Claims Department
PO Box 21008
Dept 0514
Greensboro, NC 27420-1008
Phone 800-487-1485

ASSIGNMENT OF BENEFITS

I, _____ Owner/Power of Attorney for Policy

Number _____ hereby authorize Lincoln Financial

Life Insurance Company to pay Convalescent Care Benefit Payments directly to the facility:

Name of Facility: _____

Address: _____

Telephone Number: _____

Fax Number: _____

Tax ID Number: _____

_____ _____

Signature of Owner Date

_____

Name (Please Print)