Lincoln Financial Group®

Group Life Insurance Claim Form

Lincoln Life & Annuity Company of New York
Service Office Address: PO Box 2649, Omaha, NE 68103-2649
Home Office: Syracuse, NY
toll free (800) 423-2765 Fax (800) 462-4660
www.LincolnFinancial.com
LifeClaims@lfg.com - For claims submission
Claims@lfg.com - For direct claim status inquiries and questions on existing claims

Employer or Plan Administrator Statement

To avoid delays or denial of benefits, please complete all questions.

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 # _____ _____
(Employee's SSN) (Dependent SSN)

   Insurance Class (Refer to policy schedule of insurance) _____
4. Amount of Life Benefit:

   Basic $ _____ Optional Life $ _____ Voluntary Life $ _____

   Dependent Life $ _____ Other Life Benefit Claimed: _____ Amount $ _____

   If death is due to an Accident, amount of Accidental Death (AD) Benefit:

   AD Basic $ _____ Optional AD $ _____ Voluntary AD $ _____

   Dependent AD $ _____ Other AD Benefit Claimed: _____ Amount $ _____
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)

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.

Completed by _____ Date _____

Title _____ Phone Number _____

E-mail Address _____ Fax Number _____

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Beneficiary's Statement

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

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

Beneficiary's Social Security Number or Taxpayer Identification Number _____

Date of Birth (MM/DD/YY) _____ Home Phone _____ Daytime Phone _____

Address _____

City _____ State _____ Zip _____

E-mail Address _____

Name of Deceased _____ Relationship to Deceased _____

If the beneficiary is one of the following: ☐ Minor ☐ Estate ☐ Incompetent ☐ Organization ☐ Trust

Please provide contact name and phone number of the personal or legal representative of that beneficiary:

_____

You have the right to choose how you will receive the payment of life proceeds.

PAYMENT OPTIONS: Please select one of the following two options (One Single Check or Direct Deposit) and please also make sure to sign and date on page 3.

☐ **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 Lincoln Life & Annuity Company of New York, 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 Lincoln Life & Annuity Company of New York or BANK. Any such notification to Lincoln Life & Annuity Company of New York shall be effective only with respect to entries initiated by Lincoln Life & Annuity Company of New York after receipt of such notification and a reasonable opportunity to act on it. I understand that Lincoln Life & Annuity Company of New York is required to send a notification and a reasonable opportunity to act on it. I understand that Lincoln Life & Annuity Company of New York 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.

I understand that Lincoln Life & Annuity Company of New York furnishes this form without waiving any defense the Company may have or admitting that any insurance is in force.

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.

* If the Insured Person previously designated a payment option available under the policy, we are required to disburse funds pursuant to that designation.

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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: Lincoln Life & Annuity Company of New York
   PO Box 2649
   Omaha, NE 68103-2649

4. I understand the information obtained by use of this Authorization will be used by Lincoln Life & Annuity Company of New York ("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)

Accidental Death Benefit Information

A beneficiary or the personal/legal representative of the deceased will only complete this page when applying for Accidental Death Benefits.

1. Group Name:_____
2. Name of Insured:_____
3. Name of Deceased (If different from above): _____ Relationship to Insured: _____
4. On what date did the Accident occur? (MM/DD/YY) _____

   Where did the Accident Occur? (Address, City, State): _____

   Describe in detail how the Accident occurred:

5. Did the Deceased have any disease or physical defect? ☐ Yes ☐ No

   If Yes, please describe in detail:

6. Was a police or other investigative report completed? ☐ Yes ☐ No

   If Yes, please provide a copy of the official investigative report (i.e. police, accident, OSHA, etc) and/or provide contact information:

7. List name/address/phone number of all physicians who treated the deceased in connection with the accident:

8. List name/address/phone number of all hospitals who treated the deceased in connection with the accident:

9. Was an Autopsy performed? ☐ Yes ☐ No

   If Yes, please submit copy of the Autopsy report and/or provide contact information:

Person completing form: _____ Phone: _____

Address: _____

City: _____ State:_____ Zip:_____

Relationship to Deceased:_____

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Signature of Person Completing this form: _____ Date:_____

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.

- 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. Please complete the Accidental Death Benefit Information portion of the claim form to provide background information regarding accident.

