Lincoln Financial Group®

Lincoln Life & Annuity Company of New York
Service Office Address: PO Box 2649, Omaha, NE 68103-2649
Home Office: Syracuse, NY
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www.LincolnFinancial.com

EXTENSION OF DEATH BENEFITS APPLICATION

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.

EMPLOYEE'S STATEMENT

To Be Completed By The Employee

A. Information about you

Full Name:_____

Address:_____
City State Zip Code

Phone Number:_(_____)_____ Social Security No._____

Date of Birth_____ Date of Total Disability_____ Hour_____ AM PM

Occupation_____ E-mail Address _____

B. Information about the disability

Did disability result from employment? Yes☐ No☐

Have you been CONTINUOUSLY disabled since you became unable to work? Yes☐ No☐
If YES, when CAN you resume your duties at work?
If NO, when DID you become able to work? Date _____

Is your disability due to an ☐ACCIDENT ☐ILLNESS? If an accident, describe the incident (including date and place) and if an illness, identify when the symptoms first appeared: (Attach explanation if more space needed) _____

_____

First medical attention for the current disability was given by (complete below):

Doctor's Name	Telephone: ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates Seen To
List all other physicians and hospitals you have seen for this condition:		
Doctor's Name	Telephone: ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates Seen To
Doctor's Name	Telephone: ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates Seen To
Doctor's Name	Telephone: ( ) Fax: ( )	Specialty
Address (Street, City, State, Zip)		Dates Seen To
Hospital		
Address (Street, City, State, Zip)		Dates of Hospitalization To

C. Information about your training, education, and experience

1. Did you graduate from high school? Yes☐ No☐ If no, grade completed? _____ GED? ☐

2. Did you attend college? Yes☐ No☐ Did you graduate? Yes☐ No☐ List Degree(s) earned_____

   Name of College?_____ Major(s)_____

3. Do you have any other formal or vocational training? Yes ☐ No☐ Please list_____

4. Were you in the military? Yes ☐ No☐ _____
   Branch Rank Specialty

5. WORK EXPERIENCE

Please list your work experience beginning with your most recent employer in chronological order. Feel free to use the back of this form if you need additional space.

Employer_____ Job Title_____ Dates Worked_____

Duties & Responsibilities_____

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Employer_____ Job Title_____ Dates Worked_____

Duties & Responsibilities_____

Employer_____ Job Title_____ Dates Worked_____

Duties & Responsibilities_____

6. List any additional courses you have taken, any hobbies and special skills and any languages you speak fluently. (Please be specific such as sales, carpentry, auto repair, etc.)

These statements are true and complete to the best of my knowledge. **I have completed and attached the Authorization for Release of Information.**

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.

Date_____ Signature_____

EMPLOYER'S STATEMENT

To Be Completed By The Employer

Employer's Name_____

Group Policy Number_____ Phone Number(_____)_____

Employee's Certificate Number_____ Effective Date of Policy_____

Effective Date of Employee's Insurance_____ Hire Date_____

Insurance Class_____ Average Hours Worked Per Week _____

Dep Coverage Yes☐ No☐ Spouse Name/Date of Birth _____

Child(ren) Name(s)/Date(s) of Birth _____

_____

_____

Date last worked (Month - Day - Year)_____ Salary $_____ per_____

Is claim being made for Workman's Compensation or similar benefits? Yes☐ No☐

Was the insured in your employ when disability began? Yes☐ No☐

Was group insurance in effect when disability began? Yes☐ No☐

Has / did the insured return to work? Yes☐ No☐ Date_____

Is insured's group insurance still in force? Yes☐ No☐ Date Terminated_____

Current Life BENEFIT AMOUNT of insurance on above employee: $_____ Class_____

Please note that a current premium statement verifying the benefit amount and enrollment form verifying employee coverage may be requested.

