IMPORTANT INFORMATION REGARDING APPLICATION FOR GROUP INTEGRATED DISABILITY BENEFITS

PLEASE READ THESE INSTRUCTIONS BEFORE COMPLETING THE ATTACHED FORMS

This is a multi-purpose form that requires completion in full by all parties concerned. This information ***must be provided immediately following the employee's last day worked.*** In order to allow sufficient processing time, each responsible party should complete their section as soon as possible. Please fax completed claim forms and attachments (only) to 267-256-3519 or mail to Reliance Standard Life Insurance Company, P.O. Box 7749, Philadelphia, PA 19101-7749. If you have any questions, please call our Customer Service Department at 1-800-351-7500.

THE EMPLOYER IS RESPONSIBLE FOR COMPLETING THE FOLLOWING SECTIONS:

Section 2 Employer's Statement
Section 3 Job Description and Requirements

THE EMPLOYEE IS RESPONSIBLE FOR COMPLETING THE FOLLOWING SECTIONS:

Section 1 Employee's Statement
Section 4 Sign and Date the Authorization for Use in Obtaining Information

THE ATTENDING PHYSICIAN IS RESPONSIBLE FOR COMPLETING THE FOLLOWING:

Section 5 Physician's Statement

Please be sure that all responsible parties completing and filing a claim for benefits are aware of the following statements which concern claim fraud and abuse:

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.

State of California

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

State of Florida

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

State of New Jersey

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

State of New York

Any person who knowingly and with intent to defraud any insurance company or other person, file sand 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 such violation.

State of Ohio

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

State of Oregon

Any person who, with an intent to knowingly 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, may be subject to prosecution for insurance fraud.

State of 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.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Reset

Integrated Disability Benefits
Initial Statement of Claim
Group Life Waiver of Premium

Section 1 – To be completed by Claimant *(Please print or type)*

Name	Social Security Number	Date of Birth

Street Address	City	State	Zip

Home Phone ( )	E-mail Address

Sex ☐ Male ☐ Female	Type of Disability ☐ Accident ☐ Illness ☐ Pregnancy	Date of Accident

Dominant Hand: ☐ Right ☐ Left	Date first unable to work

Spouse's Name (Last, First)

Spouse's Date of Birth (Month, Day, Year)	Is your Spouse Employed? ☐ Yes ☐ No

Child's Name (Last, First)	Date of Birth (M/D/Y)	Is Child Handicapped? ☐ Yes ☐ No	Is Child a Full-Time Student? ☐ Yes ☐ No If Yes, where?_____
Child's Name (Last, First)	Date of Birth (M/D/Y)	Is Child Handicapped? ☐ Yes ☐ No	Is Child a Full-Time Student? ☐ Yes ☐ No If Yes, where?_____
Child's Name (Last, First)	Date of Birth (M/D/Y)	Is Child Handicapped? ☐ Yes ☐ No	Is Child a Full-Time Student? ☐ Yes ☐ No If Yes, where?_____
Child's Name (Last, First)	Date of Birth (M/D/Y)	Is Child Handicapped? ☐ Yes ☐ No	Is Child a Full-Time Student? ☐ Yes ☐ No If Yes, where?_____

Describe how and where accident occurred or list symptoms of illness and diagnosis.

Name and Address of Primary Physician

Name and Address of other Physician(s) or other medical provider(s) (attach additional sheets if necessary)

Have you returned to work? ☐ Yes ☐ No If "Yes," on what date:_____ Part-time _____ Full-time

If you have not returned to work, on what date do you expect to return to work:_____ Part-time _____ Full-time

Check if you are receiving or are entitled to receive benefits from any of the following sources:

☐ Salary, Wages or Commissions
☐ State Disability
☐ Worker's Compensation
☐ Retirement or Pension Plan
☐ Social Security Disability
☐ Social Security Retirement
☐ Railroad Retirement Act
☐ Other Sources

For each source indicated, please provide the following information as well as copies of applications and any award or denial notices:

Source	Amount of Income Amount	Amount of Income Frequency	Date Application Filed	Benefit Effective Date

Computer Usage Information

Do you use a computer at home? ☐ Yes ☐ No

If yes, check all uses that apply: ☐ Word Processing ☐ Spreadsheets ☐ Data-entry ☐ E-mail ☐ Internet
☐ Other (specify): _____

