Lincoln Financial Group®

Short-Term Continuance of Disability

Lincoln Life & Annuity Company of New York
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LincolnFinancial.com

TO FACILITATE PROMPT SERVICE TO YOUR PATIENT, PLEASE ANSWER ALL QUESTIONS COMPLETELY. PLEASE COMPLETE AND RETURN BY_____ . LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK IS NOT RESPONSIBLE FOR CHARGES INCURRED FOR COMPLETION OF THIS FORM. IT IS THE INSURED'S RESPONSIBILITY TO PROVIDE PROOF OF CONTINUED DISABILITY AT HIS/HER EXPENSE.

Attending Physician's Statement Claim Number:_____

1. Patient's Name: _____ Date of Birth: _____
2. Diagnosis, nature of sickness or injury that causes functional impairments: (describe complications, if any)

   _____

3. a. Date of first treatment _____
   b. Date of most recent treatment _____
   c. Frequency of treatments _____
   d. Type of treatment rendered _____
   f. Type and dates of recent diagnostic testing _____
   e. Is surgery scheduled? If so, when? _____
4. a. Is the patient incapable of performing the duties of a _____ ? ☐ Yes ☐ No
   b. If yes, from (date)_____ to (date)_____
   c. Is the inability total or partial (some restriction or light duty)? ☐ Total ☐ Partial ☐ N/A
5. What specifically prevents the patient from performing these duties?
   a. Limitations (what is the patient incapable of doing based on the impairments listed above?)

      _____

   b. Restrictions (what activities must the patient avoid due to substantial risk of medical harm?)

      _____

6. Remarks or comments (please include the basis of your conclusions above)

   _____

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.

Attending Physician Signature: _____ Date (MM/DD/YYYY): _____

Degree/Specialty: _____

Address: _____

City/State/Zip: _____

Phone:_____ Fax:_____

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