IMPORTANT INFORMATION REGARDING APPLICATION FOR GROUP LONG TERM DISABILITY AND GROUP LIFE-WAIVER OF PREMIUM 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 two months prior to the end of the elimination period in order to allow sufficient processing time. Each responsible party should complete their section as soon as possible. The entire claim form should be sent immediately upon completion to Reliance Standard Life Insurance Company, P.O. Box 8330, Philadelphia, PA 19101-8330. 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 1 Employer's Statement, both sides
Section 2 Occupation Analysis, both sides

THE EMPLOYEE IS RESPONSIBLE FOR COMPLETING THE FOLLOWING SECTIONS:
Section 3 Employee's Statement, both sides
Section 4 Employment and Education Information, both sides
Section 5 Sign and date the Authorization for Use in Obtaining Information

THE ATTENDING PHYSICIAN IS RESPONSIBLE FOR COMPLETING THE FOLLOWING:
Section 6 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 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 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, 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.

**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.
## TO BE COMPLETED BY EMPLOYER

<table>
<thead>
<tr>
<th>THIS CLAIM IS FOR (EMPLOYEE NAME)</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
</table>

### A. INFORMATION ABOUT THE EMPLOYER

1. **COMPANY’S NAME**

2. **ADDRESS (STREET, CITY, STATE, ZIP)**

3. Indicate under which coverage benefits are being applied on employee's behalf:
   - [ ] Long Term Disability
   - [ ] Life-Waiver of Premium

4. **NAME AND ADDRESS OF DIVISION WHERE EMPLOYEE WORKS (IF DIFFERENT FROM ABOVE)**

### B. INFORMATION ABOUT THE EMPLOYEE

1. **DATE EMPLOYEE WAS HIRED? (MTH, DAY, YR)**

2. **WHAT WAS THE EMPLOYEE’S REGULARLY SCHEDULED WORK WEEK?_________hrs/wk.**

3. **DATE EMPLOYEE BECAME INSURED UNDER THIS PLAN?**
   - LTD: MTH DAY YR
   - LIFE: MTH DAY YR

4. **DATE EMPLOYEE BECAME INSURED UNDER YOUR PRIOR PLAN?**
   - LTD: MTH DAY YR
   - LIFE: MTH DAY YR

5. **NAME AND ADDRESS OF DIVISION WHERE EMPLOYEE WORKS (IF DIFFERENT FROM ABOVE)**

6. **NAME AND ADDRESS OF DIVISION WHERE EMPLOYEE WORKS (IF DIFFERENT FROM ABOVE)**

7. **IF SALARIED, BASIC MONTHLY EARNINGS AS OF LAST DAY WORKED**

8. **DATE TO WHICH PREMIUM IS PAID FOR THIS EMPLOYEE**
   - LTD: MTH DAY YR
   - LIFE: MTH DAY YR

9. **DATE EMPLOYEE BECAME INSURED UNDER THIS PLAN?**
   - LTD: MTH DAY YR
   - LIFE: MTH DAY YR

10. **IF SALARIED, BASIC MONTHLY EARNINGS AS OF LAST DAY WORKED**

11. **DATE TO WHICH PREMIUM IS PAID FOR THIS EMPLOYEE**
    - LTD: MTH DAY YR
    - LIFE: MTH DAY YR

12. **IF SALARIED, BASIC MONTHLY EARNINGS AS OF LAST DAY WORKED**

### C. INFORMATION NEEDED FOR WITHHOLDING AND REPORTING TAXES

1. **DOES EMPLOYEE CONTRIBUTE TOWARDS THE PREMIUM?**
   - [ ] YES
   - [ ] NO

2. **IF YES, WHAT PERCENT IS PAID BY THE EMPLOYEE?**
   - ON A PRE TAX BASIS _______%
   - ON A POST TAX BASIS _______%

3. **WHAT TYPE OF BENEFIT?**

4. **WHEN DO BENEFITS BEGIN?**

5. **END?**

6. **IS EMPLOYEE CONDITION WORK RELATED?**
   - [ ] YES
   - [ ] NO

7. **WILL EMPLOYEE FILE FOR DISABILITY BENEFITS PROVIDED BY ANY EMPLOYER/EMPLOYEE LABOR MANAGEMENT, STATE DISABILITY OR UNION WELFARE PLAN?**
   - [ ] YES
   - [ ] NO

