Claims Department
PO Box 21008
Dept 0514
Greensboro, NC 27420-1008
Phone 800-487-1485

ASSIGNMENT OF BENEFITS

I, ______________________________ Owner/Power of Attorney for Policy

Number ______________________________ hereby authorize Lincoln Financial

Life Insurance Company to pay Convalescent Care Benefit Payments directly to the facility:

Name of Facility: ______________________________

Address: ______________________________

Telephone Number: ______________________________

Fax Number: ______________________________

Tax ID Number: ______________________________

______________________________ ______________________________
Signature of Owner Date

____
Name (Please Print)

Lincoln Financial Group®

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CARE PROVIDER ASSESSMENT

- Please answer all questions completely.
- This form should be completed by the agency or individual that is providing care services for our Insured. If there are multiple agencies or individuals, each provider will need to complete a separate form.
- Please feel free to contact us at 800-487-1485 if you have any questions regarding this form or its completion.

INSURED INFORMATION

Insured's Name: ______________________ Policy Number: ______________________

Date of Birth: ______________________ Age: ______ SSN: ______________________

PROVIDER INFORMATION

Please Choose Type: ☐ Facility ☐ Individual Caregiver

Facility/Agency

Corporate Name: ______________________

D/B/A: ______________________

Address: ______________________

City: ______________________ State: ________ ZIP: ______________________

Phone: ______________________ Fax: ______________________

Type of Facility/Agency: ______________________

Please list any licenses or accreditations (Please Submit copies of any listed.): ______________________

____

Are you Medicare Certified? ☐ Yes ☐ No

If yes, is the insured bed classification Medicare Certified? ☐ Yes ☐ No

Are the patient's expenses covered by Medicaid, workers' compensation, employer's liability, occupational disease, motor vehicle no fault, and/or any governmental program coverage? ☐ Yes ☐ No

If yes, list policy or contract holder, policy or contract number(s) and name and address of the insurance company or administrator.

Medicare ☐ Part A ☐ Part B (Doctor's Plan)

INDIVIDUAL CAREGIVER

Name: ______________________

Address: ______________________

City: ______________________ State: ________ ZIP: ______________________

Phone: ______________________

Are you related to the insured in any way? ☐ Yes ☐ No

If Yes, what is the relationship? ______________________

PATIENT CARE INFORMATION

Date of Admission/Date care began: ____________________

Date of Discharge/Date care ended: ____________________

Number of Days charged for (services/room & board): ____________________

Charge Per Day: $____________________

Please note that we require itemized bills statements for reimbursement.

Patient Diagnosis/Reason for Admission: 1. ____________________

2. ____________________

3. ____________________

Attending/Recommending Physician: ____________________

Contact Phone: ____________________

ACTIVITIES OF DAILY LIVING

Please review each activity of daily living and provide an objective assessment of the assistance provided to the patient by checking the most appropriate response for each activity. Please describe specific needs/limitations in notes section below.

Rating Scale:
0=Without assistance
1=Supervised
2=Hands-on assistance
3=Completely dependent

Task Description:

Task				
1. Bathing	☐ 0	☐ 1	☐ 2	☐ 3
2. Dressing	☐ 0	☐ 1	☐ 2	☐ 3
3. Eating/Feeding	☐ 0	☐ 1	☐ 2	☐ 3
4. Toileting	☐ 0	☐ 1	☐ 2	☐ 3
5. Transferring	☐ 0	☐ 1	☐ 2	☐ 3
6. Continence	☐ 0	☐ 1	☐ 2	☐ 3

NOTES:

COGNITIVE ASSESSMENT

Is a cognitive deficit present? ☐ No ☐ Yes If yes, please answer the following questions.

Level of cognitive deficit? ☐ Mild ☐ Moderate ☐ Severe

Describe any supervision required: ____________________

____

Are there any other *issues* arising from the cognitive impairment? ____________________

SIGNATURES

Fraud Warning for New York Residents:

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature: ______________________________ Date: ______________

Print Name: ____

Title: ______________________________ Hours Available: ______________

FRAUD WARNING

Warning – Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files a statement of claim containing any false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material to the claim, commits a fraudulent insurance act, which may be a crime, and in certain states a felony. Penalties may include imprisonment, fines, denial of insurance and civil damages.

These states require the following fraud warnings:

California (For your protection, California law requires this to appear.) – Any person who knowingly presents 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.

District of Columbia: WARNING: 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.

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.

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, defrauds or deceives 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 **N.H. Rev. Stat. Ann. Subsection 638:20.**

New Jersey – Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.

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 ($5,000) dollars and not more than ten thousand ($10,000) dollars, 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.

Lincoln Financial Group
Premium Waiver Dept. 0514
PO Box 21008
Greensboro, NC 27420

Lincoln Financial Group®

Authorization for Release of Health-Related Information to The Lincoln National Life Insurance Company

This authorization complies with the HIPAA Privacy Rule

Name of Insured/Certificateholder/Patient (Please Print) ______________________ Date of Birth ______________

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The Lincoln National Life Insurance Company ("the Company") and its agents, employees, representatives and affiliates. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this Authorization so that the Company may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at PO Box 21008, Greensboro, NC 27420, Attention: Privacy Officer. I understand that a revocation is not effective if any of My Providers have relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy/certificate or to contest the policy/certificate itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization, the Company may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Insured/Certificateholder/Patient or Personal Representative ______________________ Date ______________

Policy/Certificate number(s) ______________________

Description of Personal Representative's Authority or Relationship to Insured/Certificateholder/Patient ______________________

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Lincoln Financial Group®

Claims Department
PO Box 21008
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Phone 800-487-1485

INSURED'S STATEMENT OF LOSS

- Please answer all questions completely.
- Please feel free to contact us at 800-487-1485 if you have any questions regarding this form or its completion.

