DISABILITY CLAIM FORM

PLEASE CHECK BENEFITS APPLIED FOR: ☐ STD ☐ LTD

Mail to:
Group Market Disability Claims
Lincoln Life Assurance Company of Boston
P.O. Box 7211
London, KY 40742-7211
Phone No.: 888-440-6118
Fax No.: 603-422-0117

TO BE COMPLETED BY EMPLOYEE
(PLEASE COMPLETE ALL APPLICABLE SPACES)

Employee's Name			Employee's Social Security No.
Street Address	City	State	Zip Code
Home Telephone No. ( )	Work Telephone No. ( )	Sex ☐ M ☐ F	Date of Birth
Employer's Name	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Spouse's Name	Spouse's Date of Birth
List Names and Dates of Birth of Unmarried Children Who Have Not Finished High School (under age 19)			No. of Dependents

Treated By: (Please include all treating physicians; use additional paper if needed)

HOSPITAL _____
Name Street Address City/State/Zip Code

DOCTOR _____
Name Street Address City/State/Zip Code
Doctor's Phone No. ( )

Date Injury/Illness Began	Date First Treated	Date Last Worked	Date Returned to Work

Is your illness or injury related to your occupation? ☐ Yes ☐ No

If "Yes", then please explain:

Have you or do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No

Describe how and where injury occurred or describe the onset and nature of your illness.

Identify other income you are receiving or for which you have applied: Yes	No	Type	Amount per Week/Month	Date Began Receiving	Date Ceased Receiving	Date Income Applied for
☐	☐	Wages, Salary, or Separation Pay	$			
☐	☐	Social Security (disability or retirement)	$			
☐	☐	State Disability	$			
☐	☐	Retirement (normal, early, or disability)	$			
☐	☐	Workers' Compensation	$			
☐	☐	Group Disability	$			
☐	☐	Other (please describe) _____	$			

If your request for disability benefits is approved, all or a part of your benefits may be considered taxable income if they are attributable to: 1) employer contributions toward the disability plan or, 2) your contributions, on a pre tax basis, toward the disability plan.

Apply a voluntary federal income tax withholding to each benefit payment? ☐ Yes ☐ No If "Yes", select *one* of the following:

☐ Withhold a specific whole dollar amount based upon the disability payment mode (weekly, bi-weekly, semi-monthly, monthly), *or*

$ _____ weekly ($20.00 min.) $ _____ bi-weekly ($40.00 min.) $ _____ semi-monthly ($44.00 min.) $ _____ monthly ($88.00 min.)

☐ Use the completed and signed IRS Form W-4S *I have attached* which specifies my withholding request.

Apply a voluntary state income tax withholding to each benefit payment? ☐ Yes ☐ No If "Yes", select *one* of the following:

☐ Withhold $ _____ ($10.00 minimum) for the State of _____, *or*

☐ Use the completed and signed state employee withholding certificate *I have attached* which specifies my withholding request.

Signature: _____ Date: _____

UNIVERSITY LOCATION FROM WHICH YOUR PAYCHECK IS ISSUED: UC Santa Barbara (UCSB)

PLEASE READ CAREFULLY, SIGN AND DATE BELOW

The information I have provided is true and complete to the best of my knowledge and belief. I agree that a Photostat copy of this form will be as valid as the original. I understand that any person who knowingly or with intent to injure, defraud, or deceive an insurance company, files a statement containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

CALIFORNIA EMPLOYEES: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO EMPLOYEES: 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 EMPLOYEES: It shall be a fraudulent insurance act for a person to knowingly, by act or omission, with intent to injure, defraud or deceive: prepare, present or cause to be presented to any insurer, any oral or written statement including computer-generated documents as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, containing false, incomplete or misleading information concerning any fact material to such claims.

FLORIDA EMPLOYEES: I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement or claim or an application containing any false, incomplete, or misleading information is guilty of a felony of third degree.

KENTUCKY EMPLOYEES: I understand that 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 purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MINNESOTA EMPLOYEES: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW JERSEY EMPLOYEES: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK EMPLOYEES: 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 and the stated value of the claim for each such violation.

NORTH CAROLINA EMPLOYEES: Any person who with the intent to injure, defraud, or deceive an insurer or insurance claimant: presents or causes to be presented a written or oral statement, including computer-generated documents as part of, in support of, or in opposition to a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning any fact or matter material to the claim, or assists, abets, solicits or conspires with another person to prepare or make any written or oral statement that is intended to be presented to an insurer or insurance claimant in connection with, in support of, or in opposition to a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning fact or matter material to the claim is guilty of a felony.

OHIO EMPLOYEES: I understand that 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 EMPLOYEES: I understand that any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

PENNSYLVANIA EMPLOYEES: 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.

EMPLOYEE SIGNATURE: _____ **DATE SIGNED:** _____