The Lincoln National Life Insurance Company, PO Box 2609, Omaha, NE 68103-2609
toll free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com

LINKS DISABILITY CLAIM FORM

To Be Completed by the Employer

Employee's Name: _____ Date of Birth: _____

Social Security Number: _____ Class Number: _____ Eff Date: _____

A. Information about the employer

Name: The School District of Osceola County

Group Policy Number: 010232277; 010232276 Div # and Name: _____

Address: 817 Bill Beck Blvd

City: Kissimmee State: FL Zip: 34744

Telephone: 407-870-4899 Fax: _____ E-mail: insurance@osceola.k12.fl.us

Name and Address of division where employee works (if different from above):

_____

B. Information about the employee

Date employee was hired (Month, Day, Year): _____

Date employee became insured under this plan? _____ Date employee became insured under prior plan? _____

What was the employee's regularly scheduled work week? _____ Hrs/Week _____ Hrs/Day

What was the employee's permanent occupation on his or her last day of work? (Please attach a copy of their job description)

How long had the employee been in this occupation? _____

Last day employee actually worked (Month, Day, Year): _____

On that day, did the employee work a full day? ☐ Yes ☐ No If No, how many hours were worked? _____

Reason for ceasing active work: ☐ Maternity Leave ☐ Sickness ☐ Accident ☐ Resigned ☐ Vacation ☐ Dismissed ☐ Laid Off ☐ Retired ☐ Other ☐ Granted Leave of Absence

Has employee returned to work? ☐ Yes ☐ No Part-Time Date: _____ Full-Time Date: _____

Is the employee's condition work related? ☐ Yes ☐ No

Has a claim been filed with Workers' Compensation? ☐ Yes ☐ No If Yes, send initial report of illness or injury and award notice.

Name, address and telephone number of your compensation carrier:

_____

Name, address and telephone number of your medical insurance carrier:

_____

C. Benefit Information

Employee's Basic Weekly Earnings: $ _____ **Please provide proof of earnings (Payroll Records)**

Does the employee contribute toward the STD Premium? ☐ Yes ☐ No If Yes: ☐ Pre-Tax ☐ Post-Tax

If Post-Tax: _____ % Paid by Employer _____ % Paid by Employee

Does the employee contribute toward the LTD Premium? ☐ Yes ☐ No If Yes: ☐ Pre-Tax ☐ Post-Tax

If Post-Tax: _____ % Paid by Employer _____ % Paid by Employee

If you leave this section blank, we will assume it is 100% employer contribution and calculate FICA taxes accordingly.

Has insured received other income since the last worked?

Salary continuance: ☐ Yes ☐ No Weekly Amount: $ _____

Salary Begin Date: _____ Date Salary will END: _____

(To include any future amounts the employee may receive)

Any Other Type: ☐ Yes ☐ No Weekly Amount: $ _____ Paid from _____ to _____

D. Information about your pension plan (do not complete unless Long Term Disability expected)

Do you have a pension plan? ☐ Yes ☐ No If Yes, what type? ☐ Defined benefit ☐ Defined Contribution ☐ 401(k) ☐ Profit Sharing ☐ Other: (specify)_____

Is the employee eligible for your pension plan? ☐ Yes ☐ No If No, why? _____

If eligible, does the employee participate? ☐ Yes ☐ No If No, why? _____

If the employee is participating, when is he or she eligible for benefits under the plan? (Month, Day, Year) _____

Note: If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the percentage of his/her contribution to the total contribution. This should include a copy of the contract.

_____ _____

Please Print Name of person completing form Phone Number

_____ _____

Signature Date

_____

Title

Physical Requirements

A. General information about the employee's occupation

Title: _____

Minimum education or training required: _____

Does the employee perform supervisory functions? ☐ Yes ☐ No If Yes, how many people are supervised? _____

B. Information about the aspects of the employee's occupation

Check the items below that relate to the employee's job. Use these definitions for the frequency of occurrence.

Occasionally means the person does the activity up to 33% of the time.
Frequently means that the person does the activity 34% to 66% of the time.
Continuously means that the person does the activity 67% to 100% of the time.