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Integrated Disability Benefits
Initial Statement of Claim
Group Life Waiver of Premium

We are required to withhold federal income tax from any benefit payments upon your request. If benefits are taxable by your state, we will also withhold state income tax upon your request. We must also send a report to your employer at the end of each calendar year showing your name, social security number, any benefits paid and any taxes withheld. If you would like us to withhold any taxes, please indicate the dollar amount to be withheld each week:

Federal Taxes to be withheld ($20.00 minimum per week, whole dollars only)	**$ .00**
State Taxes to be withheld ($2.00 minimum per week, whole dollars only)	**$ .00**

Any person who knowingly and with intent to injure, defraud or deceive Reliance Standard Life Insurance Company, files a statement of claim or submits any information in conjunction with a claim containing fraudulent, false, misleading, incomplete or deceptive information commits a fraudulent insurance act, which is a crime. These actions will result in the denial of the claim, and are subject to prosecution under state and/or federal law. Reliance Standard Life Insurance Company will cooperate fully with any prosecution and will seek any and all appropriate legal remedies.

Employee's Signature _____ **Date:** _____

Telephone Number (_____)_____ **E-mail Address:** _____

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Section 2 – To be completed by Employer

Short Term Disability Policy Number	Long Term Disability Policy Number (if applicable)	Life-Waiver of Premium Policy Number (if applicable)
	LTD 129197	

Claimant's Name	Date Employed	Eff. Date of insurance under this plan

Has claimant made prior claim for benefits?	Was insurance effective when disability began?	Occupation, title or position
☐ Yes ☐ No When?_____	☐ Yes ☐ No Termination date _____	

Describe the claimant's job duties. If available, attach a formal job description.	Did this disability occur as a result of the claimant's employment?
	☐ Yes ☐ No ☐ Currently disputed

Date last worked _____ No. of hours worked that day _____	How is Claimant paid? ☐ Hourly ☐ Salary + Commission ☐ Salaried ☐ Commission only ☐ Salary + Bonus ☐ Other _____	Weekly earnings *(as defined in policy)*	Class

Work schedule at time of disability _____ day/week _____ hrs./day

Has claimant returned to work?	Was Claimant covered under your prior disability plan? ☐ Yes ☐ No
☐ Yes ☐ No If "Yes", on what date: _____ ☐ With restrictions ☐ Full capacity	Effective date under prior plan _____ Termination date under prior plan _____

Percentage of premium paid by employer: _____ % Is claimant taxed on this amount? ☐ Yes ☐ No
Percentage of premium paid by claimant: _____ % ☐ Pre-tax dollars ☐ Post-tax dollars
Percentages must total 100%. If left blank, we will assume 100% of premium is paid by employer and that claimant is not taxed on this amount. FICA taxes will be calculated accordingly.

Is there any reason why FICA taxes should not be withheld from claimant's benefits? ☐ Yes ☐ No If "Yes," please explain:

Date Laid Off (if applicable)	Date Retired (if applicable)

Employer's Name Northwestern Medical Center, Inc.	Your name and title

Telephone Ext. ( )	Fax Number ( )	E-mail Address

REQUIRED ATTACHMENTS

PROOF OF EARNINGS AS DEFINED BY APPLICABLE POLICY (EXAMPLE: PAYROLL RECORDS, W-2, K1, 1099, ETC.)

IF EMPLOYEE WAS COVERED UNDER A PRIOR PLAN, INCLUDE COPY OF PRIOR PLAN.

IF THE EMPLOYEE CONTRIBUTES TO THE PREMIUMS, ATTACH A COPY OF THE ENROLLMENT FORM.

IF YOU HAVE MEDICAL INFORMATION FROM THE EMPLOYEE'S FILE RELATING TO DISABILITY, PLEASE ATTACH COPIES.
IF A WORKER'S COMPENSATION CLAIM IS FILED, SEND INITIAL REPORT OF INJURY OR ILLNESS AND AWARD NOTICE.

