Lincoln Financial Group
Disability Claims
100 Liberty Way
Mailstop 01-4
Dover, NH 03820
Phone: 800-210-0268 x16309
Fax: 603-334-3853

AUTHORIZATION FOR THE RELEASE OF INFORMATION INCLUDING PROTECTED HEALTH INFORMATION

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF INFORMATION ABOUT ME AS DESCRIBED BELOW:

Person(s) or group(s) of persons authorized to use or 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, the Medical Information Bureau, 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 and other work related information and credit reports, bank records, 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): For purposes of investigating, evaluating and processing my claim, and/or for insurance-related functions.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure 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 revocation to the Company in the Lincoln Financial Group of companies to which I have submitted a claim, except to the extent that action has been taken in reliance on this authorization, or to the extent that 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 provision of health care services to me is not conditioned on whether I sign this authorization. If I choose not to sign this authorization, insurance coverage or claim payments may be denied or delayed.

This authorization shall remain in force for 24 months from the date of signature, except to the extent applicable 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/Personal Representative (Print)

Name of Claimant/Personal Representative (Signature)_____

Description (Title) of Personal Representative _____

Date of Birth: Claim Number Date:

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