Lincoln Financial Group®

Authorization For Release Of Information

The Lincoln National Life Insurance Company
PO Box 2616, Omaha NE 68103-2615
Toll Free: (800) 423-2765 Fax: (877) 573-6177
www.LincolnFinancial.com

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

   Employee/Insured Name: _____
   (Last) (First) (Middle)

   Date of Birth: _____ Social Security Number: _____

2. Information to be released:

   _____

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

   ☐ Telephone _____ - _____ - _____ Best Day to call _____
   Include Area Code and Phone number Best time to call _____ am/pm

   ☐ 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 redisclosure by the recipient and may no longer be protected by state or federal law. 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 anytime except to the extent Lincoln has taken action in reliance on this Authorization. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of my signature below.

7. A photocopy of this Authorization is to be considered as valid as the original.

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

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

PRINT NAME: _____

Relationship to Employee/Insured of personal/legal representative signing for Employee/Insured: _____

ADDRESS: _____
(Street/PO Box) (City) (State) (Zip Code)

TELEPHONE: _____ - _____ - _____
Include Area Code and Phone number

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

BJ-03567BR THIRDPTY 5/17