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Date_____ By AUTHORIZED SIGNATURE _____

P.O. Box 7749, Philadelphia, PA 19101-7749

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SECTION 3 – TO BE COMPLETED BY EMPLOYER

Job Description and Requirements

Policyholder	Insured
Signature of Employer: _____ Date: _____ Title: _____	

To be completed by Employer:

Job Title: _____

Detailed Description of Job Duties: (Disregard if detailed job description previously submitted)

_____

_____

_____

Required Education and Training: _____

_____

_____

PHYSICAL REQUIREMENTS

In an eight hour work day, employee is required to: (Circle daily requirement for each activity.)

1. Sit Number of Hours 1 2 3 4 5 6 7 8
2. Stand Number of Hours 1 2 3 4 5 6 7 8
3. Walk Number of Hours 1 2 3 4 5 6 7 8
4. Drive Number of Hours 1 2 3 4 5 6 7 8

INTERMS OF AN 8 HOUR WORKDAY,

On the job, employee must:	Not at all	Occasionally (1/4-2 ½ hours)	Frequently (2 ½ - 5 ½ hours)	Continuously (5 ½ - 8 hours)
A. Bend/Stoop	☐	☐	☐	☐
B. Climb	☐	☐	☐	☐
C. Reach above shoulder level	☐	☐	☐	☐
D. Kneel	☐	☐	☐	☐
E. Balance	☐	☐	☐	☐
F. Push/Pull	☐	☐	☐	☐
G. Squat	☐	☐	☐	☐
H. Crawl	☐	☐	☐	☐
I. Crouch	☐	☐	☐	☐

During work the employee must lift:

On the job, employee must:	Not at all	Occasionally (1/4-2 ½ hours)	Frequently (2 ½ - 5 ½ hours)	Continuously (5 ½ - 8 hours)
A. Usual amount _____ lbs. B. Maximum amount _____ lbs.	☐ ☐	☐ ☐	☐ ☐	☐ ☐

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SECTION 3 CONTINUED

During work the employee must carry:

On the job, employee must:	Not at all	Occasionally (1/4-2 ½ hours)	Frequently (2 ½ - 5 ½ hours)	Continuously (5 ½ - 8 hours)
A. Usual amount _____ lbs. B. Maximum amount _____ lbs.	☐ ☐	☐ ☐	☐ ☐	☐ ☐

On the job, employee uses feet for repetitive movements as in operating foot controls:
Right: ☐ Yes ☐ No Left: ☐ Yes ☐ No Both: ☐ Yes ☐ No

I. On the job, employee uses hands for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
A. Right B. Left	☐ ☐	☐ ☐	☐ ☐

II. Does Job Require:

A. Working at heights	☐ Yes ☐ No Explain: _____
B. Operating heavy machinery	☐ Yes ☐ No Explain: _____
C. Operating heavy machinery	☐ Yes ☐ No Explain: _____
D. Precise manual dexterity	☐ Yes ☐ No Explain: _____
E. Exposure to marked changes in temperature and humidity or extremes thereof	☐ Yes ☐ No Explain: _____
F. Exposure to dust, fumes, gases, chemicals	☐ Yes ☐ No Explain: _____

Can the occupation be modified to accommodate the disability either temporarily or permanently: ☐ Yes ☐ No If "Yes," please explain.

_____

Is it possible to offer the employee assistance in doing the occupation (through use of technology or personal assistance for example) ☐ Yes ☐ No
If "Yes," please explain. _____

_____

(ATTACH COPY OF THE EMPLOYEE'S OCCUPATION DESCRIPTION)

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I CERTIFY THAT THE FACTS AS INDICATED ABOVE ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

X_____ _____
SIGNATURE DATE

RELIANCE STANDARD
LIFE INSURANCE COMPANY
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P.O. Box 8330
Philadelphia, PA 19101-8330
(800) 351-7500 Fax: (267) 256-4262

AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF INSURED: _____
INSURED'S DATE OF BIRTH: _____
POLICYHOLDER: _____

To all physicians and other health care professionals, hospitals, other health care institutions, insurers, medical, hospital and prepaid health plans, pharmacies, pharmacy benefit managers, employers, group policyholders, contract holders, governmental agencies (including but not limited to the Internal Revenue Service and the Social Security Administration), private and/or public benefit plan administrators, and/or attorney representatives, including but not limited to covered entities and business associates under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the accompanying regulations:

You are authorized to provide Reliance Standard Life Insurance Company and/or its authorized administrators, including but not limited to Matrix Absence Management, with information concerning medical care, advice, and/or treatment provided to me, the above named Insured, and/or any employment, salary, tax and/or benefit-related information concerning me, the above named Insured. I understand that the disclosure of information may include disclosure of protected health information under HIPAA and the accompanying regulations, information regarding treatment for mental illness, the human immunodeficiency virus (HIV) and/or the use of drugs and alcohol. I also understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be subject to protection under HIPAA and the accompanying regulations. A statement of Reliance Standard Life Insurance Company's privacy policy is available at www.rsli.com or upon request.

