Lincoln Financial Group®

Notice And Proof Of Claim For Disability Benefits

Lincoln Life & Annuity Company of New York
Servicing Office: PO Box 2609, Omaha NE 68103-2609
Toll Free (800) 423-2765 Fax (877) 843-3950
LincolnFinancial.com
disabilityclaims@LFG.com

Read instructions on page 4 carefully to avoid a delay in processing. You must answer all questions in Part A and questions 1 through 3 in Part B. Health care providers must complete Part B on page 3.

PART A - CLAIMANTS INFORMATION (Please Print or Type)

1. Last Name:_____ First Name:_____ MI: _____
2. Mailing Address (Street & Apt. #): _____

   City: _____ State: _____ Zip: _____
3. Daytime Phone #:_____ Email Address: _____
4. Social Security #: _____-_____-_____ 5. Date of Birth: _____/_____/_____ 6. Gender: ☐ Male ☐ Female ☐ X
7. Describe your disability (if injury, also state how, when and where it occurred):

   _____
8. Date you became disabled: _____/_____/_____ Did you work on that day?: ☐ Yes ☐ No

   Have you recovered from disability?: ☐ Yes ☐ No If Yes, date you were able to return to work: _____/_____/_____

   Have you since worked for wages or profit?: ☐ Yes ☐ No If Yes, List Dates: _____
9. Name of last employer prior to disability. If more than one employer in previous eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last (8) weeks worked.

LAST EMPLOYER PRIOR TO DISABILITY			PERIOD OF EMPLOYMENT		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day (MM/DD/YYY)	Last Day Worked (MM/DD/YYY)	
OTHER EMPLOYER (during last eight (8) weeks)			PERIOD OF EMPLOYMENT		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Firm or Trade Name	Address	Phone Number	First Day (MM/DD/YYY)	Last Day Worked (MM/DD/YYY)	

Enter total wages earned in the last 8 weeks prior to the first day of disability below (Include wages for all employers listed above)

Week No.	Last Day Worked (MM/DD/YYYY)	No. of Days Worked	Gross Amount Paid
1.			$
2.			$
3.			$
4.			$
5.			$
6.			$
7.			$
8.			$
		Calculated average gross weekly wage:	$

10. My job is or was: _____ 11. Union Member: ☐ Yes ☐ No If "Yes": _____
Occupation — Name of Union or Local Number

12. Were you claiming or receiving unemployment prior to this disability? ☐ Yes ☐ No

If you did **not** claim or if you claimed but did **not** receive unemployment insurance benefits *after* LAST DAY WORKED, explain reasons fully:

_____

If you receive unemployment benefits, provide all periods collected:

_____

13. For the period of disability covered by this claim:

A. Are you receiving wages, salary or separation pay? ☐ Yes ☐ No

B. Are you receiving or claiming:

1. Unemployment Benefits? ☐ Yes ☐ No
2. Paid Family Leave? ☐ Yes ☐ No
3. Workers' compensation for work-connected disability? ☐ Yes ☐ No
4. No-Fault motor vehicle accident? ☐ Yes ☐ No
   or personal injury involving third party? ☐ Yes ☐ No
5. Long-term disability benefits under the Federal Social Security Act for *this* disability? ☐ Yes ☐ No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 13, COMPLETE THE FOLLOWING:

I have: ☐ received ☐ claimed from: _____ for the period: _____/_____/_____to:_____/_____/_____

14. In the year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐ Yes ☐ No

If yes, Paid by: _____ from: _____/_____/_____to:_____/_____/_____

15. In the year (52 weeks) before your disability began, have you received Paid Family Leave? ☐ Yes ☐ No

If yes, Paid by: _____ from: _____/_____/_____to:_____/_____/_____

16. If you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability Law within 5 days of your notice or request for disability forms? ☐ Yes ☐ No

17. You also may elect Direct Deposit at any time by calling the 800 number at the top of this form, or by going to our website, www.Lincoln4Benefits.com.

Please indicate your preferred method of payment for your benefits.

☐ Check ☐ Direct Deposit

For Payment Method: Direct Deposit

Financial Institution's name: _____

Type of Account: ☐ Checking ☐ Savings

Bank Routing Number: _____

Account Number: _____

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions on page 4 of this form and that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

_____ _____
Claimant's Signature — Date

An individual may sign on behalf of the claimant only if he or she is legally authorized to do so the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print Information below and complete and submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

_____ _____ _____
On behalf of Claimant — Address — Relationship to Claimant

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. For item 7-d, you must give estimated date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS.**

1. Last Name:_____ First Name:_____ MI: _____
2. Gender: ☐ Male ☐ Female ☐ X 3. Date of Birth: _____/_____/_____
4. Diagnosis/Analysis: _____ Diagnosis Code:_____
   a. Claimant's symptoms:_____
   _____
   b. Objective findings: _____
   _____
5. Claimant hospitalized?: ☐ Yes ☐ No From: _____/_____/_____ To: _____/_____/_____
6. Operation indicated?: ☐ Yes ☐ No a. Type _____ b. Date:_____/_____/_____

