

Long Term Disability Employee's Statement



ING Employee Benefits
P.O. Box 1290 • Minneapolis, MN 55440-1290
1-800-328-4090

- ReliaStar Life Insurance Company of New York (outside NY)
- ReliaStar Life Insurance Company

To be completed by the participant (employee) and returned to the employer.

| | | | |
|--|-----|--|-------------------------------------|
| Plan number | | Division/location | |
| Employee's name | | | Social Security number |
| | | | Employee's phone () |
| Date of birth | Sex | <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed | Dependent Children and birthdate(s) |
| Cause of disability | | | Employee's home address |
| Date employed | | Occupation | |
| Has employment been terminated? If so, Why? Give date. | | | Date last worked |
| | | | Date disability began |

On what date did you first see a physician for this sickness or injury? _____

| | | | |
|--|---------|---------------|---------------|
| Name of treating physician | Address | | |
| If hospitalized for this sickness or injury, give name and address of hospital | | Date admitted | Date Released |

Are you bed confined? Yes No Are you house confined? Yes No
 Have you ever had the same kind of sickness or injury before? Yes No
 If yes, give date and physician's name and address: _____

If disability resulted from accident or sickness, answer these questions:

On what date were you first able to leave your home for any purpose? _____
 On what date were you first able to do any part of your work, supervisory or otherwise? _____

If disability resulted from sickness only, answer this question:

When did you first note symptoms? _____
 Have you had any medical or surgical advice during the past five years for any other condition? Yes No
 For what? _____
 When? _____ Physician's name and address: _____

If disability resulted from accident only, answer these questions:

Where did accident occur? _____ Date of accident? _____
 What time? _____ Was accident work-related? Yes No

What was your basic weekly or monthly salary or wage (excluding any commissions, overtime, bonus, etc.) immediately prior to your stopping work because of your disability? _____

State the amount of your weekly or monthly salary or wage (including overtime, bonus, etc.) that your employer is paying while disabled. _____ How long payable? _____

Are you eligible for or receiving:

- Workers' compensation benefits?
- Unemployment compensation disability?
- Sick pay?
- Salary continuance benefits?
- Social Security benefits?
- Retirement income (current or past employers)?
- Other?

| Date benefit began | Date benefit terminates | Amount | Paid weekly | Paid monthly |
|--------------------|-------------------------|--------|--------------------------|--------------------------|
| | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> |

Have you returned to work? No Yes At what date? _____

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse the insurance company to the extent of any overpayment which is in excess of the amounts payable under this group plan.

Date
35366h

Employee's Signature
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Education

| | | |
|---|--------------------|---------------------|
| Last year completed | Name of school | |
| Last year in school | Degree/certificate | Additional training |
| Attitude towards school <input type="checkbox"/> Like <input type="checkbox"/> Dislike | Favorable courses | |

Military service

| | | |
|--------------------------------|--------------------------------|---|
| Branch | Dates From: _____ To: _____ | Discharge <input type="checkbox"/> Honorable <input type="checkbox"/> General <input type="checkbox"/> Other _____ |
| Rank | Special training | |
| Duties/responsibilities | | |
| Service connected disabilities | | |

Vocational history

List most recent first.

1.

| | | |
|--------------------------------|----------------|--------|
| Employer | Supervisor | |
| Job title(s) | | |
| Dates From: _____ To: _____ | Salary | Duties |
| Union | Representative | |

2.

| | | |
|--------------------------------|----------------|--------|
| Employer | Supervisor | |
| Job title(s) | | |
| Dates From: _____ To: _____ | Salary | Duties |
| Union | Representative | |

3.

| | | |
|--------------------------------|----------------|--------|
| Employer | Supervisor | |
| Job title(s) | | |
| Dates From: _____ To: _____ | Salary | Duties |
| Union | Representative | |

4.

| | | |
|--------------------------------|----------------|--------|
| Employer | Supervisor | |
| Job title(s) | | |
| Dates From: _____ To: _____ | Salary | Duties |
| Union | Representative | |

Please return this authorization with your claim.

Authorization to Release Information to ReliaStar Life Insurance Company

| | |
|--------------------|------------------------|
| Participant's name | Contract holder number |
|--------------------|------------------------|

For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, Inc. (MIB), Social Security Administration, employer or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative acting on its behalf (including ChoicePoint or any consumer reporting agency), ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information, including Social Security benefits or earnings information and other employment-related information, as they apply to me. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life and its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This authorization will be valid for the duration of my claim for benefits. I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice and Insurance Information Practices Notice.

| | |
|---|------|
| Patient's signature <i>(parent or guardian's signature if patient is a minor)</i> | Date |
|---|------|

Fraud Warnings

STANDARD:

Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.

In CALIFORNIA:

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

In COLORADO:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

In DISTRICT of COLUMBIA:

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

In FLORIDA:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

In LOUISIANA:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

In NEW JERSEY:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

In OREGON:

Any person who knowingly and with intent to defraud submits an application or files a statement of claim containing any materially false or misleading information, may be guilty of insurance fraud.

In PENNSYLVANIA:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.