Lincoln Life Assurance Company of Boston
Disability Claims
P.O. Box 7208
London, KY 40742-7208
Phone No.: 866-213-2937
Fax No.: 866-214-7839

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

I authorize any licensed physician, medical provider, hospital, medical facility, HMO, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer to release any and all medical information with respect to my physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, mental health and any non-medical information to the particular Company in the Lincoln Life Assurance Company of Boston to which I am submitting a claim, or to its legal representative, or to my employer, Wells Fargo (Plan Sponsor) in its capacity as administrator of its short term disability benefit plan and my leave request, or to persons or other organizations providing claims management services, including Wells Fargo Accommodations Management.

I understand the information obtained under this Authorization or directly from me will be used to determine eligibility for benefits, which may include assessing ongoing treatment. Any information obtained will not be released to any person or organizations EXCEPT to the Plan Sponsor, reinsuring companies, other companies in the Lincoln Life Assurance Company of Boston to which I am submitting a claim, Employee Assistance Programs (EAP) or other disease management or assistance programs providing services to the Plan Sponsor, persons or other organizations providing claims management and claim advisory services to the Plan Sponsor and/or to Lincoln, the Plan Sponsor or its agents/vendors for purposes of auditing Lincoln's administration of claims and/or assessing statistical claim data related to its benefit programs, and persons or organizations providing medical treatment or services in connection with my claim for benefits and/or my leave request consistent with law.

If I receive a disability benefit greater than that which I should have been paid, I understand that Lincoln and/or the Plan Sponsor has the right to recover such overpayment from me, including the right to reduce future disability benefits, if any.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive Lincoln and/or the Plan Sponsor, files a statement or claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

I know that I may request a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. This Authorization shall become effective on the date appearing next to my signature below. I understand that this Authorization shall be valid for two years from the date appearing below with my signature and that I have the right to revoke this Authorization at any time by writing to Lincoln at the above address, except to the extent that action has been taken in reliance on it.

_____
Team Member Name

_____
Team Member Signature (or Authorized Representative)

_____ _____
DOB Date

_____ Claim
Number