Lincoln Financial Group®

Steps to file your claim:

- Part A and Authorization for Release of Information - To be completed by you.
- Part B - To be completed by your Health Care Provider.
- Part C - To be completed by your Employer.

Your completed claim should be submitted within (30) days after you become sick or disabled. In order to expedite your claim, please have all portions completed in their entirety.

Completed Claim forms can be sent to:
Lincoln Life & Annuity Company of New York
PO Box 2609, Omaha, NE 68103-2609
Toll Free (800) 423-2765
Fax: (877) 843-3950
disabilityclaims@lfg.com

NEW JERSEY TEMPORARY DISABILITY INSURANCE

Claimant Rights and Responsibilities

Rules for Filing a Claim and Appeal Rights

1. It is your responsibility to file this claim form promptly after you stop working due to your disability. Benefits may be denied or reduced if the claim is filed late. If your claim is filed beyond the thirty day period, please use the space provided on the reverse side of Part A to give your reasons for the late filing.
2. If you disagree with a determination on your claim and wish to appeal, you must do so in writing within ten days from the date the decision was mailed. You do not need a lawyer at the appeal hearing.

Claimant Responsibilities:

1. Your signature certifies that you understand any misrepresentation of fact or failure to disclose a material fact may be punishable under the law. This includes any changes to the Medical Certificate or the Employer's Statement made by you without authorization by your physician or your employer.
2. You must inform us of any other payments you are receiving such as sick pay or wages, a pension from your last employer, worker's compensation benefits, Social Security Disability benefits, or disability benefits from your employer or union.
3. If you receive a request for continued medical certification (Form P30), you must have your physician complete and sign the form. You should return it promptly.
4. When you recover or return to work, you must report this date immediately to the Division of Temporary Disability Insurance.
5. If you are requesting voluntary Federal Income Tax (F.I.T.) deductions to be withheld from your disability benefits, attach Form W-4S (Request for Federal Income Tax Withholding From Sick Pay) to your claim. Forms should be obtained from your employer or the Internal Revenue Service.

NEW YORK STAUTORY DISABILITY BENEFITS

Claimant: please read the following instructions carefully

1. Use this form if you become sick or disabled while employed or if you become sick or disabled within four (4) weeks after termination of employment. Use claim form db-300 if you become sick or disabled after having been unemployed more than four (4) weeks.
2. You must complete all items of part a - the "claimant's statement". Be accurate. Check all dates.
3. Be sure to date and sign your claim . If you cannot sign this claim form, your representative may sign it in your behalf. In that event, the name, address and representative's relationship to you should be noted under the signature.

If you have any questions about claiming New York statutory disability benefits, contact the nearest office of the NYS Workers' Compensation Board, or write to: Workers' Compensation Board, Disability Benefits Bureau, 100 Broadway-Menands, Albany, NY 12241-0005.	Si tiene dudas relacionadas con la reclamación de beneficios, por incapacidad, comuniquese con la oficina mas cercana de la Junta de Compensación Obrera de Nueva York, o escriba a: Workers' Compensation Board, Disability Benefits Bureau, 100 Broadway-Menands, Albany, NY 12241-0005.

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Statutory And Short Term Disability Claim Form

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

PART A - CLAIMANT'S STATEMENT (Please Print or Type) Answer All Questions

1. Name (First/Middle/Last): _____

2. Social Security Number: _____ 3. Age: _____

4. Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Email Address: _____

5. Date of Birth: _____ 6. Married (Check One): ☐ Yes ☐ No 6a. Gender ☐ Male ☐ Female

7. Reason for Inability to Work (if injury, state how, when and where it occurred): ☐ Illness ☐ Accident ☐ Pregnancy/Childbirth

_____

_____

8. Date Unable to Work (Month/Day/Year): _____ 8a. I worked on that day: ☐ Yes, number of hours _____ ☐ No

I am (check one): ☐ still employed ☐ no longer employed – my last date of employment was: _____

Reason no longer employed: _____

8b. I have since worked for wages or profit: ☐ Yes ☐ No If Yes, when: _____

9. Provide the following information for all employers during the last 12 months.

Employer's			Date of Employment		Average Weekly Wages
Business Name	Business Address	Telephone Number	From (Mo/Day/Yr)	Through (Mo/Day/Yr)	Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.