8. **EFFECITIVE DATE OF CURRENT SALARY OR HOURLY RATE**
   - MTH DAY YR

9. **IF SALARIED, BASIC MONTHLY EARNINGS AS OF LAST DAY WORKED**

10. **IS EMPLOYEE CONDITION WORK RELATED?**
    - [ ] YES
    - [ ] NO

11. **NAME AND ADDRESS OF YOUR WORKER’S COMPENSATION CARRIER: (Include Policy Number)**
    - Contact Name: 
    - Phone Number:

12. **NAME AND ADDRESS OF YOUR MEDICAL INSURANCE CARRIER OR ADMINISTRATOR IF SELF FUNDED: (Include Policy Number)**
    - Contact Name: 
    - Phone Number:

13. **NAME AND ADDRESS OF YOUR MEDICAL INSURANCE CARRIER OR ADMINISTRATOR IF SELF FUNDED: (Include Policy Number)**
    - Contact Name: 
    - Phone Number:

### C. INFORMATION NEEDED FOR WITHHOLDING AND REPORTING TAXES

1. **DOES EMPLOYEE CONTRIBUTE TOWARDS THE PREMIUM?**
   - [ ] YES
   - [ ] NO

2. **IF YES, WHAT PERCENT IS PAID BY THE EMPLOYEE?**
   - ON A PRE TAX BASIS _______%
   - ON A POST TAX BASIS _______%

3. **IF YOU LEAVE THIS SECTION BLANK, WE WILL ASSUME IT IS 100% EMPLOYER CONTRIBUTION AND CALCULATE FICA TAXES ACCORDINGLY**
# DISABILITY CLAIM EMPLOYER'S STATEMENT

## D. INFORMATION ABOUT THE CLAIM

1. **WERE THERE ANY CHANGES TO THE EMPLOYEE'S OCCUPATIONAL RESPONSIBILITIES DUE TO THE DISABLING CONDITION BEFORE THE EMPLOYEE BECAME FULLY DISABLED?**
   - Yes
   - No

   - **IF YES, WHAT WERE THE CHANGES AND WHEN WERE THEY MADE?**

2. **WHAT WAS THE EMPLOYEE'S PERMANENT OCCUPATION ON HIS OR HER LAST DAY AT WORK?**

3. **HOW LONG HAS THE EMPLOYEE BEEN IN THIS OCCUPATION?**

4. **LAST DAY EMPLOYEE ACTUALLY WORKED (MONTH, DAY, YR.)**

5. **ON THAT DAY, DID THE EMPLOYEE WORK A FULL DAY?**
   - Yes
   - No

   - **IF NO, HOW MANY HOURS WERE WORKED?**

6. **WHY DID EMPLOYEE STOP WORKING?**
   - Layoff
   - Termination for Cause
   - Family Medical Leave Act
   - Resignation
   - Retired
   - Disability

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## INFORMATION ABOUT YOUR PENSION PLAN (DO NOT COMPLETE FOR MATERNITY CLAIM)

1. **DO YOU HAVE A PENSION PLAN?**
   - Yes
   - No

2. **IF YES, WHAT TYPE?**
   - Defined Benefit Sharing
   - 401K
   - Defined Contribution
   - Profit Sharing
   - Other (explain)

3. **IS THE EMPLOYEE ELIGIBLE FOR YOUR PENSION PLAN?**
   - Yes
   - No

4. **IF ELIGIBLE, DOES THE EMPLOYEE CONTRIBUTE?**
   - Yes
   - No

5. **IF YES, WHAT PERCENTAGE?**


7. **IS THE EMPLOYEE RECEIVING ANY OTHER INCOME RELATED TO THIS DISABILITY?**
   - Yes
   - No

---

## F. INFORMATION ABOUT YOUR REHIRE OR RETURN-TO-WORK POLICIES

1. **DOES YOUR COMPANY HAVE A REHIRE OR RETURN-TO-WORK POLICY FOR DISABLED EMPLOYEES?**
   - Yes
   - No

2. **DO YOU HAVE FULL OR PART-TIME POSITIONS AVAILABLE THAT THIS EMPLOYEE WOULD BE SUITED FOR UNDER A SUPERVISED REHABILITATION PROGRAM?**
   - Yes
   - No

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## G. REQUIRED ATTACHMENTS AND SIGNATURE

- 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.

