The Lincoln National Life Insurance Company, PO Box 2649, Omaha, NE 68103-2649
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

GROUP LIFE INSURANCE CLAIM FORM

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)

Completed by _____ Date _____

Title _____ Phone Number _____

E-mail Address _____ Fax Number _____

The Lincoln National Life Insurance Company, PO Box 2649, Omaha, NE 68103-2649
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

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 Options.**

☐ **One Single Check - This is the default payment option if no option is selected.**

☐ **SecureLine Interest-Bearing Checking Account (Not available in New York).**

SecureLine is a service offered to help you manage insurance proceeds. With SecureLine, an account is established from the proceeds payable on a policy administered by a Lincoln Financial Group® company (Lincoln). Lincoln's contractual obligation to pay those proceeds is satisfied by depositing the proceeds into your account. The Northern Trust Bank (Northern Trust) administers your account on Lincoln's behalf and the funds supporting your account are held within Lincoln's general account. Once your SecureLine account is opened, you will receive a personalized checkbook. If you decide you want the entire proceeds immediately, you just need to write one check for the entire balance. Otherwise you can use this account for paying expenses as they occur – while earning interest on your money. You can write as many checks as you wish. Each check must be for at least $250 and the total of all checks written may not exceed your balance.

- **Interest Rates – Your SecureLine account starts earning interest the day the account is opened. Interest is compounded daily and credited to your account on the last day of each month. The minimum rate credited is equal to the national average for interest-bearing checking accounts as published daily by Bloomberg, plus 1%. The Company may update that minimum rate at our discretion. The interest will be updated monthly. You can find the current interest rate that will becredited to your account at www.lfg.com by clicking on the Quick Link "File a Claim". You begin to earn interest the day the account is opened and continue to earn interest until all the funds are withdrawn. The interest rate credited to your SecureLine account may be more or less than the rate earned on funds held in Lincoln's general account. Consider comparing this interest rate to your bank account interest rate or consult your financial professional to compare interest rates on comparable bank or mutual fund accounts. Interest earned on your account balance may be taxable; IRS form 1099-INT will be sent in January of each year to report taxable income. You should consult your tax advisor for more information.**
- **Protection Of Deposits – Your money in your SecureLine account is protected because it is held in Lincoln's general account and is guaranteed by the full faith and credit of the Lincoln Financial Group® company that established your account. Because your funds are not held in a federally-regulated bank, your funds are not protected by the Federal Deposit Insurance Corporate (FDIC). However, in the unlikely case of insolvency of Lincoln, your funds are protected by your state's insurance guaranty system. Contact the National Organization of Life and Health Guaranty Associations (http://nolhga.com; 703-481-5206) to learn more about what limits might exist related to state insurance guaranty protection.**

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

- **Monthly Statements – Each month you will receive a statement showing your current balance, withdrawals, interest credited and any other activity. Cancelled checks are not returned with your statement.**
- **Fees or Administrative Charges – There are no special fees for checks and no fees for monthly checking account service. You will be charged a fee of $15 if you stop a payment and $10 if you present a check for payment without sufficient funds. Additional checks may be ordered at no cost. Just contact a Customer Service Representative at Northern Trust at 1-800-343-2551.**
- **Minimum Balance – Your SecureLine account will remain open until your balance drops below $1000, at which time your account will be automatically closed and a check for the remaining funds plus interest will be mailed to you.**
- **Settlement Options - The Lincoln policy may provide you with other benefit settlement options. You may choose to withdraw the balance of your account and place it in another payment option offered by Lincoln. Contact a Customer Service Representative at 800-423-2765 for more information.**
- **Inactive Accounts - If there is no activity on your account and we have not heard from you for a prolonged period (2-7 years depending on your State's unclaimed property act), Lincoln will write you to verify your continued interest in the account and to confirm your contact information. If you do not respond to that correspondence, the funds in your account will be reported to your State as unclaimed property in accordance with your State's unclaimed property act.**
- **Louisiana Department of Insurance, PO Box 94214, Baton Rouge, LA 70804, (225) 342-1226**

FOR FURTHER INFORMATION, PLEASE CONTACT YOUR STATE DEPARTMENT OF INSURANCE.

☐ **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 The Lincoln National Life Insurance Company, 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 The Lincoln National Life Insurance Company or BANK. Any such notification to The Lincoln National Life Insurance Company shall be effective only with respect to entries initiated by The Lincoln National Life Insurance Company after receipt of such notification and a reasonable opportunity to act on it. I understand that The Lincoln National Life Insurance Company is required to send a notification and a reasonable opportunity to act on it. I understand that The Lincoln National Life Insurance Company 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 The Lincoln National Life Insurance Company 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 for my SecureLine Account and other purposes.

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: The Lincoln National Life Insurance Company
   PO Box 2649
   Omaha, NE 68103-2649

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 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:_____

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 The Lincoln National Life Insurance Company 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.