



PROTECTED HEALTH INFORMATION FORM

You have the right to obtain a copy of your protected health information as it relates to your insurance coverage through The Lincoln National Life Insurance Company. Information for the most recent calendar year will be provided for the individuals selected below unless otherwise specified. Please complete, sign and return this form to The Lincoln National Life Insurance Company, 8801 Indian Hills Drive, Omaha, NE 68114, ATTN: PHI Request.

Insured Information:

Insured Name _____ Social Security No. _____
(First) (Middle) (Last)

Address _____
(Street/PO Box) (City) (State) (Zip Code)

Spouse Information:

Please check this box if Spouse information is being requested.

Spouse Name _____ Date of Birth (mmddyyyy) _____
(First) (Middle) (Last)

Dependent Information:

Please check this box if Dependent/Child information is being requested.

Signatures:

I hereby authorize The Lincoln National Life Insurance Company to release my protected health information as indicated above:

Insured Signature Date Signed Spouse Signature Date Signed
(Required if spouse information is requested.)