



# Lincoln Mutual

Life & Casualty Insurance Company

4510 13th Avenue South • P.O. Box 1918 • Fargo, North Dakota 58107-1918  
Toll-free 1-800-233-6050

## EXTENDED LIFE INSURANCE (PREMIUM WAIVER) APPLICATION

This form should be completed in full by the employee, employer and physician; and mailed to above address.

All questions on this form should be fully answered by the Insured if competent to do so. If not, and if no guardian has been appointed, the form may be completed by the beneficiary or a close relative. If a guardian has been appointed, the form should be completed by the guardian and a certified copy of letters of guardianship forwarded. By furnishing this form the insurance company is not held to admit the validity of any claim or to waive the breach of any condition of the policy.

I make the following statement in support of my claim for extended life insurance (premium waiver) benefits provided in the policy of insurance identified herein. Such information is submitted with the understanding that the insurance company may rely thereon, and I represent that all statements and answers are true and complete. I understand that the insurance company reserves the right to require, as proofs of disability, all documentary evidence, in addition to the items submitted, which it may reasonably deem necessary.

<b>INSURED'S STATEMENT</b>	Name – Last	First	Middle	Address-Street	City	State	Zip		
	Date you first became disabled:		Date you became totally disabled so as to be prevented from doing any work:			Last date worked:			
	Month	Day	Year	Month	Day	Year	Month	Day	Year
	Principle cause of disability:					Are you now totally disabled so as to be prevented from doing any work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	If not totally disabled, please state briefly the extent of your disability and present daily activities.								
	What physicians have you consulted during your present disability?								
	Name		Address			From	Date	To	
	_____		_____			_____	_____	_____	_____
	_____		_____			_____	_____	_____	_____
	_____		_____			_____	_____	_____	_____
At what hospitals or institutions have you been confined or treated for this disability?									
Name		Address			From	Date	To		
_____		_____			_____	_____	_____	_____	
_____		_____			_____	_____	_____	_____	
On what date do you expect to be able to return to work? _____									
AUTHORIZATION									
I hereby authorize any hospital, physician, insurance company, employer, or organization to furnish to the insurance company providing this form, or its representatives, any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. A photostatic copy of this authorization shall be considered as valid as the original.									
Date			Employee Signature						

<b>EMPLOYER'S STATEMENT</b>	Name of Insured				Social Security Number		Amount of Insurance					
	Name of Employer				Group Number		\$					
	Address of Employer				Date of Birth							
	Street		City		State		Zip					
	Month		Day		Year							
	Was Insured in your employ at time disability began?				Date Employed?							
	<input type="checkbox"/> Yes <input type="checkbox"/> No				Month		Day		Year			
	Date on which Insured last worked on full-time			When did Insured stop work?			A.M. <input type="checkbox"/>					
	Month		Day		Year		Month		Day		Year	
	P.M. <input type="checkbox"/>											
When did Insured return to work?				If not back at work, when do you expect Insured to return?								
Month		Day		Year		Month		Day		Year		
What is the Insured's job title and principle duties?												
Other Remarks:												
Name of Authorized Individual (Type or Print) _____												
Title or Position _____												
Signature _____ Date _____												
			Month			Day			Year			



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<b>ATTENDING PHYSICIAN'S STATEMENT</b>	Patient's Name			Age		
	1. Diagnosis and current conditions (If diagnosis code other than ICDA* used, give name):					
	2. Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is condition due to pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
				If yes, approximate date pregnancy commenced.		
				Month Day Year		
	3. Report of services (or attach itemized bill) (If previous form submitted to this carrier, you need show only dates and services since last report)					
	Date of services:		Place of services:		Description of surgical or medical services rendered:	
					Procedure Code – If used (If code other than CPT** used, give name):	
	†O – Doctor's Office H – Patient's Home		IH – Inpatient Hospital OH – Outpatient Hospital		NH – Nursing Home OL – Other Location	
	*ICDA – International Classification of Diseases **CPT – Current Procedural Terminology (current edition)					
4. Date symptoms first appeared or accident happened.			5. Date patient first consulted you for this condition.			
Month Day Year			Month Day Year			
6. Patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No			7. Describe:		Patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes" when: Month Day Year						
8. Patient was continuously disabled (unable to work)			9. Patient was partially disabled			
From: Month Day Year		To: Month Day Year	From: Month Day Year		To: Month Day Year	
10. If still disabled, date patient			11. Patient was house confined			
From: Month Day Year		To: Month Day Year	From: Month Day Year		To: Month Day Year	
Physician's Name (Type or Print)			Physician's Social Security Number			
			- -			
Physician's Signature		Degree	Date		Telephone Number	
					- -	
Street Address		City or Town		State or Province		
				Zip Code		