filed? ☐ Yes ☐ No (If WC claim was denied include copy of denial notice.)

18. Name of your Worker's Compensation Carrier: _____
    Worker's Compensation Carrier Address: _____
    City: _____ State: _____ Zip Code: _____

19. Do you expect to rehire? ☐ Yes ☐ No

20. Is employee a member of a union which provides N.Y. State disability benefits? ☐ Yes ☐ No

21. If employee is no longer in your employ, check reason: ☐ Labor Dispute ☐ Lack of Work ☐ Fired ☐ Quit
    Explain: _____

22. Has the claimant received U.I. Benefits? ☐ Yes ☐ No If Yes, give dates: _____

Please complete Table A if the employee is eligible for NY DBL benefits or Table B if the employee is eligible for New Jersey TDB benefits.

Table A - New York DBL

Earnings for 8 weeks Prior to Disability (including the week in which the disability began)				
Month	Day	Year	Number Days Worked	Amount
			Total	

Indicate weekly value of board, lodging and tips $ _____

Table B - New Jersey TDB (if applicable)

Indicate below dates and claimant's GROSS earning in N.J. employment during the listed calender weeks.

Description of Calender Week	Calender Week Ending Date	Gross Wages
Disability Began		$
2nd Week Before Disability		$
3rd Week Before Disability		$
4th Week Before Disability		$
5th Week Before Disability		$
6th Week Before Disability		$
7th Week Before Disability		$
8th Week Before Disability		$
9th Week Before Disability		$
10th Week Before Disability		$
Total Gross Wages For Above Weeks		$

Base Weeks and Base Year Gross Wages

A BASE WEEK is a calender week in which the claimant had New Jersey earnings of at least the minimum NJ TDB earnings during the Base year. The BASE YEAR is the 52 calender weeks preceding the week in which the disability occurred.

Total Number of Base Weeks:_____ Total Gross Wages in Base Year: _____

Short Term Disability Policy Number: _____ Effective Date:_____

LTD Policy Number: _____ Effective Date:_____

Date Employee Insured: _____

STD: ☐ Yes ☐ No LTD: ☐ Yes ☐ No

If Yes: ☐ Pre-Tax ☐ Post-Tax _____% paid by employer _____ % paid by employee

Does the employee contribute toward the STD premium? ☐ Yes ☐ No

If Yes: ☐ Pre-Tax ☐ Post-Tax _____% paid by employer _____ % paid by employee

Employer Name: _____

Employer Address: _____

City:_____ State: _____ Zip Code: _____

Name of person completing form: _____

Phone Number: _____

_____ _____

Signature Date

E-mail Address:_____