Reporting Your Disability Claim

The University of Puget Sound Long-Term Disability Policy is issued by Lincoln Life Assurance Company of Boston.

Lincoln Financial Group offers employees direct access to claims resources and information. You can easily report a claim and check the status of your claim through Lincoln Financial Group's dedicated secure website or by telephone. Please visit: **www.MyLincolnPortal.com** to access employee resources and online tools, as referenced below.

When Do I Report a Claim?

You may report a claim as soon as you are aware that you will be disabled due to illness or injury for 90 or more calendar days.

How Do I Report a Claim?

1. Contact your supervisor to report your absence.
2. Print this document, sign and date the Authorization to Release Information section below, and leave with your physician or medical care provider at your next visit.

   Note: Lincoln Financial Group requires your physician to provide information about your medical condition. If this information cannot be obtained, benefits may be delayed.
3. Report your claim via **www.MyLincolnPortal.com**. First time users must register using Company Code **UniversityofPuget**.

   Please have the following information available when you report your claim:

   - Your physician or medical care provider's name, address, fax and telephone numbers
   - Your manager's name, telephone number and e-mail address
   - Reason you are out of work (diagnosis/symptoms)
   - Your last day worked, first day absent from work, and anticipated return to work date
4. Keep a record of your claim number. Reporting your claim online provides the added convenience of printing a claim report which includes your claim number and a summary of your claim details.
5. You may securely check the status of your claim online at **www.MyLincolnPortal.com** or by calling your Case Manager at 1-800-320-7585.

Authorization to Release Information

I authorize any health care provider having information about my physical or mental condition and treatment to give all information to the Company in the Lincoln Financial Group of companies and/or Plan Sponsor to which I am submitting a claim. I understand the information obtained by this Authorization will be used to determine eligibility for benefits. Information obtained under this Authorization or directly from me may be released to persons/organizations providing medical treatment or claim management/advisory services in connection with my claim, including Employee Assistance Programs (EAP), or other similar disease management/assistance programs providing services to the Plan Sponsor and/or the Company. This Authorization is valid for two years from the date appearing below with my signature. I have the right to revoke this Authorization by notifying the Company. I know that I may request a copy of the Authorization and I agree that a photographic copy shall be as valid as the original.

Employee Signature: Date:

Print Employee Name: