Lincoln Financial Group®

Disability Claim Filing Process:

Fill out the employee part and fax or email to 877-573-6177 or disabilityclaims@lfg.com

Doctor's office needs to fax or email physicians forms to 877-573-6177 or disabilityclaims@lfg.com

Notify Insurance Department of the last working day.

Lincoln Financial Group

Service Contact Sheet

Customer Service Center: (800) 423.2765

Press "Option One" for claims.
Press "Option Two" for administration and other questions.

*You will receive **immediate assistance**.*

Customer Service Center Hours of Operation:

Monday through Thursday, 7 a.m. – 7 p.m. Central Time
Friday, 7 a.m. – 5 p.m. Central Time

Email us at:

claims@LFG.com **for any claims questions.**
clientservices@LFG.com **for administration and other questions.**

*You will receive a **response within 24 hours or less.***

Email address to submit disability claims is:

disabilityclaims@LFG.com

Enrollments and adjustments fax to: (877) 573.6177

Visit us at:

www.jpfic.com **for real-time information and benefit administration.**

Lincoln Financial Group®

Short Term Disability Claim Form Statement Of Employee

The Lincoln National Life Insurance Company
PO Box 2609, Omaha, NE 68103-2609
Toll Free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com
disabilityclaims@lfg.com

1. Your Information

Full Name (First) | (M.I.) | (Last Name)

Street Address

City | State | Zip Code

Social Security Number | Date of Birth

☐ Male ☐ Female

Phone Number

Email Address

2. Your Employer

Sharyland ISd
Employer Name

000010102421
Group ID

Job Title

000010102422
Policy Number

Billing Location

3. Reason for inability to work

Description of Sickness, Injury or Pregnancy

Date Last Worked

Injury work related? ☐ Yes ■ No

4. Other Income Being Received

	Amount $	Date Began	Date Will Terminate	Date Applied For
Social Security		__/__/____	__/__/____	__/__/____
Workers' Comp		__/__/____	__/__/____	__/__/____
Salary Continuance		__/__/____	__/__/____	__/__/____
State Disability		__/__/____	__/__/____	__/__/____
Other Disability		__/__/____	__/__/____	__/__/____
Sick Pay		__/__/____	__/__/____	__/__/____

If approved, should Lincoln National Life Insurance Co. withhold Federal Income Taxes from your benefits?

☐ Yes ☐ No If yes, indicate how much? _____

(Minimum: $20 per week Short-Term Disability) (Minimum: $88 per Month Long-Term Disability)

5. Who is your treating health care provider?

This is your primary health care professional. Please have them complete the Attending Physician's Statement. If you have additional health care providers, please also complete the Treating Medical Professional form

Physician's Full Name

Phone Number | Fax Number

Street Address

City | State | Zip Code

6. Account for Direct Deposit ☐ Checking ☐ Saving

Bank Name

Routing Number

Account Number

The above statements are true and complete to the best of my knowledge and belief. I have read and understand Fraud Warning Statements. I have completed and attached the Authorization for Release of Information

Signature | Date

Print Name

Illness or Injury Supplemental Questionnaire

Instructions: Please answer the questions to the best of your ability and sign and date below.

1. Is someone else responsible for your illness/injury? ☐ Yes ■ No
2. Are you making a claim against anyone or any insurance company other than Lincoln Financial Group? ☐ Yes ■ No

If you answered yes to either question above, please answer the following questions:

3. Please describe in detail the cause of your illness or injury:

   NOT APPLICABLE

4. Please provide the location and address where the illness or injury occurred:

   NOT APPLICABLE

5. Please provide the Responsible Party's information:

   1. Name: NOT APPLICABLE
   2. Address: _____
   3. Telephone Number: _____
   4. Insurance Company's Name: _____
   5. Claim Number: _____

6. If you have hired an attorney to investigate or prosecute a claim related to your illness or injury, please provide your attorney's information:

   1. Name: NOT APPLICABLE
   2. Address: _____
   3. Telephone Number: _____

7. If you have any documents related to any investigation into how your illness or injury occurred, please attach them.

I have answered the above questions to the best of my ability. I understand that fraudulently answering any of these questions could result in the suspension or termination of my benefits. I further understand that I have an obligation to supplement any of the above responses should any of the above information change in the future.

Print Name: _____

Signature: _____ Date: _____/_____/_____

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Authorization For Release Of Information

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Toll Free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com
disabilityclaims@lfg.com

1. In connection with a claim for benefits, 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:

Name of Insured: _____
(Last) (First) (Middle)

Date of Birth: ____ /____ /_____ Social Security Number: XXX-XX-_____

2. **Information to be released (hereinafter referred to as "My Information"):**
   - 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, claims or benefits; and/or
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history).

3. **Information to be released to:** The Lincoln National Life Insurance Company ("Lincoln")
   PO Box 2609
   Omaha, NE 68103-2609

4. **I understand My Information will be used by Lincoln to evaluate and administer my claim for benefits. I also authorize Lincoln to release My Information as follows:**
   - 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 Lincoln, which specializes in the application for Social Security Disability Benefits
   - to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
   - for self-insured disability plans only, to my employer; or
   - for fully insured plans, I understand the information obtained with this Authorization may be used in discussions between Lincoln and my employer regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
   - as otherwise may be required by law or as I may further authorize.

5. I understand My Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. For Colorado claims, the disclosed information may not be re-disclosed 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 Lincoln has taken action in reliance on this Authorization. To initiate revocation of this Authorization, direct all correspondence to Lincoln at the above address. 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, or the duration of my claim for benefits, whichever is shorter.

7. A photocopy of this Authorization is to be considered as valid as the original. 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: _____
(Street)

_____
(City) (State) (Zip Code)

PHONE NO: _____

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Short Term Disability Claim Form Physician's Statement

The Lincoln National Life Insurance Company
PO Box 2609, Omaha, NE 68103-2609
Toll Free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com
disabilityclaims@lfg.com

1. Patient Information

Full Name (First) | (M.I.) | (Last Name) | Social Security Number

Height | Weight | Blood Pressure | Employer Name (Sharyland ISD)

2. Diagnosis

Primary ICD diagnostic Code (Required) | Primary ICD diagnosis Description

Secondary ICD Diagnosis Code | Secondary ICD Diagnosis Description

Pregnancy — First Treated (__/__/____) | Estimated Delivery (__/__/____) | Date of Delivery (__/__/____) | ☐ Vaginal ☐ C-Section

Symptoms

Objective Findings (Include copies of any x-rays, laboratory data, EKG's, MRI's, scans and any clinical findings)

3. Disability Circumstances - *Check if applicable*

☐ Illness ☐ Injury ☐ Work Related

If work related or injury, summarize circumstances

Date of

Symptoms first Appeared (__/__/____) | Reduced Ability to work (__/__/____) | Advised to stop work (__/__/____)

Initial Treatment (__/__/____) | Most Recent Treatment (__/__/____) | Next Treatment (__/__/____)

Dates hospital confined: (__/__/____) to (__/__/____)

The Lincoln National Life Insurance Company is not responsible for charges incurred due to completion of this form. The patient is responsible for any charges associated with form completion.

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4. Limitations and Restrictions

Restrictions (what the patient SHOULD NOT do)

Limitations (what the patient CANNOT do)

Indicate frequency per day the listed activities below can be used performed using:
N= Never 0% O= Occasionally <33% F= Frequently 34%-66% C= Continuously 67% - 100%

Lifting/Carrying				Reaching	
1-5 lbs.	Standing	Crouching		Overhead	
6-10 lbs.	Walking	Crawling		Desk Level	
11-25 lbs.	Sitting	Grasping		Below Waist	
26-50 lbs.	Balancing	Climbing			
51-100 lbs.	Stooping	Pushing			
100 + lbs.	Kneeling	Pulling			
	Fingering	Bending			

What job modifications would allow the patient to return to work?

Activities of Daily Living

If patient cannot complete these activities of Daily living indicate, when they were first unable to do so (M/D/Y)

Continence ____/____/____

Dressing ____/____/____

Transferring ____/____/____

Bathing ____/____/____

Toileting ____/____/____

Eating ____/____/____

Date patient experienced loss of

Cognitive Functioning: ____/____/____

5. Treatment

Describe current and recommended treatment plans including any completed or future surgeries. (Include dates)

6. Prognosis

Describe the patients prognosis for recovery

Describe ongoing treatment frequency

Patient able to return to work Full-Time on

____/____/____ to ____/____/____

If a specific date is unavailable, please provide a date range you expect a fundamental or marked change

7. Physician's Information

Name

Street Address

City State Zip Code

Phone Number Fax Number

Signature Date

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