7. ENTER DATES FOR THE FOLLOWING	MONTH	DAY	YEAR
a. Date of your first treatment for disability			
b. Date of your most recent treatment for this disability			
c. Date Claimant was unable to work because of this disability			
d. Date Claimant will again be able to perform work (even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)			
e. If pregnancy related, please check box and enter the date ☐ estimated delivery date OR ☐ actual delivery date			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?:
   ☐ Yes ☐ No If "Yes", has Form C-4 been filed with the Board? ☐ Yes ☐ No

I certify that I am a:

_____ _____ _____
(Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife) **Licensed or Certified in the State of** **License Number**

_____ _____ _____
Health Care Provider's Printed Name **Health Care Provider's Signature** **Date**

_____ _____
Health Care Provider's Address **Phone #**

IMPORTANT NOTICE TO CLAIMANT - READ THESE INSTRUCTIONS CAREFULLY

PLEASE NOTE: Do not date and file this form prior to your first date of disability. In order for your claim to be processed, Parts A and B must be completed.

1. If you are using this form because you became disabled **while employed** or you became disabled **within four (4) weeks after termination of employment,** your completed claim should be mailed **within thirty (30) days of your first date of disability to your employer or your last employer's insurance carrier.** You may find your employer's disability insurance carrier on the Workers' Compensation Board's website. www.wcb.ny.gov, using Employer Coverage Search.

2. If you are using this form because you became **disabled after having been unemployed for more than four (4) weeks,** your completed claim MUST be mailed to: **Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029**. If you answered "Yes" to question 13.B.3, please complete and attach Form DB-450.1.

If you do not receive a response within 45 days or if you have questions about your disability benefits claim, please call your employer's insurance carrier. For general information about disability benefits, please visit www.wcb.ny.gov or call the Board's Disability Benefits Bureau at (877) 632-4996.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Worker's Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

HIPPA NOTICE - In order to adjudicate a workers' compensation claim or disability benefits claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the insurance carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPPAA's restrictions on disclosure of health information.

Disclosure of information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized part, you must file with the Board an original signed Form OC-110A "Claimants Authorization to Disclose Workers' Compensation Records." This form is available on the WCB website (www.wcb.ny.gov) and can accessed by clicking the "Forms" link. If you do not have access to the internet please call (877) 632-4996 or visit our nearest Customer Service Center to obtain a copy of the form. In Lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

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New York State Disability Claim Employer's Statement

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Part C - Employer's Statement *Please print or type*

1. Business's full legal name and mailing address

Business Name: _____

Mailing Address: _____

City, State: _____

Zip Code: _____

Country (if not U.S.A.) _____

2. Employer's FEIN: _____

Employee's Full Name:	Social Security No.:	Job Title:	Date Employed:

3. Is employee insured for Statutory Disability benefits? ☐ Yes ☐ No

Effective Date: _____

Policy Number: _____

Is employee insured for Short Term Disability benefits? ☐ Yes ☐ No

Effective Date: _____

Is employee insured for Long Term Disability benefits? ☐ Yes ☐ No

Effective Date: _____

4. Is disability work related? ☐ Yes ☐ No ☐ Undetermined

Work Location

Address: _____

State: _____ Zip: _____

5. Has the employee filed for:

Workers' Compensation ☐ Yes ☐ No

Other: _____ ☐ Yes ☐ No

WeeklyAmount: _____

6. Is the employee a member of a union that provides the statutory disability benefits? ☐ Yes ☐ No

*If yes, provide Union name, address, and contact information:

_____

Employee Information:

Employee's role: ☐ Employee ☐ Proprietor ☐ Partner ☐ Spouse of Employer ☐ Owner ☐ Co-Owner

7. In the preceding 52 weeks has the employee taken leave for:

☐ NYS Disability ☐ PFL ☐ Both Disability and PFL ☐ None

Disability: Please provide specific dates for disability

PFL: Please provide specific dates for PFL

Is employee still in your employment? ☐ Yes ☐ No

If no, date employment was terminated: _____

If employee received unemployment benefits, date the benefit was last received:

_____

8. Employee's earnings 8 weeks prior to disability:

Enter the average gross weekly wage. Include only the wages earned from the employer listed on this request form. **The gross weekly wage is the total weekly pay - including overtime, tips, bonuses and commissions - before any deductions are made by the employer**, such as federal and state taxes.

Step 1: Add all gross wages received (before any deductions) over the last eight weeks prior to the start of DBL, including overtime and tips earned. *(See Step 3 for instructions for calculating bonuses and/or commissions.)*

Step 2: Divide the gross wages calculated in step one by eight (or the number of weeks worked if less than eight) to calculate the average weekly wage.

Step 3: If the employee received bonuses and/or commissions during the 52 weeks preceding DBL, add the prorated weekly amount to the average weekly wage. To determine the prorated weekly amount, add all bonuses/commissions earned in the preceding 52 weeks and then divide by 52.