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.

---

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

---

**SIGNATURE**

**DATE**

**TITLE**

**TELEPHONE**

**E-MAIL ADDRESS**

**FAX**
SECTION 2
OCCUPATION ANALYSIS
GROUP LONG TERM DISABILITY
P.O. Box 8330
GROUP LIFE- WAIVER OF PREMIUM
Philadelphia, PA 19101-8330

TO BE COMPLETED BY THE EMPLOYER

<table>
<thead>
<tr>
<th>THIS CLAIM IS FOR (EMPLOYEE'S NAME)</th>
<th>SOCIAL SECURITY NUMBER</th>
<th>DATE OF DISABILITY (MONTH, DAY, YEAR)</th>
</tr>
</thead>
</table>

### A. GENERAL INFORMATION ABOUT THE EMPLOYEE'S OCCUPATION

#### OCCUPATION TITLE

<table>
<thead>
<tr>
<th>DOT CODE (DICTIONARY OF OCCUPATIONAL TITLES)</th>
<th>MINIMUM EDUCATION OR TRAINING REQUIRED</th>
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</table>

**DOES THE EMPLOYEE PERFORM SUPERVISORY FUNCTIONS?**  □ YES  □ NO  **IF YES, HOW MANY PEOPLE ARE SUPERVISED?**  ____

**DESCRIBE OCCUPATION DUTIES.**

**CHECK THE ITEMS BELOW THAT RELATE TO THE EMPLOYEE'S OCCUPATION, USE THESE DEFINITIONS FOR THE FREQUENCY OF OCCURRENCE.**

**OCCASIONALLY** MEANS THE PERSON DOES THE ACTIVITY 1% TO 33% OF THE TIME

**FREQUENTLY** MEANS THE PERSON DOES THE ACTIVITY 34% TO 66% OF THE TIME

**CONTINUOUSLY** MEANS THE PERSON DOES THE ACTIVITY 67% TO 100% OF THE TIME

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<th>OCCASIONALLY</th>
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**RELATE TO OTHERS**

**WRITTEN AND VERBAL COMMUNICATIONS**

**REASONING, MATH AND LANGUAGE**

**MAKE INDEPENDENT JUDGEMENTS**

**WHICH OF THE FOLLOWING DESCRIBE THE EMPLOYEE'S WORKING ENVIRONMENT? CHECK ALL THAT APPLY.**

- □ UNPROTECTED HEIGHTS
- □ CHANGES IN TEMPERATURE OR HUMIDITY
- □ EXPOSURE TO DUST, FUMES, AND GASES
- □ BEING NEAR MOVING MACHINERY
- □ DRIVING AUTOMOTIVE EQUIPMENT
- □ OTHER HAZARDS

**IS THE EMPLOYEE REQUIRED TO TRAVEL?**  □ YES  □ NO

**IF YES, COMPLETE THE FOLLOWING INFORMATION:**

- **HOW DOES THE EMPLOYEE TRAVEL? (AUTOMOBILE, PLANE, ETC.)**
- **WHERE DOES THE EMPLOYEE TRAVEL?**
- **WHAT PERCENT OF THE TIME DOES THE EMPLOYEE TRAVEL?**

### B. INFORMATION ABOUT THE PHYSICAL ASPECT OF THE EMPLOYEE'S OCCUPATION

**CHECK THE ITEMS BELOW THAT RELATE TO THE EMPLOYEE'S OCCUPATION AND COMPLETE THE INFORMATION REQUESTED. USE THESE DEFINITIONS FOR THE FREQUENCY OF OCCURRENCE:**