Activity	Frequency of Occurrence			
	Never	Occasionally	Frequently	Continuously
☐ Standing	☐	☐	☐	☐
☐ Walking	☐	☐	☐	☐
☐ Sitting	☐	☐	☐	☐
☐ Balancing	☐	☐	☐	☐
☐ Stooping	☐	☐	☐	☐
☐ Kneeling	☐	☐	☐	☐
☐ Crouching	☐	☐	☐	☐
☐ Crawling	☐	☐	☐	☐
☐ Reaching/working overhead	☐	☐	☐	☐
☐ Climbing:	☐	☐	☐	☐
☐ Stairs Number of stairs: _____	☐	☐	☐	☐
☐ Ladders Height of Ladder: _____	☐	☐	☐	☐
☐ Pushing	☐	☐	☐	☐
☐ Pulling	☐	☐	☐	☐
☐ Lifting/carrying	☐	☐	☐	☐

Describe Activity	Weight
_____	_____ lbs.
_____	_____ lbs.
_____	_____ lbs.

Can this occupation be performed by alternating sitting and standing? ☐ Yes ☐ No

Does this occupation require using the feet to operate foot controls? ☐ Yes ☐ No

If Yes, on what type of equipment? _____

How important is good vision for this occupation? _____

What are the major tasks requiring use of one or both hands?	One Hand	Both Hands
_____	☐	☐
_____	☐	☐
_____	☐	☐

C. Information about the occupation as it relates to the disability

Can the occupation be modified to accommodate the disability either temporarily or permanently? ☐ Yes ☐ No

If Yes, explain _____

Is it possible to offer the employee assistance in doing the occupation (through use of technology or personal assistance for example)? ☐ Yes ☐ No

Does your company have a rehire or return-to-work policy for disabled employees? ☐ Yes ☐ No

What is the name and title of the manager we should contact if we identify a rehabilitation or return-to-work option?

_____

To Be Completed by the Employee

A. Information about you

Last Name: _____ First _____ M.I. _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ E-mail: _____

Date of Birth: _____ Social Security Number: _____ Height: _____ Weight: _____

☐ Right Handed ☐ Left Handed ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse Name: _____

Date of Birth: _____ Social Security Number: _____

Dependent Name: _____

Date of Birth: _____ Social Security Number: _____

Your Employer (include division if applicable) _____

Occupation: _____

B. Information about the disability

Last day you worked before the disability (Month/Day/Year): _____

Did you work a full day? ☐ Yes ☐ No If No, explain: _____

Date you were first unable to work (Month/Day/Year): _____

Have you returned to work? ☐ Yes ☐ No Part-Time Date: _____ Full-Time Date: _____

If you have not returned to work, do you expect to? ☐ Yes ☐ No Part-Time Date: _____ Full-Time Date: _____

Are you currently self-employed or working for another employer? ☐ Yes ☐ No

If so give details: _____

Describe how and where accident occurred or describe the onset and nature of your illness:

_____

Date you were first treated for your illness or injury: _____

Dates Hospital confined: From _____ To _____

Treated by: (on another piece of paper, provide names & addresses of all doctors who have treated you for this disabling condition).

Hospital Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Doctor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Pharmacy Name 1: _____ Pharmacy Name 2: _____

Have you ever had the same or similar condition in the past? ☐ Yes ☐ No

If Yes, provide details: _____

Do you require another person's active, hands-on help to safely perform activities of daily living? ☐ Yes ☐ No

If Yes, please explain what kind of help you receive and who provides it: _____

C. Information about other income you are receiving

Yes	No		Amount	Date Began	Date Terminate
☐	☐	Social Security (Disability Retirement)	$_____	_____	_____
☐	☐	Salary Continuance	$_____	_____	_____
☐	☐	Retirement (Normal, Early or Disability)	$_____	_____	_____
☐	☐	Workers' Compensation	$_____	_____	_____
☐	☐	Unemployment, Government or State Benefits	$_____	_____	_____
☐	☐	Any other income related to your disability	$_____	_____	_____

Have you, or do you plan to apply for benefits described above? ☐ Yes ☐ No

Type: _____ Date Application Filed:_____

The above statements are true and complete to the best of my knowledge and belief. I have completed and attached the Authorization for Release of Information.

