Lincoln Financial Group®

Claims Department
PO Box 21008
Dept 0514
Greensboro, NC 27420-1008
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

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 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

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.