Lincoln Financial Group®

The Lincoln National Life Insurance Company, PO Box 2609, Omaha, NE 68103-2609
toll free (800) 423-2765 Fax (877) 843-3950
www.LFG.com

LINKS DISABILITY CLAIM FORM

To Be Completed by the Employer

Employee's Name	Social Security Number	Date of Birth	Class Number	Eff Date

A. Information about the employer

Name	Group Policy Number	Div # and Name
East Baton Rouge Parish School Board	000400003002-02069	

Address (Street, City, State, Zip)	Telephone:	Fax:
1050 South Foster Dr., Baton Rouge LA 70821	(225) 922-5650	(225) 928-4392

Name and address of division where employee works (if different from above)

E-Mail

B. Information about the employee

Date employee was hired (Month, Day, Year)

Date employee became insured under this plan?

Date employee became insured under prior plan?

What was the employee's regularly scheduled work week? Hrs/week Hrs/Day

What was the employee's permanent occupation on his or her last day of work? *(Please attach a copy of their job description)*

How long had the employee been in this occupation?

Last day employee actually worked (Month, Day, Year)

On that day, did the employee work a full day? ☐ Yes ☐ No If no, how many hours were worked?

Reason for ceasing active work:
☐ Maternity Leave
☐ Sickness ☐ Vacation ☐ Laid Off ☐ Retired
☐ Accident ☐ Dismissed ☐ Other
☐ Resigned ☐ Granted Leave of Absence

Has employee returned to work?
☐ Yes ☐ No
Part-Time Date
Full-Time Date

Is the employee's condition work related? ☐ Yes ☐ No

Has a claim been filed with Workers' Compensation? ☐ Yes ☐ No If yes, send initial report of illness or injury and award notice.

Name, address and telephone number of your compensation carrier:

Name, address and telephone number of your medical insurance carrier:

C. Benefit Information

Employee's Basic Weekly Earnings: $ **please provide proof of earnings (payroll records)**

Does the employee contribute toward the STD Premium? ☐ Yes ☐ No
If Yes: ☐ Pre Tax ☐ Post Tax
If Post Tax: _____ % paid by employer
_____ % paid by employee

Does the employee contribute toward the LTD Premium? ☐ Yes ☐ No
If Yes: ☐ Pre Tax ☐ Post Tax
If Post Tax: _____ % paid by employer
_____ % paid by employee

If you leave this section blank, we will assume it is 100% employer contribution and calculate FICA taxes accordingly.

Has insured received other income since time last worked?
Salary continuance ☐ Yes ☐ No Weekly Amount $_____ Salary Begin Date
(To include any future amounts the employee may receive) Date Salary will ***END***
Any Other Type ☐ Yes ☐ No Weekly Amount $_____ Paid from to

D. Information about your pension plan (do not complete unless Long Term Disability expected)

Do you have a pension plan? ☐ Yes ☐ No
If yes, what type? ☐ Defined benefit ☐ 401(k) ☐ Other: (specify)
☐ Defined contribution ☐ Profit sharing

Is the employee eligible for your pension plan? ☐ Yes ☐ No If no, why?

If eligible, does the employee participate? ☐ Yes ☐ No If no, why?

If the employee is participating, when is he or she eligible for benefits under the plan? (Month, Day, Year)

NOTE: If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the percentage of his/her contribution to the total contribution. This should include a copy of the contract.

Please print the name of person completing form: Phone Number:

Signature Title Date

Physical Requirements Form

A. General information about the employee's occupation

Title

Minimum education or training required

Does the employee perform supervisory functions?
☐ Yes ☐ No If yes, how many people are supervised?

B. Information about the aspects of the employee's occupation

Check the items below that relate to the employee's job. Use these definitions for the frequency of occurrence.

Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

Activity	Frequency of Occurrence: Never	Occasionally	Frequently	Continuously	Describe Activity	Weight
Relate to others	☐	☐	☐	☐		
Written and verbal communication	☐	☐	☐	☐		
Reasoning, math and language	☐	☐	☐	☐		
Makes independent judgments	☐	☐	☐	☐		
☐ Standing	☐	☐	☐	☐		
☐ Walking	☐	☐	☐	☐		
☐ Sitting	☐	☐	☐	☐		
☐ Balancing	☐	☐	☐	☐		
☐ Stooping	☐	☐	☐	☐		
☐ Kneeling	☐	☐	☐	☐		
☐ Crouching	☐	☐	☐	☐		
☐ Crawling	☐	☐	☐	☐		
☐ Reaching/working overhead	☐	☐	☐	☐		
☐ Climbing	☐	☐	☐	☐		
☐ Stairs Number of stairs: _____	☐	☐	☐	☐		
☐ Ladders Height of ladder: _____	☐	☐	☐	☐		
☐ Pushing	☐	☐	☐	☐	_____	_____ lbs
☐ Pulling	☐	☐	☐	☐	_____	_____ lbs
☐ Lifting/carrying	☐	☐	☐	☐	_____	_____ lbs

Can this occupation be performed by alternating sitting and standing?
☐ Yes ☐ No

Does this occupation require using the feet to operate foot controls?
☐ Yes ☐ No If yes, on what type of equipment?

How important is good vision for this occupation?