10. Current Occupation (Describe Job): _____

10a. Name of Union and Local Number, if member: _____

I am insured by ☐ The Union ☐ My Employer

11. For the period of disability covered by this claim	Yes	No
a. Are you receiving wages, salary or separation pay:	☐	☐
b. Are you receiving or claiming:		
i. Workers compensation for work connected disability	☐	☐
ii. Unemployment Insurance Benefits	☐	☐
iii. Damages for personal injury	☐	☐
iv. Benefits under the Federal Social Security Act for long term disability	☐	☐
v. Any other disability benefits provided by your employer or union	☐	☐
vi. Pension benefits from your most recent employer	☐	☐
vii. Temporary Disability Benefits from another state	☐	☐

c. If "Yes" is checked in any of the items 11a or 11b, complete the following:
I have ☐ received ☐ claimed benefits for the period Date: _____ to Date: _____ .

12. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began. ☐ Yes ☐ No

If "Yes", fill in the following: I have been paid by: _____

from Date: _____ to Date: _____.

Certification and Signature I was unable to work during the period for which benefits are claimed and hereby certify that I have read and understand my benefit rights and responsibilities. I am aware that if any of the foregoing statements made by me are known to be false, or I knowingly fail to disclose a material fact, I may be subject to penalties, which may include criminal prosecution.

Claimant's Signature _____ Date _____

Phone Number: _____ E-mail Address: _____

If signed by other than claimant, print below: name, address, and relationship of representative:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship: _____

For Payment Method: Direct Deposit

Financial Institution's name _____

Type of Account ☐ Checking ☐ Savings

Bank Routing Number _____

Account number _____

Information about income tax withholding

If your request for **Short Term Disability** benefits is approved, should Lincoln Life & Annuity Company of New York withhold Federal Income taxes from your benefit checks?

☐ Yes ☐ No If yes, how much should be withheld from each check (minimum is $22.00 per week)? $_____.00

Health Care Provider or Attending Physician must complete Part B on page 6.

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 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.

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 by 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 be 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, Virginia, 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 AND KANSAS. 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.

Lincoln Financial Group®

Authorization For Release Of Information

Lincoln Life & Annuity Company of New York
Service Office: PO Box 2609, Omaha, NE 68103-2609
Home Office: Syracuse, NY
Toll free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com

1. In connection with a claim for benefits, 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:

Name of Insured: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security Number: XXX-XX-_____

2. **Information to be released (hereinafter referred to as "My Information"):**
   - 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, claims or benefits; and/or
   - any information, data or records regarding my activities (including records relating to my Social Security, Workers' Compensation, retirement income, financial information, earnings and employment history).

3. **Information to be released to:** Lincoln Life & Annuity Company of New York ("Lincoln")
   PO Box 2609
   Omaha, NE 68103-2609

4. **I understand My Information will be used by Lincoln to evaluate and administer my claim for benefits. I also authorize Lincoln to release My Information as follows:**
   - to its reinsurer, or other persons or organizations performing business or legal services in connection with my claim(s); or
   - to a vendor, approved by Lincoln, which specializes in the application for Social Security Disability Benefits
   - to vendors/consultants providing me with wellness, disability or leave related services as part of an employer sponsored benefit plan; or
   - for self-insured disability plans only, to my employer; or
   - for fully insured plans, I understand the the information obtained with this Authorization may be used in discussions between Lincoln and my employer regarding my functional capacity, and any related restrictions and limitations, in order to facilitate my return to work; or
   - as otherwise may be required by law or as I may further authorize.
5. I understand My Information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. For Colorado claims, the disclosed information may not be re-disclosed 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 Lincoln has taken action in reliance on this Authorization.To initiate revocation of this Authorization, direct all correspondence to Lincoln at the above address. 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, or the duration of my claim for benefits, whichever is shorter.
7. A photocopy of this Authorization is to be considered as valid as the original. 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 _____

PHONE NO: _____

ADDRESS: _____
(Street)

_____
(City) (State) (Zip Code)

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

1. Patient's Name (First/Middle/Last): _____

2. Date of Birth: _____

3. Primary Diagnosis/Analysis: _____ Diagnosis Code: _____
   Secondary Diagnosis/Analysis: _____ Diagnosis Code: _____
   a. Patient's Symptoms: _____
   b. Objective Findings: _____
   c. If inability to work is pregnancy related: Enter delivery date: _____ ☐ Estimated ☐ Actual
   Type: ☐ Vaginal ☐ C-Section

