

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: ()	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	
Doctor's Name		Telephone: ()	Specialty
		Fax: ()	
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 _____

Employer _____ Job Title _____ Dates Worked _____

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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.**

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 _____

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)
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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)
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Date of the patient's last visit (Month, Day, Year)	How often do you see the patient?
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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 for each 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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use of hands in repetitive actions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use of feet in repetitive movements	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bending	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reaching above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 PRESENT occupation?

Yes No

Is patient now TOTALLY disabled from ANY OTHER 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: ())
Address	Fax: ())

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.