What are the major tasks requiring use of one or both hands?	One Hand	Both Hands
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

C. Information about the occupation as it relates to the disability

Can the occupation be modified to accommodate the disability either temporarily or permanently?
☐ Yes ☐ No If yes, explain

Is it possible to offer the employee assistance in doing the occupation (through use of technology or personal assistance for example)?
☐ Yes ☐ No

Does your company have a rehire or return-to-work policy for disabled employees?
☐ Yes ☐ No

What is the name and title of the manager we should contact if we identify a rehabilitation or return-to-work option?

To Be Completed by the Employee

A. Information about you

Last Name | First | Middle Initial

Address | City | State/Province | Zip

Telephone | Fax | E-Mail

Date of Birth (Month, Day, Year) | Social Security Number | ☐ Rt. Handed ☐ Lt. Handed ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Height: | Weight:

Spouse Name: | Soc Sec No.: | Date of Birth:

Dependent Name: | Soc Sec No.: | Date of Birth:

Your Employer (include division if applicable)

Occupation

B. Information about the disability

Last day you worked before the disability (Month, Day, Year)

Did you work a full day? ☐ Yes ☐ No If no, explain

Date you were first unable to work (Month, Day, Year)

Have you returned to work?
☐ Yes Part time (date)_____Full time (date)_____
☐ No

If you have not returned to work. do you expect to?
☐ Yes Part time (date)_____Full time (date)_____
☐ No

Are you currently self-employed or working for another employer?
☐ Yes ☐ No If so, give details

Describe how and where accident occurred or describe the onset and nature of your illness.

Date you were first treated for your illness or injury:

Dates Hospital confined: From: To:

Treated by: (on another piece of paper, provide names & addresses of all doctors who have treated you for this disabling condition).

Hospital: _____
Name | Street Address | City | State | Zip Code

Doctor: _____
Name | Street Address | City | State | Zip Code

Pharmacy Name 1: _____

Pharmacy Name 2: _____

Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If yes, provide details.

C. Information about other income you are receiving

Yes	No		Amount	Date Began	Date will Terminate
☐	☐	Social Security (Disability Retirement)	$		
☐	☐	Salary Continuance	$		
☐	☐	Retirement (Normal, Early or Disability)	$		
☐	☐	Workers' Compensation	$		
☐	☐	Unemployment, government, or state benefits	$		
☐	☐	Any other income related to your disability	$		

Have you, or do you plan to apply for benefits described above? ☐ Yes ☐ No

Type | Date Application Filed

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

_____ Signature of Employee

_____ Date

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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; acquaintance; group policyholder; employer; or policy or benefit plan administrator to release information from the records of:

   Claimant/Patient 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: The Lincoln National Life Insurance Company
   PO Box 2609
   Omaha, NE 68103-2609

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 disability 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 <u>not</u> 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/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: _____ PHONE NO: (_____) _____
(Street)

_____
(City) (State) (Zip Code)

SOCIAL SECURITY ADMINISTRATION AUTHORIZATION TO RELEASE INFORMATION

To: Department of Health, Education and Welfare Social Security Administration	Authorization to Disclose Re: _____ Social Security Number: _____

You are hereby requested and authorized to disclose, make available and furnish to The Lincoln National Life Insurance Company, 8801 Indian Hills Drive, Omaha, Nebraska 68114, or its authorized representative, pursuant to P.L. 93-579: 42 U.S.C. Section 1306 (a): 20 C.S.R. 401, 3 (a), all information relative to my applications for disability benefits from the Department of Health, Education and Welfare, Social Security Administration made including all medical records or forms submitted to your administration either by me or on my behalf, including examinations of me by any physician on behalf of the Social Security Administration and advise as to the disposition of each application.

This authorization is given in connection with a claim pending with The Lincoln National Life Insurance Company, 8801 Indian Hills Drive, Omaha, Nebraska 68114.

_____ _____

Signature Date

State of _____

County of _____

To Be Completed by the Attending Physician

A. General Information.

Patient's Name				Employer's Name
Social Security Number	Height	Weight	Blood Pressure	Date of Birth (Month, Day, Year)
Primary Diagnosis (Please include ICD 9 or DSM code.)				

B. Complete this section for normal pregnancy, then go to section E.

What was the date of the last menstrual period?	What is the expected date of delivery?
What is the expected length of postpartum recovery?	What was the first date of treatment?	What was the last date of treatment?

C. Complete this section for all conditions except normal pregnancy.

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.)

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?

Has the patient been hospital confined?
☐ Yes ☐ No If yes, complete the following:
Name of Hospital

Address

Dates of Confinement
From ___/___/___ through ___/___/___

D. 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)

When could patient return to work? Date:_____ ☐ Full-Time ☐ Part-Time Patient's Job Date:_____ ☐ Full-Time ☐ Part-Time Any other work

Please indicate other types and frequencies of treatment.

Is this patient under the care of another physician? ☐ Yes ☐ No
If yes, please list physician:

Was the patient referred to you by another physician? ☐ Yes ☐ No
If yes, please list referring physician:

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.

What is your prognosis for the patient's 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
☐ 3-4 months ☐ more than 6 months

Give details concerning expected improvement or deterioration:

In an eight hour workday, patient 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 restriction 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 patient to return to prior level of functioning?

Would you recommend vocational rehabilitation for this patient?
☐ Yes ☐ No

E. 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
Hospital discharge summaries
Consulting physician reports

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

X_____ _____
Signature of Attending Physician (no stamp) Date

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.

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.