4. Patient Hospitalized? ☐ Yes ☐ No From: _____ To: _____

5. Surgery Indicated? ☐ Yes ☐ No a. Type: _____ b. Date: _____
   Is surgery for cosmetic purposes only? ☐ Yes ☐ No
   List of Restrictions and Limitations: _____
   Nature of treatment: _____

6. Enter Dates for the Following:

	Month	Day	Year
a. Date of first treatment for this disability			
b. Date of most recent treatment for this disability			
c. Date of next office visit for this disability			
d. Date patient was unable to work because of this disability			
e. Date patient will be able to perform usual work (give approximate date)			

7. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐ Yes ☐ No
   Remarks (Attached additional sheet , if necessary) _____
   Name(s), address and specialty of other treating physicians:
   _____
   _____

I affirm that I am a: ☐ Chiropractor ☐ Physician ☐ Psychologist ☐ Dentist ☐ Podiatrist ☐ Nurse-Midwife
☐ Other: _____

Licensed in the State of: _____ License Number: _____

_____ _____
Health Care Provider's Signature Date

_____ _____
Health Care Provider's Name (Please Print) Telephone Number

Office Address: _____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Fax Number: _____

PART C - EMPLOYER'S STATEMENT

1. Employee's Name: _____

2. Employee's Address: _____

   City: _____ State: _____ Zip Code: _____

3. Employee's Occupation: _____ Social Security Number: _____

4. Date Employed: _____ Employee Work State: _____

5. Statutory Disability Policy Number _____ Claim Location Number: _____ Group ID _____

   Employee Effective Date _____

   Indicate percentage Employer contributes to premium _____% ☐ Post Tax ☐ Pre Tax
   (If blank or not percentage we will tax at 100%)

6. Short Term Disability Policy Number _____ Claim Location Number: _____ Group ID _____

   Employee Effective Date _____

   Indicate percentage Employer contributes to premium _____% ☐ Post Tax ☐ Pre Tax
   (If blank or not a percentage we will tax at 100%)

7. Employee works: ☐ Full time ☐ Part time Number of Hours Per Week: _____
   Check usual days worked: ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun

   Is claimant an: ☐ Employee ☐ Owner ☐ Partner ☐ High School Student Date employee last worked: _____

   Date employee's wage ceased: _____ Date employee returned to work: _____

   For STD, if return to work was intermittent, list dates worked: _____

   _____

8. Are wages being continued during disability? ☐ Yes ☐ No If Yes ☐ Salary Continuance ☐ Sick Pay ☐ Vacation ☐ PTO
   Beginning Date: _____ Ending Date: _____ Weekly Amount Paid: _____

   Is reimbursement requested for the Statutory Disability Benefit? ☐ Yes ☐ No

9. Date you received the completed claim form: _____

   Did the disability occur as a result of employment? ☐ Yes ☐ No
   Has a Worker's Compensation claim been filed? ☐ Yes ☐ No (If WC claim was denied include copy of denial notice.)

   Name of your Worker's Compensation Carrier: _____

   Worker's Compensation Carrier Address: _____

   City: _____ State: _____ Zip Code: _____

   Do you expect to rehire? ☐ Yes ☐ No

   Is employee a member of a union which provides N.Y. State disability benefits? ☐ Yes ☐ No

   If employee is no longer in your employ, check reason: ☐ Labor Dispute ☐ Lack of Work ☐ Fired ☐ Quit

   Explain: _____

   Has the claimant received U.I. Benefits? ☐ Yes ☐ No If Yes, give dates: _____

Indicate below dates and claimant's GROSS earnings during the listed calender weeks. For NY statutory disability benefits, please include the weekly value of board, lodging and tips.

Date	Description of Calender Week	Number of Days Worked	Gross Wages
	Disability Began		$
	2nd Week Before Disability		$
	3rd Week Before Disability		$
	4th Week Before Disability		$
	5th Week Before Disability		$
	6th Week Before Disability		$
	7th Week Before Disability		$
	8th Week Before Disability		$
	Total Gross Wages For Above Weeks		$

For **NEW JERSEY** Statutory Disability Benefits **ONLY**:

Base Weeks and Base Year Gross Wages

A BASE WEEK is a calender week in which the claimant had New Jersey earnings of at least the minimum NJ TDB earnings during the Base year. The BASE YEAR is the 52 calender weeks preceding the week in which the disability occurred.

Total Number of Base Weeks: _____ Total Gross Wages in Base Year: _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Name of person completing form: _____

Telephone Number: _____ E-mail Address: _____

_____ _____

Signature Date