Lincoln Financial Group®

Authorization for Release of Dental Information

The Lincoln National Life Insurance Company
PO Box 2616, Omaha, NE 68103-2616
Toll Free (800) 423-2765 Fax (402) 361-1482
DentalAuths@LFG.com

1. I (the undersigned) authorize The Lincoln National Life Insurance Company ("Company") to release information regarding:

   Claimant/Patient Name: _____
   Last First Middle

   Date of Birth: _____ Certificate Number/Social Security Number: _____

2. Information to be released:

   _____

3. Information to be released to: _____
   Name of individual or company authorized to receive information

   Best Day to call _____

   ☐ Telephone _____ Best time to call _____ ☐ am or ☐ pm
   Include Area Code and Phone number

   ☐ Address

   _____
   Street/PO Box City State Zip

4. I understand the information obtained by use of this Authorization will be used by _____ for the purpose of _____ .

   It will be subject to the following limitations (if applicable): _____

5. I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law. For Colorado claims, the disclosed information may not be redisclosed or reused by the recipient under Colorado law.

6. I understand that I may revoke this Authorization in writing at any time, except to the extent: 1) the Company has previously taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my coverage with the Company. If written revocation is not received, this Authorization will be considered valid for 24 months from the date of signing. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.

7. I understand I am entitled to receive a copy of this Authorization.

SIGNATURE: _____ DATE: _____
Claimant/legal representative (Nearest relative, legal guardian, or appointed representative to sign only if claimant/patient is a minor, legally incompetent, or deceased) Power of attorney or guardianship must be attached.

PRINT NAME: _____

Relationship to Claimant/Patient of personal/legal representative signing for Claimant/Patient: _____

ADDRESS: _____
Street/PO Box City State Zip Code

TELEPHONE: _____
Include Area Code and Phone number

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