Reliance Standard Life Insurance Company will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on the provision of this Authorization, except that this Authorization may be required to allow a covered entity to disclose protected health information where such disclosure is necessary to evaluate my claim for benefits.

I understand that any such information will be used for the purpose of evaluating my claim for benefits. Upon request, I understand that I am entitled to receive a copy of this Authorization. This Authorization is valid from the date signed for the duration of the claim, and may be revoked by me at any time upon written request to the address above. A reproduction of this Authorization shall be considered as valid as the original.

_____ _____
Date Insured's Signature

(If the Insured is unable to sign, an authorized person may sign.)

_____ _____
Date Authorized Person's Signature

Description of Authorized Person's authority to sign on behalf of Insured:

_____

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SECTION 5-To be completed by Attending Physician (*please print or type)* **Patient's Name:** _____

History & Prognosis

Patient's symptoms result from *(check all that apply)*
Employment ☐ Illness ☐ Auto accident ☐ Other accident
☐ Pregnancy (expected/actual delivery date) _____/_____/_____ Type of delivery: _____
Has patient had same or similar condition? ☐ Yes ☐ No
Date symptoms first appeared _____/_____/_____ First visit for this condition _____/_____/_____
First date unable to work _____/_____/_____
Expected/Actual return to work date: Full-time ____/_____/_____ Part-time _____/_____/_____
Has the patient reached maximum medical improvement? ☐ Yes ☐ No If "No," when _____ ☐ Unknown
What limitations prevent the patient from returning to gainful employment?

Would job modifications enable patient to work with impairments? ☐ Yes ☐ No

Most recent visit _____/_____/_____
Name(s) and address(es) of other treating physician(s)

Hospital name _____

Confinement dates _____/_____/_____ thru _____/_____/_____

Diagnosis

Diagnoses *(including complications):*

ICD-9 or ICD-10 Code(s):

Subjective symptoms:

Objective findings *(including results/copies of x-rays, lab tests, EKGs, MRIs, and scans)*

Treatment

Describe treatment program, including surgery or medications

Physical Impairment

☐ Class 1 – No limitation of functional capacity; capable of heavy work* ……..No restrictions (0-10%)
☐ Class 2 – Medium manual activity* ……(15-30%)
☐ Class 3 – Slight limitation of functional capacity; capable of light work* ……..(35-55%)
☐ Class 4 – Moderate limitation of function capacity; capable of clerical or administrative (sedentary*) activity ……..……(60-70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity ……(75-100%)
☐ Remarks _____As defined in the Federal Dictionary of Occupational Titles

Psychiatric Impairment

Complete only if applicable.
☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations *(no limitations)*.
☐ Class 2 – Patient is able to function in most stress situations and engage in only limited interpersonal relations *(slight limitations)*.
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations *(moderate limitations)*.
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations *(marked limitations)*.
☐ Class 5 – Patient has significant loss of psychological, physiological, personal, and social adjustments *(severe limitations)*.
☐ Remarks _____

Please define stress as it applies to this patient.
What stress and problems in interpersonal relations has patient had on the job?
Do you believe a legal guardian or conservator should be appointed for this problem? ☐ Yes ☐ No

COMPLETE THIS SECTION ONLY IF DISABILITY IS DUE TO CARDIAC CONDITION

CARDIAC

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

Blood Pressure and Dates:_____

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Physician's Name, Address, Zip (Please Print or Type)		
Telephone ( )	Fax Number ( )	Physician's SSN or EIN
Physician's Signature	Degree	Date

IMPORTANT: PLEASE ATTACH ALL MEDICAL RECORDS FROM THREE (3) MONTHS PRIOR TO DATE OF DISABILITY TO PRESENT.