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 First Reliance Standard Life Insurance Company, Seven Skyline Drive, Suite 275, Hawthorne, NY 10532. If you have any questions, please call 1-800-559-0954.

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 crimeand subjects such person to criminal and civil penalties.

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SECTION 1
EMPLOYER'S STATEMENT
DISABILITY CLAIM
GROUP LONG TERM DISABILITY
GROUP LIFE-WAIVER OF PREMIUM

7 Skyline Drive Suite 275
Hawthorne, New York 10532-2156

TO BE COMPLETED BY EMPLOYER

THIS CLAIM IS FOR (EMPLOYEE NAME)	SOCIAL SECURITY NUMBER	DATE OF BIRTH

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:

Group Policy Number

☐ 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?

UNDER YOUR PRIOR PLAN?

	LTD	LIFE
	MTH DAY YR	MTH DAY YR
	MTH DAY YR	MTH DAY YR

4. PLEASE IDENTIFY THE CLASS OF THIS EMPLOYEE: (Refer to Policy Schedule of Benefits)

5. DATE TO WHICH PREMIUM IS PAID FOR THIS EMPLOYEE

LTD	LIFE
MTH DAY YR	MTH DAY YR

LIFE BENEFIT IN FORCE

$

6. THE EMPLOYEE IS (CHECK ALL THAT APPLY) PROVIDE COPY OF PAYROLL RECORD AS OF LAST DAY WORKED

☐ HOURLY (RATE:) ☐ UNION ☐ EXEMPT ☐ FULL-TIME ☐ COMMISSIONED

☐ SALARIED ☐ NON-UNION ☐ NON-EXEMPT ☐ PART-TIME ☐ RECEIVES BONUSES

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

8 EFFECTOVE DATE OF CURRENT SALARY OR HOURLY RATE

MTH ____ / DAY ____ / YR ____

9 WILL EMPLOYEE FILE FOR DISABILITY BENEFITS PROVIDED BY ANY EMPLOYER/EMPLOYEE LABOR MANAGEMENT STATE DISABILITY OR UNION WELFARE PLAN? ☐ YES ☐ NO

A. IF YES, WHAT IS THE WEEKLY AMOUNT? _____ B WHAT TYPE OF BENEFIT? _____

C WHEN DO BENEFITS BEGIN? _____ END? _____

10 IS EMPLOYEE CONDITION WORK RELATED? ☐YES ☐ NO

11 HAS CLAIM BEEN FILED WITH WORKER'S COMPENSATION? ☐YES ☐NO
IF YES, SEND INITIAL REPORT OF ILLNESS OR INJURY AWARD NOTICE

12 NAME AND ADDRESS OF YOUR WORKER S COMPENSATION CARRIER: (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 _____%

IF YOU LEAVE THIS SECTION BLANK,WE WILL ASSUME IT IS 100% EMPLOYER CONTRIBUTION AND CALCULATE FICA TAXES ACCORDINGLY

TO BE COMPLETED BY THE EMPLOYER

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 FULLY 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

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?

6 IF THE EMPLOYEE IS PARTICIPATING WHEN IS HE OR SHE ELIGIBLE FOR BENEFITS UNDER THE PLAN? (MONTH/DAY/YEAR)

7 IS THE EMPLOYEE RECEIVING ANY OTHER INCOME RELATED TO THE DISABILITY? ☐ YES ☐ NO
SOURCE AMOUNT PER WEEK/MONTH?

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

3. WHAT IS THE NAME, TITLE AND TELEPHONE NUMBER OF THE INDIVIDUAL WE SHOULD CONTACT IF WE IDENTIFY A REHABILITATION OR RETURN-TO-WORK OPTION?

G. REQUIRED ATTACHMENTS AND SIGNATURE

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 SALARY IS BASED ON W-2, K1, 1099, OR SIMILAR DOCUMENT, ATTACH A COPY OF THE DOCUMENT.

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

NAME/TITLE OF PERSON COMPLETING THIS FORM

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 hereto, 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.

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

X _____ _____
SIGNATURE DATE

_____ ( ) _____
TITLE TELEPHONE

_____ ( ) _____
E-MAIL ADDRESS FAX

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Hawthorne New York 10532-2156

SECTION 2
OCCUPATION ANALYSIS
GROUP LONG TERM DISABILITY
GROUP LIFE-WAIVER OF PREMIUM

TO BE COMPLETED BY THE EMPLOYER

THIS CLAIM IS FOR (EMPLOYEE'S NAME)	SOCIAL SECURITY NUMBER	DATE OF DISABILITY (MONTH, DAY, YEAR)

A. GENERAL INFORMATION ABOUT THE EMPLOYEE'S OCCUPATION

OCCUPATION TITLE	DOT CODE (DICTIONARY OF OCCUPATIONAL TITLES)	MINIMUM EDUCATION OR TRAINING REQUIRED

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 EMLOYEE'S OCCUPATION. USE THESE DEFINITIONS FOR THE FREQUENCY OF OCCURRENCE.

