Need to make a claim? We can help!

Accident, Critical Illness, Hospital Indemnity, and Health Assessment Benefit claims

At Lincoln Financial Group, we want to make the claim process as easy for you as we can. We will let you know what information we need, when we need it by, and what you can expect from us. From the first point of contact until the benefit decision, we're here to support you every step of the way.

Ways to submit a claim

- **Online:** Through our secure self-service portal
- **Email:** FileClaim@LFG.com
- **Fax:** 888-735-7636
- **Mail:** The Lincoln National Life Insurance Company
  P.O. Box 2609
  Omaha, NE 68103
- **Phone :** 800-423-2765

Download claim forms for mail, fax, and email submissions at **LincolnFinancial.com/ClaimForms**.

Accident claim	▪ Employer ▪ Group policy number ▪ Employee's information: – Name and birthdate – Address, phone number, and email – Social Security number (SSN) or employee's work ID	▪ Patient's information and relationship to employee ▪ Reason for claim ▪ Accident details: – Date – Location – Injuries sustained – Hospital information	▪ Payment preference, either check or direct deposit ▪ Authorization for release of information ▪ Physician's statement and verification, to be completed by your provider ▪ Supporting medical records or medical information
Critical illness claim	▪ Employer ▪ Group policy number ▪ Employee's information: – Name and birthdate – Address, phone number, and email – SSN or employee's work ID	▪ Patient's information and relationship to employee ▪ Type(s) of illness	▪ Payment preference, either check or direct deposit ▪ Authorization for release of information ▪ Physician's statement and verification, to be completed by your provider ▪ Supporting medical records or medical information
Hospital indemnity claim	▪ Employer ▪ Group policy number ▪ Employee's information: – Name and birthdate – Address, phone number, and email – SSN or employee's work ID	▪ Patient's information and relationship to employee ▪ Confinement or admission details: – Admission date/time – Discharge date/time – Injuries sustained – Hospital information	▪ Payment preference, either check or direct deposit ▪ Authorization for release of information ▪ Physician's statement and verification, to be completed by your provider ▪ Supporting medical records or medical information
Health assessment benefit claim	▪ Employer ▪ Employee's name ▪ Policy number ▪ Employee's SSN or work ID	▪ Employee's address, phone number, and email ▪ Patient's name and birthdate ▪ Payment preference check ▪ Tests performed	▪ Physician information: – Name – Specialty – Phone number – Fax number – Address