SHORT TERM DISABILITY INCOME
ATTENDING PHYSICIAN'S STATEMENT OF IMPAIRMENT AND FUNCTION

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY (outside NY)
Members of the Voya® family of companies
(the "Company")
Submit at voya.com/claims *(select Upload Documents);*
Disability Reinsurance Management Services, Inc.
is the claims administrator on behalf of the Company.
P.O. Box 9757, Portland, ME 04101-9757
Phone: 888-305-0602; Fax: 888-305-0605

The patient is responsible for the completion of this form without expense to the Company.

CLAIM CHECKLIST

- ☐ This completed form must be submitted using one of the above methods.
- ☐ The Insured must complete Sections 1 and 2.
- ☐ The Attending Physician must complete Sections 3 - 12.

SECTION 1. GROUP INFORMATION *(This information is mandatory and can be obtained from the Employer.)*

Group Name _____ Group Policy Number _____

SECTION 2. INSURED / PATIENT INFORMATION

Select, if applicable.: ☐ International / Foreign Address

Patient Name *(First)* _____ *(Middle Initial)* ____ *(Last)* _____

Patient Birth Date _____

Address _____

Address _____

City _____ Province / State _____ ZIP _____

Country _____ Email _____

Phone (_____)_____ International Phone _____

Under the Short Term Disability Income Plan, an employee is eligible to receive benefits if medically disabled from performing the duties of his/her **own occupation** and meets contractual requirements.

SECTION 3. PRESENT CONDITION

Height _____ ft. _____ in. Weight _____ lbs. Hand Dominance: ☐ Right-hand ☐ Left-hand

In order to determine benefit eligibility and rehabilitation, answer the following:

When did symptoms first appear or accident happen? _____

On what date did you advise your Patient to cease work because of disability? _____

Is condition due to an illness or an injury that is work related? . . . . . ☐ Yes ☐ No

Has Patient ever had the same or similar condition? . . . . . ☐ Yes ☐ No

Did another Physician refer this Patient to you?. . . . . ☐ Yes ☐ No

If "yes," provide the name and address of the referring Physician. _____

Subjective Symptoms _____

Objective Findings _____

Primary Diagnosis _____ ICD-10 Code(s) _____

Initial Diagnosis Date _____ Any Subsequent Diagnosis Dates _____

Secondary Conditions _____

Has Patient been confined to a hospital? . . . . . ☐ Yes ☐ No

If "yes," provide dates. _____

Has Patient had surgery? . . . . . ☐ Yes ☐ No

If "yes," provide dates. _____

Surgery Type _____ CPT Code(s) _____

Prognosis _____

Group Policy Number _____

Patient Name *(First)* _____ *(Middle Initial)* ____ *(Last)* _____

SECTION 4. CURRENT PLAN OF TREATMENT

Date of First Visit _____ Date of Last Visit _____ Next Scheduled Appointment _____

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other _____

Treatment Plan _____

SECTION 5. FOR PREGNANCY DISABILITY ONLY

Date First Treated _____ Estimated Date of Confinement (EDC) _____ Type of Delivery: ☐ Vaginal ☐ C-Section

Has Patient Delivered? ☐ Yes ☐ No If "yes," provide delivery date. _____ Post Partum Recovery Weeks: ☐ 6 ☐ 8

SECTION 6. EXTENT OF DISABILITY

Is Patient totally disabled from performing the duties of their own occupation? . . . . . ☐ Yes ☐ No

If the disability is not considered total and permanent, do you anticipate a release to their OWN occupation? . . . . . ☐ Yes ☐ No

If "yes," when? _____

If "no," do you anticipate a release to a less physically and/or emotionally demanding occupation?. . . . . ☐ Yes ☐ No

If "yes," when? _____

If the Patient cannot perform the duties of their own occupation, would you feel it appropriate to consider Vocational and/or Medical Rehabilitation? . . . . . ☐ Yes ☐ No

If the Patient is disabled from his/her own occupation but appropriate for rehabilitation or a release to a less demanding occupation, complete Section 10 (Physical Capacity Evaluation) on this form. This is used to lend direction in exploring medical/vocational alternatives.

SECTION 7. COMPETENCY

Is the Patient competent to endorse checks and direct the use of the proceeds? . . . . . ☐ Yes ☐ No

SECTION 8. CARDIAC FUNCTIONAL CAPACITY *(Complete this section IF disability is due to Cardiac Condition.)*

American Heart Association Classification: ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

Blood Pressure _____

SECTION 9. VISUAL IMPAIRMENT *(Complete this section IF disability is due to Visual Impairment.)*

What was vision at last observation? (Snellen Notation)

With Glasses O. D. _____ O.S. _____ Date _____

Without Glasses O. D. _____ O.S. _____ Date _____

SECTION 10. PHYSICAL CAPACITIES EVALUATION *(Important: complete the following items based on your clinical evaluation, other testing results, Patient discussions, and/or job analysis. Any item that you do not believe you can answer should be marked N/A (not available).*

NOTE: In terms of an eight hour workday, "Occasionally" equals zero to 33 percent; "Frequently" equals 34-66 percent; "Continuously" equals 67-100 percent.

In an eight hour work day, Patient can:

Sit (hours): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

Stand (hours): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

Walk (hours): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

If any of the above three capabilities require alternating positions, indicate frequency. _____

Patient can lift:	Never	Occasionally	Frequently	Continuously
Up to 10 pounds	☐	☐	☐	☐
11-20 pounds	☐	☐	☐	☐
21-50 pounds	☐	☐	☐	☐
51-100 pounds	☐	☐	☐	☐

Patient can carry:	Never	Occasionally	Frequently	Continuously
Up to 10 pounds	☐	☐	☐	☐
11-20 pounds	☐	☐	☐	☐
21-50 pounds	☐	☐	☐	☐
51-100 pounds	☐	☐	☐	☐

Group Policy Number _____

Patient Name *(First)* _____ *(Middle Initial)* ____ *(Last)* _____

SECTION 10. PHYSICAL CAPACITIES EVALUATION *(Continued)*

Patient is able to:	Never	Occasionally	Frequently	Continuously
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐

Restrictions on activities involving:	None	Mild	Moderate	Total
Unprotected heights	☐	☐	☐	☐
Being around moving machinery	☐	☐	☐	☐
Exposure to marked changes in temperature and humidity	☐	☐	☐	☐
Driving automotive equipment	☐	☐	☐	☐
Exposure to dust, fumes, or gasses	☐	☐	☐	☐

Patient can use hands for repetitive action such as:	Right		Left	
	Yes	No	Yes	No
Simply Grasping	☐	☐	☐	☐
Pushing and Pulling	☐	☐	☐	☐
Fine Manipulation	☐	☐	☐	☐

Patient can use feet for repetitive movements, as in operating foot controls:	Yes	No
Right	☐	☐
Left	☐	☐
Both	☐	☐

SECTION 11. REMARKS

SECTION 12. PHYSICIAN INFORMATION AND SIGNATURE

New York Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Attending Physician Name _____ Degree _____

TIN _____ Phone (_____)_____ Fax (_____)_____

Email _____

Address _____

City _____ State _____ ZIP _____

Attending Physician Signature _____ Date _____

FRAUD WARNINGS

Alaska, Alabama, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files a statement of claim containing any materially 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 may subject such person to criminal and civil penalties, and denial of insurance benefits.

Arizona: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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

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 or information 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.

District of Columbia: WARNING: 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.

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.

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

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

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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 civil fines and criminal penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially 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.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.