OCCASIONALLY MEANS THE PERSON DOES THE ACTIVIITY 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

	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
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
☐ EXPOSURE TO DUST, FUMES, AND GASES
☐ DRIVING AUTOMOTIVE EQUIPMENT
☐ CHANGES IN TEMPERATURE OR HUMIDTY
☐ BEING NEAR MOVING MACHINERY
☐ 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 DEFINTIONS FOR THE FREQUENCY OF OCCURRENCE:
OCCASIONALLY MEANS THE PERSON DOES THE ACTIVIITY 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

ACTIVITY	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
STANDING	☐	☐	☐	☐
WALKING	☐	☐	☐	☐
SITTING	☐	☐	☐	☐
BALANCING	☐	☐	☐	☐
STOOPING	☐	☐	☐	☐
KNEELING	☐	☐	☐	☐
CROUCHING	☐	☐	☐	☐
CRAWLING	☐	☐	☐	☐
REACHING/WORKING OVERHEAD	☐	☐	☐	☐
CLIMBING	☐	☐	☐	☐
STAIRS Number of Stairs:	☐	☐	☐	☐
LADDER Height of Ladder	☐	☐	☐	☐
Describe Activity				
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	ONE HAND	BOTH HANDS

TO BE COMPLETED BY THE EMPLOYER

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 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 hereto, 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.

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

X _____ SIGNATURE

_____ DATE

( ) _____ TELEPHONE

_____ TITLE

( ) _____ FAX

E-MAIL ADDRESS_____

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SECTION 3
EMPLOYEE'S STATEMENT
DISABILITY CLAIM
GROUP LONG TERM DISABILITY
GROUP LIFE-WAIVER OF PREMIUM

TO BE COMPLETED BY THE EMPLOYEE

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 ☐ WIDOWED ☐ DIVORCED

9. YOUR EMPLOYER (INCLUDE DIVISION IF APPLICABLE)

10. OCCUPATION | 11. DOMINANT HAND RIGHT ☐ LEFT ☐

B. INFORMATION ABOUT YOUR FAMILY

(REQUIRED TO DETERMINE YOUR ELIGIBILITY FOR SOCIAL SECURITY BENEFITS)

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 BE 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

TO BE COMPLETED BY THE EMPLOYEE

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 ( ) FAX ( )	SPECIALTY:
ADDRESS (STREET. CITY, STATE ZIP)		DATES SEEN
DOCTOR'S NAME	TELEPHONE ( ) FAX ( )	SPECIALTY:
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)

SOURCE OF INCOME	AMOUNT (WK MONTH)	DATE CLAIM WAS FILED	DATE PAYMENTS BEGAN	DATE PAYMENTS ENDED
SALARY CONTINUANCE	$_____/_____	_____	_____	_____
SHORT TERM DISABILITY	$_____/_____	_____	_____	_____
STATE DISABILITY	$_____/_____	_____	_____	_____
WORKER'S COMPENSATION	$_____/_____	_____	_____	_____
SOCIAL SECURITY/RETIREMENT	$_____/_____	_____	_____	_____
SOCIAL SECURITY/DISABILITY	$_____/_____	_____	_____	_____
SOCIAL SECURITY FOR DEPENDANTS	$_____/_____	_____	_____	_____
CANADIAN PENSION PLAN	$_____/_____	_____	_____	_____
PENSION/RETIREMENT	$_____/_____	_____	_____	_____
PENSION/DISABILITY	$_____/_____	_____	_____	_____
UNEMPLOYMENT	$_____/_____	_____	_____	_____
NO-FAULT INSURANCE	$_____/_____	_____	_____	_____
JONES ACT	$_____/_____	_____	_____	_____
RAILROAD RETIREMENT	$_____/_____	_____	_____	_____
OTHER (INCLUDE INDIVIDUAL OR GROUP)	$_____/_____	_____	_____	_____

G. INFORMATION ABOUT INCOME TAX WITHOLDING

IF YOUR REQUEST FOR BENEFITS IS APPROVED, SHOULD INCOME TAXES BE WITHHELD FROM YOUR BENEFIT CHECKS? ☐YES ☐ NO

IF YES HOW MUCH SHOULD BE WITHHELD FROM EACH CHECK. FEDERAL TAXES (MINIMUM IS $87.00 PER MONTH) $_____.00

STATE TAXES (MINIMUM IS $10.00 PER MONTH) $_____.00

H. SIGNATURE (REQUIRED FOR ALL CLAIMS)

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 hereto, 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.

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

X _____ _____

SIGNATURE DATE

E-MAIL ADDRESS: _____

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Hawthorne New York 10532-2156

SECTION 4
EMPLOYEE'S STATEMENT

TO BE COMPLETED BY THE EMPLOYEE

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: WHEN?

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.