- 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 Lincoln Life & Annuity Company of New York 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. 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.
  2. 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. If guardianship papers are not obtained and if UTMA does not apply, the benefit will be paid once the minor reaches the age of majority.

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.

Lincoln Financial Group® privacy practices notice

The Lincoln Financial Group companies* are committed to protecting your privacy. To provide the products and services you expect from a financial services leader, we must collect personal information about you. **We do not sell your personal information to third parties.** This Notice describes our current privacy practices. While your relationship with us continues, we will update and send our Privacy Practices Notice as required by law. Even after that relationship ends, we will continue to protect your personal information. **You do not need to take any action because of this Notice, but you do have certain rights as described below.**

Information we may collect and use

We collect personal information about you to help us identify you as our customer or our former customer; to process your requests and transactions; to offer investment or insurance services to you; to pay your claim; or to tell you about our products or services we believe you may want and use; and as otherwise permitted by law. The type of personal information we collect depends on the products or services you request and may include the following:

- Information from you: When you submit your application or other forms, you give us information such as your name, address, Social Security number; and your financial, health, and employment history.
- Information about your transactions: We maintain information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; and your payment and claims history.
- Information from outside our family of companies: If you are purchasing insurance products, we may collect information from consumer reporting agencies such as your credit history; credit scores; and driving and employment records. With your authorization, we may also collect information, such as medical information from other individuals or businesses.
- Information from your employer: If your employer purchases group products from us, we may obtain information about you from your employer in order to enroll you in the plan.

How we use your personal information

We may share your personal information within our companies and with certain service providers. They use this information to process transactions you have requested; provide customer service; and inform you of products or services we offer that you may find useful. Our service providers may or may not be affiliated with us. They include financial service providers (for example, third party administrators; broker-dealers; insurance agents and brokers, registered representatives; reinsurers and other financial services companies with whom we have joint marketing agreements). Our service providers also include non-financial companies and individuals (for example, consultants; vendors; and companies that perform marketing services on our behalf). Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law.

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners, regulatory authorities and law enforcement officials, and to other non-affiliated or affiliated parties as permitted by law. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or share your information with outside marketers who may want to offer you their own products and services; nor do we share information we receive about you from a consumer reporting agency. You do not need to take any action for this benefit.**

Security of information

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. Our employees are authorized to access your information only when they need it to provide you with products, services, or to maintain your accounts. Employees who have access to your personal information are required to keep it confidential. Employees are trained on the importance of data privacy.

Your rights regarding your personal information

Access: We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you request a copy of the information, we may charge you a fee for copying and mailing costs. In very limited circumstances, your request may be denied. You may then request that the denial be reviewed.

Accuracy of Information: If you feel the personal information we have about you is inaccurate or incomplete, you may ask us to amend the information. Your request must be in writing and must include the reason you are requesting the change. We will respond within 30 business days. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years. If your requested change is denied, we will provide you with reasons for the denial. You may write to request the denial be reviewed. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request.

Accounting of Disclosures: You may request an accounting of disclosures made of your medical information, except for disclosures:

- For purposes of payment activities or company operations;
- To the individual who is the subject of the personal information or to that individual's personal representative;
- To persons involved in your health care;
- For notification for disaster relief purposes;
- For national security or intelligence purposes; or
- To law enforcement officials or correctional institutions; or
- For which an authorization is required.

You may request an accounting of disclosures for a time period of less than two years from the date of your request.

You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate, or terminate your coverage.

Your state may provide for additional privacy protections under applicable laws. We will protect your information in accordance with these additional protections.

Questions about your personal information should be directed to:
Lincoln Financial Group
Attn: Enterprise Compliance and Ethics
Corporate Privacy Office, 7C-01
1300 S. Clinton St.
Fort Wayne, IN 46802

Please include all policy/contract/account numbers with your correspondence.

*This privacy practices notice applies to the following Lincoln Financial Group affiliated companies:

First Penn-Pacific Life Insurance Company
Lincoln Life & Annuity Company of New York
Lincoln Financial Group Trust Company, Inc.
Lincoln Retirement Services Company, LLC
Lincoln Financial Investment Services Corporation
Lincoln Variable Insurance Products Trust
Lincoln Investment Advisors Corporation
The Lincoln National Life Insurance Company
Lincoln Financial Distributors, Inc.
Lincoln Advisors Trust