**OCCASIONALLY** MEANS THE PERSON DOES THE ACTIVITY 1% TO 33% OF THE TIME

**FREQUENTLY** MEANS THE PERSON DOES THE ACTIVITY 34% TO 66% OF THE TIME

**CONTINUOUSLY** MEANS THE PERSON DOES THE ACTIVITY 67% TO 100% OF THE TIME

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>NEVER</th>
<th>OCCASIONALLY</th>
<th>FREQUENTLY</th>
<th>CONTINUOUSLY</th>
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<td>CRAWLING</td>
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<td>REACHING/WORKING OVERHEAD</td>
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<tr>
<td>CLIMBING</td>
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**Describe Activity**

- □ STAIRS Number of Stairs:  ____
- □ LADDER Height of Ladder  ____

**PUSHING. ____ LBS.**

**PULLING. ____ LBS.**

**LIFTING/CARRYING. ____ LBS.**

**CAN THE OCCUPATION BE PERFORMED BY ALTERNATING SITTING AND STANDING?**  □ YES  □ NO

**DOES THE OCCUPATION REQUIRE USING FEET TO OPERATE FOOT CONTROLS?**  □ YES  □ NO  **IF YES, ON WHAT TYPE OF EQUIPMENT.**

**IS GOOD VISUAL ACUITY REQUIRED IN THE OCCUPATION?**

**WHAT ARE THE MAJOR TASKS REQUIRING USE OF ONE OR BOTH HANDS**

<table>
<thead>
<tr>
<th>ONE HAND</th>
<th>BOTH HANDS</th>
</tr>
</thead>
</table>
### C. INFORMATION ABOUT THE OCCUPATION AS IT RELATES TO THE DISABILITY

Can the occupation be modified to accommodate the disability either temporarily or permanently?  
☐ YES ☐ NO  If yes, explain

Is it possible to offer the employee assistance in doing the occupation (through use of technology or personal assistance for example)?  
☐ YES ☐ NO

### D. ATTACHMENTS AND SIGNATURE (ATTACH COPY OF THE EMPLOYEE'S OCCUPATION DESCRIPTION)

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.

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

X

______________________________  __________________________
SIGNATURE  DATE

(     ) __________________________
TELEPHONE  EXT.

(     ) __________________________
FAX

_________________________________________________________________
E-MAIL ADDRESS
# A. INFORMATION ABOUT YOU

1. **LAST NAME**
   - FIRST
   - MIDDLE INITIAL

2. **ADDRESS**
   - CITY
   - STATE/PROVINCE
   - ZIP

3. **TELEPHONE:** AREA CODE
   - (_____)

4. **SOCIAL SECURITY NUMBER**

5. **DATE OF BIRTH** (MONTH, DAY, YR)

6. **HEIGHT**
   - WEIGHT

7. **MALE**
   - **FEMALE**

8. **MARITAL STATUS**
   - **SINGLE**
   - **MARRIED**
   - **DIVORCED**

9. **YOUR EMPLOYER (INCLUDE DIVISION IF APPLICABLE)**

10. **OCCUPATION**

11. **DOMINANT HAND**
    - **RIGHT**
    - **LEFT**

# B. INFORMATION ABOUT YOUR FAMILY

1. **SPOUSE'S NAME** (LAST, FIRST)

2. **DATE OF BIRTH** (MONTH, DAY, YR)

3. **IS YOUR SPOUSE EMPLOYED**
   - **YES**
   - **NO**

4. **DO YOU HAVE ANY CHILDREN UNDER AGE 18?**
   - **YES**
   - **NO**

5. **DO YOU HAVE HANDICAPPED CHILDREN (REGARDLESS OF AGE)?**
   - **YES**
   - **NO**

6. **DO YOU HAVE ANY CHILDREN AGE 18-19, WHO ARE FULL TIME STUDENTS IN ELEMENTARY OR SECONDARY SCHOOLS?**
   - **YES**
   - **NO**

   IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE LIST NAMES.
   - (LAST, FIRST)
   - DATE OF BIRTH

# C. INFORMATION ABOUT THE CONDITION CAUSING YOUR DISABILITY

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. **WHAT WERE YOUR FIRST SYMPTOMS?**