INSURED INFORMATION

Insured's Name: ______________________________

Policy/Certificate No.(s): ______________________ Issued by (the Company): ______________

Please list any other policy, contract or account held by our Insured that was issued or administered by any Lincoln Financial Group company. ______________________________

Date of Birth: ______________________ Social Security Number: ______________

Address: ______________________________

City: ______________________ State: ________ ZIP: ______________

Home Phone: ______________________ Email: ______________

Does our Insured currently have a legal representative? ☐ Yes ☐ No

If yes, please complete below:

Name: ______________________________

Home Phone: ______________________ Work Phone: ______________

Address: ______________________________

City: ______________________ State: ________ ZIP: ______________

Indicate the type of legal representative:

☐ Power of Attorney ☐ Legal Guardian ☐ Conservator

Please attach a copy of the legal document.

CLAIM INFORMATION

Why are you requesting benefits at this time? (reason for claim): ______________________________

Primary Diagnosis (for this claim): ______________________________

Date you are claiming benefits as of *(mm/dd/yyyy):* ______________________________

Date care services began *(mm/dd/yyyy):* ______________________________

What type(s) of services are you currently, or will be receiving?

☐ Home Health Care ☐ Adult Day Care ☐ Respite Care ☐ Assisted Living ☐ Residential Care Facility

☐ Nursing Home ☐ Other: ______________________________

Medical Provider who recommended care services: ______________________________

Doctor's Name: ______________________ Phone: ______________

Address: ______________________________

City: ______________________ State: ________ ZIP: ______________

Date First Seen: ______________________ Most Recent Visit: ______________

CARE SERVICES

Individual Caregiver

Please provide us with information regarding care services provided by an individual caregiver.

Name: ______________________________

Relationship: ______________________________

Care Services Provided: ______________________________

______________________________ Hrs/Days: ______________

Contact Phone: ______________________________

Facility/Agency

Please provide us with information regarding care services received which have been provided by an agency or medical professional such as Assisted Living, Nursing Home or other facilities.

Agency Name: ______________________________

Care Services Provided: ______________________________

Date(s) of Service: ______________________________

Contact Name: ______________________________ Contact Phone: ______________

Agency Name: ______________________________

Care Services Provided: ______________________________

Date(s) of Service: ______________________________

Contact Name: ______________________________ Contact Phone: ______________

ACTIVITIES OF DAILY LIVING

Please review each activity of daily living and provide an objective assessment of our Insured's current functional ability by checking the most appropriate response for each activity. Space is provided for comments/notes.

Rating Scale:
0=Without assistance
1=Supervised
2=Hands-on assistance
3=Completely dependent

Task Description:

1. Bathing ☐ 0 ☐ 1 ☐ 2 ☐ 3
2. Dressing ☐ 0 ☐ 1 ☐ 2 ☐ 3
3. Eating/Feeding ☐ 0 ☐ 1 ☐ 2 ☐ 3
4. Toileting ☐ 0 ☐ 1 ☐ 2 ☐ 3
5. Transferring ☐ 0 ☐ 1 ☐ 2 ☐ 3
6. Continence ☐ 0 ☐ 1 ☐ 2 ☐ 3

Is there a cognitive deficit present? ☐ No ☐ Yes

NOTES:

CLAIM CONTACT

Authorization for Disclosure of Information Form Must be Completed.

By indicating an individual below and signing this form, the policyowner authorizes us to release information regarding this claim to the individual named below.

Name: ______________________________

Address: ______________________________

City: ______________________ State: ________ ZIP: ______________

Home Phone: ______________________ Work Phone: ______________________

Relation to our Insured: ______________________________

SIGNATURES

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______________________________ ______________________________
Signature of Insured or Insured's Legal Representative Date

______________________________ ______________________________
Print Name Title

______________________________ ______________________________
Signature of Policy Owner *(if other than Insured)* Date

______________________________ ______________________________
Print Name Title

FRAUD WARNING

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Lincoln Financial Group®

The Lincoln National Life Insurance Company
Client Services MIR1
PO Box 5048
Hartford, CT 06102-5048
Fax 860-466-2835

AFFIDAVIT

Policy/Certificate Number ____________________

Issued by (the "Company")____________________

WHEREAS, ____________________ , ("Principal"), appointed

____________________ ("Attorney"), as true and lawful attorney in fact to act on behalf of

____________________ ; under a Durable/General Power of Attorney dated ____________ ; and

WHEREAS, ____________________ desires to exercise powers, rights, duties, acts and obligations granted under such Durable/General Power of attorney.

NOW, THEREFORE, Attorney states and certifies to the Company...

- the Principal is alive on this date; and
- the Durable/General Power of Attorney, dated ____________, has not been revoked; and
- the Attorney has not been removed by either the Principal or any conservator, guardian or other fiduciary appointed by the court in the event of disability or incompetence; and
- the specific right(s) of policy ownership being exercised by the Attorney are in full compliance with the powers, rights, duties, acts and obligations under such Durable/General Power of Attorney and the laws of the state under which said Durable/General Power of Attorney was issued.

____
Attorney

STATE OF }
}
COUNTY OF }

On this ____________ day of ____________________ before me, the undersigned, a Notary Public in and for said
(month/year)

County and State personally appeared____________________ , known to me (or satisfactorily proven), to be the person whose name is subscribed to the within instrument, and acknowledge that she/he executed the same.

In Witness whereof, I hereunto set my hand and official seal.

____
Notary Public
My Commission Expires:

(Seal)