1. NAME OF EMPLOYER:

2 START DATE:	3 OCCUPATION TITLE:	4. MONTHLY SALARY:

5 REASON FOR LEAVING:

6 DETAIL YOUR DUTIES: _____

_____

_____

7 WHAT WERE THE PHYSICAL/MENTAL REQUIREMENTS? _____

_____

_____

8 NAME OF EMPLOYER:

9 START DATE:	10 OCCUPATION TITLE:	11. MONTHLY SALARY:

12. REASON FOR LEAVING:

13 DETAIL YOUR DUTIES: _____

_____

_____

14. WHAT WERE THE PHYSICAL/MENTAL REQUIREMENTS? _____

_____

_____

15 NAME OF EMPLOYER:

16 START DATE:	17 OCCUPATION TITLE:	18 MONTHLY SALARY:

19. REASON FOR LEAVING:

20 DETAIL YOUR DUTIES: _____

_____

_____

21 WHAT WERE THE PHYSICAL/MENTAL REQUIREMENTS?

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 CLAIMANT: _____

CLAIMANT'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, government agencies, private and/or public benefit plan administrators, and/or attorney representatives:

You are authorized to provide First Reliance Standard Life Insurance Company or any of its agents or representatives information concerning medical care, advise, treatment provided to me, the claimant, and any employment, salary or benefit related information concerning me, the claimant I understand that the disclosure of information may include disclosure of information regarding treatment for mental illness and/or the human immunodeficiency virus (HIV) and/or the use of drugs and alcohol.

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 A copy of this Authorization is as valid and as effective as the original.

_____ _____

Date Claimant's Signature

(If the claimant is unable to sign, then another authorized person may sign.)

_____ _____

Relationship of Authorized Person to Claimant Authorized Person's Signature

FIRST RELIANCE STANDARD
Life Insurance Company
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SECTION 6
PHYSICIAN'S STATEMENT
DISABILITY CLAIM
GROUP LONG TERM DISABILITY
GROUP LIFE-WAIVER OF PREMIUM

7 Skyline Drive, Suite 275
Hawthorne, New York 10532-2156

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

This claim is for (Patient's Name)				Policy Number
Date of Birth (Month Day Year)	Height (Ft . Inches)	Weight (Lbs)	Blood Pressure	Patient's Social Security Number
Primary Diagnosis including ICD9 or DSM code				

B. PREGNANCY: PHYSICIAN COMPLETES THIS SECTION FOR NORMAL PREGNANCY

1 DATE OF LAST MENSTRUAL PERIOD	2 EXPECTED DATE OF DELIVERY	3 TYPE OF DELIVERY EXPECTED	4 DATE OF DELIVERY
5 INITIAL VISIT FOR THIS PREGNANCY	6 LAST DATE OF TREATMENT	7 EXPECTED LENGTH OF POSTPARTUM RECOVERY	

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

1. PRIMARY DIAGNOSIS (INCLUDING ICD-9 OR DSMIII R 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 PATEINT'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:

	None	1-3 Hours	3-5 Hours	5-8 Hours
stand:	☐	☐	☐	☐
sit:	☐	☐	☐	☐
walk:	☐	☐	☐	☐
drive:	☐	☐	☐	☐

2) Patient can use upper extremities for repetitive:

	A Simple Grasping	B Pushing/Pulling	C Fine Manipulation
Right	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Left	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3) Patient is able to:

	CONTINUOUS 67-100%	FREQUENT 34-66%	OCCASIONAL 0-33%	NO RESTRICTIONS
A. Bend (at waist)	☐	☐	☐	☐
B. Squat (at waist)	☐	☐	☐	☐
C Climb	☐	☐	☐	☐
D Reach above Shoulder	☐	☐	☐	☐
E Kneel	☐	☐	☐	☐
F Crawl	☐	☐	☐	☐
G Use Feet (foot controls)	☐	☐	☐	☐
H Drive	☐	☐	☐	☐

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?

CAPACITY	NOT LIMITED	MODERATELY LIMITED	EXTREMELY LIMITED
Ability to relate to other people beyond giving and receiving instructions	☐	☐	☐
Ability to complete and follow instructions	☐	☐	☐
Ability to perform simple and repetitive tasks	☐	☐	☐
Ability to perform complex and varied tasks	☐	☐	☐

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 (American Heart Association)

- ☐ 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? _____/_____/_____ (MTH / DAY / YR)
3. IF NO WHEN DO YOU EXPECT PATIENT WILL ACHIEVE MAXIMUM MEDICAL IMPROVEMENT?
   - ☐ <2 weeks ☐ <4 weeks ☐ <2 months ☐ 3-4 months
   - ☐ 5-6 months ☐ 6-8 months ☐ <12 months ☐ <16 months
4. WHEN THE ABOVE CHANGE OCCURS, WHAT FUNCTIONAL CAPACITY WILL THE PATIENT RECEIVE?
   - ☐ FULL RECOVERY ☐ IMPROVED OVER CURRENT BUT NOT FULL ☐ REMAIN AT PRESENT

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 hereto, 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.

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.