2. **WHEN DID YOU NOTICE THEM?**

3. **DATE YOU WERE FIRST TREATED BY A PHYSICIAN?** (MONTH, DAY, YR)

4. **WHY ARE YOU UNABLE TO WORK?**

5. **BEFORE YOU STOPPED WORKING, DID YOUR CONDITION REQUIRE YOU TO CHANGE YOUR OCCUPATION OR THE WAY YOU DID YOUR OCCUPATION?**
   - **YES**
   - **NO**

6. **HAVE YOU FILED, OR DO YOU INTEND TO FILE A WORKER'S COMPENSATION CLAIM?**
   - **YES**
   - **NO**

FOR AN INJURY, ANSWER THE FOLLOWING QUESTIONS:

7. **WHERE AND HOW DID THE INJURY OCCUR?**

8. **DATE THE INJURY OCCURRED** (MONTH, DAY, YR)

9. **DATE YOU WERE FIRST TREATED FOR THIS INJURY BY A PHYSICIAN** (MONTH, DAY, YR)

# D. INFORMATION ABOUT THE DISABILITY

1. **DATE YOU WERE FIRST UNABLE TO WORK ON A FULL TIME BASIS** (MONTH, DAY, YR)

2. **LAST DAY YOU WORKED BEFORE THE DISABILITY** (MONTH, DAY, YR)

3. **DID YOU WORK A FULL DAY?**
   - **YES**
   - **NO**
   IF NO, EXPLAIN.

4. **HAVE YOU RETURNED TO WORK?**
   - **YES**
   - **NO**
   **PART TIME (DATE)**
   **FULL TIME (DATE)**

5. **IF YOU HAVE NOT RETURNED TO WORK, DO YOU EXPECT TO?**
   - **YES**
   - **NO**
   **PART TIME DATE**
   **FULL TIME DATE**
# DISABILITY CLAIM EMPLOYEE’S STATEMENT

**E. INFORMATION ABOUT PHYSICIANS AND HOSPITALS**

1. **DATE YOU WERE FIRST TREATED FOR THE CURRENT ILLNESS OR INJURY:**

   **LIST ALL MEDICAL PRACTITIONERS CONSULTED FOR THIS CONDITION:**

   **DOCTOR’S NAME**
   - TELEPHONE ( )
   - SPECIALTY:
   - FAX ( )
   - ADDRESS (STREET, CITY, STATE, ZIP)
   - DATES SEEN

   **DOCTOR’S NAME**
   - TELEPHONE ( )
   - SPECIALTY:
   - FAX ( )
   - ADDRESS (STREET, CITY, STATE, ZIP)
   - DATES SEEN

   **PLEASE ATTACH ADDITIONAL INFORMATION ON SEPARATE SHEET IF MORE DOCTORS WERE CONSULTED**

   **HOSPITAL**
   - ADDRESS (STREET, CITY, STATE, ZIP)
   - DATES OF CONFINEMENT FROM __________ TO __________

# F. INFORMATION ABOUT OTHER DISABILITY INCOME

(CHECK THE OTHER INCOME BENEFITS YOU ARE RECEIVING OR ARE ELIGIBLE TO RECEIVE AS A RESULT OF YOUR DISABILITY AND COMPLETE THE INFORMATION REQUESTED)

<table>
<thead>
<tr>
<th>SOURCE OF INCOME</th>
<th>AMOUNT (WK. MONTH)</th>
<th>DATE CLAIM WAS FILLED</th>
<th>DATE PAYMENTS BEGAN</th>
<th>DATE PAYMENTS ENDED</th>
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<td>OTHER (INCLUDE INDIVIDUAL OR GROUP)</td>
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# G. INFORMATION ABOUT INCOME TAX WITHHOLDING

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 may 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 Tax to be Withheld ____________ ($87.00 Minimum per month, whole dollars only)
- State Tax to be Withheld ____________ ($10.00 Minimum per month, whole dollars only)

# H. SIGNATURE (REQUIRED FOR ALL CLAIMS)

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.