Your Name_____ Title_____ Date_____

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; 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. 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
   Service Office Address: 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 life waiver (extension of 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)

ATTENDING PHYSICIAN'S STATEMENT

This form should be completed by the physician who was treating the claimant when he or she last worked.

To Be Completed By The Attending Physician

A. General Information

This claim is for (Patient's Name)

Patient's Social Security Number	Height	Weight	Blood Pressure	Date of Birth (Month, Day, Year)

Primary Diagnosis including ICD 9 or DSM code

B. Complete this section for all conditions.

Symptoms

Objective Findings

Are there secondary conditions contributing to the disability?

☐ Yes ☐ No If yes, what are they? (Please include ICD 9 or DSM code.)

If this is a cardiac condition, what is the functional capacity? (American Heart Association)

☐ Class 1 - No limitation
☐ Class 2 - Slight limitation
☐ Class 3 - Marked limitation
☐ Class 4 - Complete limitation

When did symptoms first appear?	Date of the patient's first visit (Month, Day, Year)	Date you believe the patient was first unable to work (Month, Day, Year)
Date of the patient's last visit (Month, Day, Year)		How often do you see the patient?

Is the patient's condition work related?

☐ Yes ☐ No If yes, explain: _____

Has the patient undergone surgery?

☐ Yes ☐ No If yes, give date, procedure and result. _____

If no, do you expect surgery to be performed in the future?

☐ Yes ☐ No If yes, give date and type of surgery.

What medication is the patient currently taking?

Please indicate other types and frequencies of treatment.

Has the patient been referred to a medical rehabilitation or therapy program?

☐ Yes ☐ No If yes, give details. _____

Have you referred the patient for other types of consultations?

☐ Yes ☐ No If yes, give details. _____

Has the patient been hospital confined?

☐ Yes ☐ No If yes, complete the following:

Name of Hospital

Address	Dates of Confinement through

(Continued on next page)

C. Information about the patient's inability to work

Briefly describe restrictions and limitations.

Restrictions (What the patient SHOULD NOT do)

Limitations (What the patient CANNOT do)

What is your prognosis for recovery?

Has patient achieved maximum medical improvement?

☐ Yes ☐ No If no, complete the following:

How soon do you expect fundamental changes in the patient's medical condition?

☐ 1 - 2 months	☐ 5 - 6 months	☐ 1 - 1.5 year
☐ 3 - 4 months	☐ 6 - 12 months	☐ more than 1.5 years

Give details concerning expected improvement or deterioration:

In an eight hour workday, claimant can: *(Circle full hourly capacity <u>for each</u> activity)*

Sit	1	2	3	4	5	6	7	8
Stand	1	2	3	4	5	6	7	8
Walk	1	2	3	4	5	6	7	8

Are there restrictions in:	Yes	No	Comments
Lifting/Carrying	☐	☐	
Use of hands in repetitive actions	☐	☐	
Use of feet in repetitive movements	☐	☐	
Bending	☐	☐	
Squatting	☐	☐	
Crawling	☐	☐	
Climbing	☐	☐	
Reaching above shoulder level	☐	☐	
Other (please specify)	☐	☐	

When do you expect claimant to return to prior level of functioning?

Would you recommend vocational rehabilitation for this patient?

☐ Yes ☐ No

Is patient now TOTALLY disabled from <u>PRESENT</u> occupation?

☐ Yes ☐ No

Is patient now TOTALLY disabled from <u>ANY OTHER</u> occupations?

☐ Yes ☐ No

D. Required Attachments and Signature

After you have fully completed this form, attach copies of the following materials:

- **Office notes for the period of treatment for the last two years**
- **Test results showing objective findings**
- **Hospital discharge summaries**
- **Consulting physician reports**

(Lincoln Financial Group is not responsible for any costs associated with providing this information)

Your Name	Degree
Specialty	Telephone: ( ) Fax: ( )

Address

X _____ _____

Signature of Attending Physician (no stamp) Date

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. 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.