Example of a gross weekly wage calculation:

Week 1 - Gross wage including overtime	$550
Week 2 - Gross wage	$500
Week 3 - Gross wage	$500
Week 4 - Gross wage	$500
Week 5 - Gross wage	$500
Week 6 - Gross wage	$500
Week 7 - Gross wage, including overtime	$600
Week 8 - Gross wage, including overtime	+ $550
Total =	$4,200
Divide by	÷ 8
Average Weekly Wage =	$525
Bonus earned in preceding 52 weeks	$2,600
Divide by 52	÷ 52
Prorated Weekly Bonus =	$50
Average Weekly Wage	$525
Prorated Weekly Bonus	+ $50
Average Weekly Wage (including bonus) =	**$575**

Employee's earnings 8 weeks prior to disability:

Week no.	Week ending date (MM/DD/YYYY)	Number of days worked	Gross amount paid
1			
2			
3			
4			
5			
6			
7			
8			
Prorated weekly bonus:			
Calculated average gross weekly wage:			

Check days normally worked:

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday
- ☐ Saturday
- ☐ Sunday

9. Last active day at work:

10. Job Status when disability began:
☐ Full-time (_____ hours/week)
☐ Part-time (_____ hours/week)

11. Date employee returned to work:

12. Does employer request Reimbursement? ☐ Yes ☐ No

13. Through what date are wages being continued? _____ Through what date is the employer requesting reimbursement? _____
Type of wages continued: ☐ Sick Pay ☐ Vacation Pay ☐ Salary Continuation ☐ Other _____

14. Is employee subject to:
Social security taxes? ☐ Yes ☐ No
Medicare taxes? ☐ Yes ☐ No

16. Are employee premiums paid with pre-tax dollars (IRC Section 125 cafeteria plans)? ☐ Yes ☐ No

15. What percentage of the Statutory Disability premium does the employer pay? _____%

Required Tax Information: Important - Indicate percentage Employer contributes to premium.

If blank or not a % we will tax at 100%.

What percentage of the Statutory Disability premium does the employee pay? _____%

☐ Post Tax ☐ Pre Tax

What percentage of the Short Term Disability premium does the employer pay? _____%

What percentage of the Long Term Disability premium does the employer pay? _____%

Has the percentage changed within the last three years for any of these coverages? ☐ Yes ☐ No

If yes, please identify the affected coverages and the effective date(s) of changes.

_____

17. Employer Contact

Employer Contact Name

Street Address

City State Zip Code

Phone Number Fax Number

Email Address

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.

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

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AUTHORIZATION FOR THE RELEASE OF INFORMATION INCLUDING PROTECTED HEALTH INFORMATION

I HEREBY AUTHORIZE THE DISCLOSURE OF INFORMATION ABOUT ME AS DESCRIBED BELOW:
Person(s) or group(s) of persons authorized to disclose the information: Any physicians, medical practitioners, hospitals, clinics, HMOs, long-term care facilities, medical or medically-related facilities, pharmacies, insurance companies, credit or consumer reporting agency, financial/educational institutions, current or former employer, governmental agency, MIB Inc., policy holder, reinsurance companies, policy or benefit plan administrator, and any insurance support organizations.

Person(s) or group(s) of persons authorized to collect or otherwise receive the information: The particular Company in the Lincoln Financial Group of companies to which I am submitting a claim and its authorized representatives, agents and/or employees, the Plan Sponsor (if self-insured Plan) and other organizations providing claims management services.
Description of the information that may be used or disclosed: This Authorization specifically includes the release of all information related to:

- My physical and mental health and my insurance policies and claims, including, but not limited to, those containing diagnosis, treatments, prognosis, prescription drug information, alcohol or drug abuse or information regarding communicable or infectious conditions, including HIV/AIDS.
- Job duties, earnings, personnel records, other work related information and federal and state tax returns.
- Information concerning Social Security benefits, including any records pertaining to me and my dependents.

The information will be used or disclosed only for the following purpose(s): To evaluate and administer my claim, and/or for insurance-related functions.

STATEMENTS OF UNDERSTANDING AND ACKNOWLEDGMENT:
I understand that information used or disclosed pursuant to this authorization could be redisclosed as necessary by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
I understand that I may revoke this authorization in writing at any time by sending a written notice to the Company in the Lincoln Financial Group of companies to which I have submitted a claim, except when action has been taken in reliance on this authorization, or when other law provides the Company with the right to contest a claim. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and health care operations.
I understand that authorizing the disclosure of my health information is voluntary and the health care services available to me are not dependent on if I sign this authorization. If I choose not to sign this authorization, insurance coverage or claim payments may be denied or delayed.
This authorization will be in force for 24 months from the date of signature, except if state law imposes or allows a different duration. The information obtained under this authorization will be retained in accordance with the Company's standard retention policy and applicable law. I understand that I may request a copy of this authorization.

Name of Claimant (print): _____

Name of Legal Representative, if applicable (print): _____ Relationship:_____

Signature of claimant or legal representative: _____ Date:_____

Date of Birth: _____ Claim Number:_____

A copy of this authorization will be considered as valid as the original.