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

SIGNATURE __________________________ DATE ____________ E-MAIL ADDRESS __________________________
# I. EMPLOYMENT AND EDUCATION INFORMATION

**PLEASE PRINT ALL INFORMATION**

1. **CLAIMANT’S NAME:**

2. **POLICY NUMBER:**

3. **SOCIAL SECURITY NUMBER:**

**PLEASE COMPLETE THE FOLLOWING INFORMATION AS ACCURATELY AS POSSIBLE. THIS DATA IS NEEDED TO HELP MAKE A THOROUGH EVALUATION OF YOUR CLAIM.**

## EDUCATION/TRAINING

### HIGH SCHOOL:

1. **COURSE OF STUDY:**

2. **HIGHEST GRADE COMPLETED:**

3. **DID YOU OBTAIN YOUR GED IF YOU DID NOT GRADUATE FROM HIGH SCHOOL?**
   
   - [ ] Yes
   - [ ] No

   **IF YES, WHEN?** ____________

   **IF NO, DO YOU PLAN TO?**
   
   - [ ] Yes
   - [ ] No

### COLLEGE:

1. **DID YOU ATTEND COLLEGE?**
   
   - [ ] Yes
   - [ ] No

2. **WHERE?**

3. **COURSE OF STUDY:**

4. **DEGREE?**
   
   - [ ] Yes
   - [ ] No

5. **NUMBER OF YEARS COMPLETED:**

6. **TYPE OF DEGREE:**

### VOCATIONAL TRAINING:

1. **WHERE?**

2. **WHAT TYPE?**

3. **CERTIFICATE OR LICENSE OBTAINED**

4. **WHAT SPECIALIZED TRAINING HAVE YOU HAD INCLUDING EQUIPMENT/MACHINERY USED?**

5. **DO YOU HAVE KNOWLEDGE OR PROFICIENCY WITH PERSONAL COMPUTERS?**
   
   - [ ] Yes
   - [ ] No

6. **IF YES, PLEASE LIST SOFTWARE PROGRAMS YOU HAVE USED:**

   __________________________________________________________________________

   __________________________________________________________________________

   __________________________________________________________________________

   __________________________________________________________________________
# TO BE COMPLETED BY THE EMPLOYEE

## EMPLOYMENT HISTORY

Starting with present employer, please list and describe all occupations you have held in the past 15 years; if more than 1 occupation with any employer, please list each.

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>NAME OF EMPLOYER:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>START DATE:</td>
<td>3.</td>
<td>OCCUPATION TITLE:</td>
</tr>
<tr>
<td>4.</td>
<td>MONTHLY SALARY:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>REASON FOR LEAVING:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>DETAIL YOUR DUTIES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>WHAT WERE THE PHYSICAL/MENTAL REQUIREMENTS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>NAME OF EMPLOYER:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>START DATE:</td>
<td>10.</td>
<td>OCCUPATION TITLE:</td>
</tr>
<tr>
<td>11.</td>
<td>MONTHLY SALARY:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>REASON FOR LEAVING:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>DETAIL YOUR DUTIES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>WHAT WERE THE PHYSICAL/MENTAL REQUIREMENTS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>NAME OF EMPLOYER:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>START DATE:</td>
<td>17.</td>
<td>OCCUPATION TITLE:</td>
</tr>
<tr>
<td>18.</td>
<td>MONTHLY SALARY:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>REASON FOR LEAVING:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>DETAIL YOUR DUTIES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.</td>
<td>WHAT WERE THE PHYSICAL/MENTAL REQUIREMENTS?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

22. WHAT IS YOUR PROJECTED RETURN TO WORK DATE?

23. HAVE YOU CONTACTED YOUR FORMER EMPLOYER?  ☐ YES  ☐ NO

24. HAVE YOU BEEN LOOKING FOR EMPLOYMENT?  ☐ YES  ☐ NO

25. ARE YOU FAMILIAR WITH YOUR LTD POLICY REGARDING RETURN TO WORK INCENTIVES AND REHABILITATION SERVICES?
AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF INSURED: ___________________________________________________

INSURED’S SSN: ___________________________________________________

POLICYHOLDER: ___________________________________________________

To all physicians and other health care professionals, hospitals, other health care institutions, insurers, medical, hospital and prepaid health plans, pharmacies, employers, group policyholders, contract holders, governmental agencies, 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 with information concerning medical care, advice, and/or treatment provided to me, the above named Insured, and/or any employment, salary 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.