_____ _____

Signature of Employee Date

The Lincoln National Life Insurance Company, PO Box 2609, Omaha, NE 68103-2609
toll free (800) 423-2765 Fax (877) 843-3950
www.LincolnFinancial.com

AUTHORIZATION FOR RELEASE OF INFORMATION

☐ **Please check this box if you or your authorized representative would like to receive a copy of this form.**

I (the undersigned) authorize any physician, medical professional, or other provider of health care services, hospital, clinic, other medical or medically related facility, or insurance or reinsurance company to release information to The Lincoln National Life Insurance Company (Lincoln) in connection with a claim for benefits.

Patient Information: (Name of Claimant Whose Information Will Be Released)

Patient Name: (Last, First, Middle) _____ Date of Birth: _____

Other Names Used: _____ Social Security Number: _____

Description of the information to be disclosed:

☐ Entire Medical Record, including but not limited to patient histories, office notes (EXCEPT psychotherapy notes), test results, radiology studies, films, prescriptions, referrals, consults, billing records, insurance records, and other related records sent to you by other health care providers.

☐ Other: _____

Expiration: This Authorization will be considered valid until the happening of the earliest following event:

1. The term of the coverage of the policy if the claim is for a health insurance benefit;
2. The duration of the claim if the claim is not for a health insurance benefit; or
3. Twelve (12) months from the date of the signature below.

Right to Revoke: I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that Lincoln has taken action in reliance on this authorization. To initiate revocation of this Authorization, direct all correspondence to Lincoln at the above address.

Claimant Rights:

1. I understand that the information used or disclosed 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 redisclosed or reused by the recipient under Colorado law.
2. I understand that a photocopy of this Authorization is to be considered as valid as the original.
3. I understand that I am entitled to receive a copy of this Authorization.
4. I understand that this information may be released to my employer for self-insured plans only.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this Authorization.

Authorized Representative Information: Complete this section if a personal representative is authorizing disclosure of the claimant's information. A copy of a power of attorney or other court-initiated document will be required, unless parent signing for patient under 18.

Name: (Last, First, Middle) _____ Relationship to claimant: _____

Address: _____ Phone: _____

Signature/Date: The Claimant whose information will be released or the claimant's authorized representative must sign and date this form in order to process.

Sign: _____ Date: _____

Social Security Administration Authorization To Release Information

To: Department of Health, Education and Welfare Social Security Administration

Authorization to Disclose

Re: _____ Social Security Number: _____

You are hereby requested and authorized to disclose, make available and furnish to The Lincoln National Life Insurance Company, 8801 Indian Hills Drive, Omaha, Nebraska 68114, or its authorized representative, pursuant to P.L. 93-579: 42 U.S.C. Section 1306 (a): 20 C.S.R. 401, 3 (a), all information relative to my applications for disability benefits from the Department of Health, Education and Welfare, Social Security Administration made including all medical records or forms submitted to your administration either by me or on my behalf, including examinations of me by any physician on behalf of the Social Security Administration and advise as to the disposition of each application.

This authorization is given in connection with a claim pending with The Lincoln National Life Insurance Company, 8801 Indian Hills Drive, Omaha, Nebraska 68114.

_____ _____

Signature Date

State of _____

County of _____

To Be Completed by the Attending Physician

A. General Information

Patient's Name: _____

Employer's Name: _____

Social Security Number: _____ Height: _____ Weight: _____ Date of Birth: _____

Primary Diagnosis (Please include ICD or DSM Code): _____

B. Complete this section for normal pregnancy, then go to Section E.

What is the date of last menstrual period? _____

What is the expected date of delivery? _____

What is the expected length of postpartum recovery? _____

What was the first date of treatment? _____

What was the last date of treatment? _____

C. Complete this section for all conditions except normal pregnancy

Symptoms: _____

Objective Findings: _____

Are these secondary conditions contributing to the disability? ☐ Yes ☐ No

If Yes, what are they? (Please include ICD or DSM code.) _____

When did symptoms first appear? _____ Date of the patient's first visit: _____

Date you believe the patient was first unable to work: _____ Date of the patient's last visit: _____

How often do you see the patient? _____

Is the patient's condition work related? ☐ Yes ☐ No If Yes, explain _____

Has the patient's undergone surgery? ☐ Yes ☐ No

If Yes, give date, procedure and result _____

If No, do you expect surgery to be performed in the future? ☐ Yes ☐ No

If Yes, Give date and type of surgery: _____

What medication is the patient currently taking? _____

Has the patient been hospital confined? ☐ Yes ☐ No If Yes, complete the following:

Name of Hospital: _____

Address: _____

Dates of Confinement From _____ through _____

D. Information about the patient's inability to work.

Briefly describe restrictions and limitations.