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 below. 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: _______________________
  ___________________________________________________________________________________

Reliance Standard Life Insurance Company
P. O. Box 8330, Philadelphia, PA 19101-8330
This form should be completed by the physician who was treating the claimant when he or she last worked.

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

A. GENERAL INFORMATION

<table>
<thead>
<tr>
<th>This claim is for (Patient's Name)</th>
<th>Policy Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth (Month, Day, Year)</td>
<td>Height (Ft., Inches)</td>
</tr>
</tbody>
</table>

Primary Diagnosis including ICD9 code

B. PREGNANCY: PHYSICIAN COMPLETES THIS SECTION FOR NORMAL PREGNANCY

<table>
<thead>
<tr>
<th>1. DATE OF LAST MENSTRUAL PERIOD</th>
<th>2. EXPECTED DATE OF DELIVERY</th>
<th>3. TYPE OF DELIVERY EXPECTED</th>
<th>4 DATE OF DELIVERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. INITIAL VISIT FOR THIS PREGNANCY</td>
<td>6. LAST DATE OF TREATMENT</td>
<td>7. EXPECTED LENGTH OF POSTPARTUM RECOVERY</td>
<td></td>
</tr>
</tbody>
</table>

C: PHYSICIAN COMPLETES THIS SECTION FOR ALL CONDITIONS EXCEPT NORMAL PREGNANCY

1. PRIMARY DIAGNOSIS (INCLUDING ICD-9 CODE):

2. SYMPTOMS (subjective)

3. OBJECTIVE FINDINGS: (Please provide copies of test results and office notes)

4. ARE THERE ANY SECONDARY CONDITIONS CONTRIBUTING TO DISABILITY? IF YES, WHAT ARE THEY? (INCLUDING ICD-9 OR DSMIII R CODE):

5. WHEN DID SYMPTOMS FIRST APPEAR

   MTH     DAY     YR

6. DATE OF PATIENT’S FIRST VISIT

   MTH     DAY     YR

7. DATE OF PATIENT’S LAST VISIT

   MTH     DAY     YR

8. FREQUENCY OF VISITS

9. WAS THE PATIENT REFERRED BY ANOTHER MEDICAL PRACTITIONER?

10. IF SO, FURNISH THE NAME AND ADDRESS.

11. IS THE PATIENT’S CONDITION WORK RELATED? ☐ YES ☐ NO IF YES, EXPLAIN:

12. HAS THE PATIENT UNDERGONE A SURGICAL PROCEDURE? ☐ YES ☐ NO IF NO, SKIP TO 13.

12a. PROCEDURE:

12b. DATE:

12c. FACILITY (NAME/ADDRESS)

13. DO YOU EXPECT SURGERY IN THE NEAR FUTURE? ☐ YES ☐ NO IF NO, SKIP TO 14.

13a. PROCEDURE:

13b. DATE:

13c. FACILITY (NAME/ADDRESS)

14. WHAT PRESCRIBED MEDICATION IS THE PATIENT CURRENTLY TAKING AND WHAT DOSAGE?

15. HAVE YOU REFERRED THE PATIENT FOR OTHER TYPES OF CONSULTATIONS? ☐ YES ☐ NO IF YES, EXPLAIN.

16. HAVE YOU REFERRED THE PATIENT TO A MEDICAL REHABILITATION OR THERAPY PROGRAM? IF YES, PLEASE IDENTIFY:

D. PHYSICIAN COMPLETES FOR ANY HOSPITAL CONFINEMENTS

1. NAME AND ADDRESS OF HOSPITAL:

2. DATE(S) CONFINED FROM/TO IN THE PRIOR 2 YEARS.
TO BE COMPLETED BY THE ATTENDING PHYSICIAN

E. DESCRIPTION OF PATIENT'S RESTRICTIONS AND LIMITATIONS

1) Over the course of an 8 hour day, with 2 breaks and lunch, the patient can alternately:

<table>
<thead>
<tr>
<th>Activity</th>
<th>0-1 Hours</th>
<th>1-3 Hours</th>
<th>3-5 Hours</th>
<th>5-8 Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stand</td>
<td>0</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sit</td>
<td>0</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Walk</td>
<td>0</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Drive</td>
<td>0</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

2) Patient can use upper extremities for repetitive:

<table>
<thead>
<tr>
<th>Area</th>
<th>Right</th>
<th>Left</th>
<th>Right</th>
<th>Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Simple Grasping</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>B. Pushing/Pulling</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>C. Fine Manipulation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

3) Patient is able to:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Continuous</th>
<th>Frequent</th>
<th>Occasional</th>
<th>No Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Bend (at waist)</td>
<td>67-100%</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>C. Squat (at waist)</td>
<td>☐</td>
<td>34-66%</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>D. Climb</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>E. Reach above Shoulder</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>F. Kneel</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>G. Crawl</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>H. Use Feet (foot controls)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I. Drive</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

4) In an 8 hour day patient can lift/carry:

- ☐ 10 lbs. maximum and occasionally carry small objects: SEDENTARY WORK
- ☐ 20 lbs. maximum and frequently lift/carry up to 10 lbs.: LIGHT WORK
- ☐ 50 lbs. maximum and frequently lift/carry up to 25 lbs.: MEDIUM WORK
- ☐ 100 lbs. maximum and frequently lift/carry up to 50 lbs.: HEAVY WORK
- ☐ In excess of 100 lbs. and frequently lift/carry 50 lbs.: VERY HEAVY WORK

F. PHYSICIAN COMPLETES IF LIMITATIONS ARE MENTAL/NERVOUS NATURE

TO WHAT DEGREE, IF ANY, ARE THE FOLLOWING CAPACITIES AFFECTED?

<table>
<thead>
<tr>
<th>Capacity</th>
<th>Not Limited</th>
<th>Moderately Limited</th>
<th>Extremely Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to relate to other people</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Ability to complete and follow instructions</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Ability to perform simple and repetitive tasks</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Ability to perform complex and varied tasks</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

In your opinion, does the claimant possess the mental capacity to understand his/her financial affairs and to direct the use of his/her funds? ☐ Yes ☐ No

G. PHYSICIAN COMPLETES ONLY IF THE CONDITION IS CARDIAC IN NATURE

Functional Capacity

- ☐ Class 1 (no limitation)
- ☐ Class 2 (slight limitation)
- ☐ Class 3 (marked limitation)
- ☐ Class 4 (complete limitation)

H. PHYSICIAN COMPLETES FOR ALL CONDITIONS: PROGNOSIS FOR RECOVERY

1. HAS THE PATIENT ACHIEVED MAXIMUM MEDICAL IMPROVEMENT? ☐ Yes ☐ No

2. IF YES, AS OF WHAT DATE CAN PATIENT RETURN TO WORK? __________/_________/_________

3. IF NO, WHEN DO YOU EXPECT PATIENT WILL ACHIEVE MAXIMUM MEDICAL IMPROVEMENT?

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>0-2 weeks</th>
<th>&lt;4 weeks</th>
<th>&lt;2 months</th>
<th>3-4 months</th>
<th>5-6 months</th>
<th>6-8 months</th>
<th>&lt;12 months</th>
<th>&lt;16 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
<td>☐</td>
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<td>☐</td>
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</tr>
</tbody>
</table>

4. WHEN THE ABOVE CHANGE OCCURS, WHAT FUNCTIONAL CAPACITY WILL THE PATIENT RECEIVE?

- ☐ FULL RECOVERY
- ☐ IMPROVED OVER CURRENT BUT NOT FULL
- ☐ REMAIN AT PRESENT

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Your Name (Please Print) __________________________ Degree __________________________

Specialty __________________________ Telephone: ( )

Fax: ( )

Address (Please Print) __________________________

Physician’s Signature (no stamp) __________________________ Date __________________________

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