Restrictions (What the patient SHOULD NOT do): _____

Limitations (What the patient CANNOT do): _____

When could patient return to work? Date for Patient's Job: _____ ☐ Full-Time ☐ Part-Time

Date any other work: _____ ☐ Full-Time ☐ Part-Time

Please indicate other types and frequencies of treatment: _____

Is this patient under the care of another physician? ☐ Yes ☐ No

If Yes, please list physician: _____

Was the patient referred to you by another physician? ☐ Yes ☐ No

If Yes, please list referring physician: _____

Has the patient been referred to a medical rehabilitation or therapy program? ☐ Yes ☐ No

If Yes, give details: _____

Have you referred the patient for other types of consultations? ☐ Yes ☐ No

If Yes, give details: _____

What is your prognosis for the patient's recovery? _____

Has the patient achieved maximum medical improvement? ☐ Yes ☐ No If No, complete the following:

How soon do you expect fundamental changes in the patient's medical condition? ☐ 1 - 2 months ☐ 3 - 4 months ☐ 5 - 6 months ☐ more than 6 months

Give details concerning expected improvement or deterioration: _____

In an eight hour workday, claimant can: (Circle full hourly capacity for each activity)

Sit	1	2	3	4	5	6	7	8
Stand	1	2	3	4	5	6	7	8
Walk	1	2	3	4	5	6	7	8

Are there restrictions in:	Yes	No	Comments
Lifting/Carrying	☐	☐	_____
Use of hands in repetitive actions	☐	☐	_____
Use of feet in repetitive movements	☐	☐	_____
Bending	☐	☐	_____
Squatting	☐	☐	_____
Crawling	☐	☐	_____
Climbing	☐	☐	_____
Reaching above shoulder level	☐	☐	_____
Other (please specify)	☐	☐	_____

When do you expect claimant to return to prior level of functioning? _____

Would you recommend vocational rehabilitation for this patient? ☐ Yes ☐ No

Has your patient had loss of cognitive functioning? "Cognitive impairment" means a permanent deterioration or loss of cognitive or intellectual capacity and requires another person's hands-on help or verbal cues to prevent harm to self or others due to impairment.

☐ Yes ☐ No

If Yes, please explain and provide supporting medical documentation and testing: _____

Based on your observations of this patient, medical history and condition, has your patient lost the ability to safely and completely perform Activities of Daily Living (ADLs) without another person's active hands-on help with all or most of the activity:

ADL	Date on which assistance was first required and received	
☐ Bathing	_____	(washing self in tub, shower or by sponge bath, with or w/o equipment)
☐ Dressing	_____	(putting on, taking off garments, braces or any artificial limbs normally worn)
☐ Toileting	_____	(getting to, from, on and off toilet; and performing related personal hygiene)
☐ Transferring	_____	(moving in & out of bed, chair or any wheelchair, with or w/o equipment)
☐ Continence	_____	(voluntarily maintaining control of bladder and bowel function)
☐ Eating	_____	(getting nourishment into one's body by any means (table/tray or special equipment)

If the claimant has lost the ability to perform ADLs listed above, please provide any supporting medical documentation and testing.

If the patient has lost the ability to perform any ADLs listed above, do you expect the limitations to be permanent? ☐ Yes ☐ No

If No, please explain when improvement may be expected: _____

E. Required Attachments and Signature.

After you have fully completed this form, attach copies of the following materials:

- **Office notes for the period of treatment for the last two years**
- **Test results**
- **Hospital discharge summaries**
- **Consulting physician reports**

Your Name: _____ Degree _____

Specialty: _____

Telephone: _____ Fax: _____

Address: _____

_____ _____

Signature of Attending Physician (No Stamp) Date

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY IS NOT RESPONSIBLE FOR CHARGES INCURRED DUE TO COMPLETION OF THIS FORM. THE PATIENT IS RESPONSIBLE FOR ANY CHARGES ASSOCIATED WITH FORM COMPLETION.

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 with the penalty of 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 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.

Tennessee 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, KANSAS, AND VIRGINIA. 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.