RESET FORM

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies
(the "Company")
Submit at voya.com/claims *(select Upload Documents);*
Phone: 888-238-4840; Fax: 844-449-2553
Voya Life Claims: PO Box 1548, Minneapolis, MN 55440
Overnight Address: 250 Marquette Ave., Suite 900, Minneapolis, MN 55401

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

CLAIM CHECKLIST

- ☐ SIGN and DATE this completed form, then submit using one of the above methods.
- ☐ The Employee / Insured must complete Sections 1 and 2.
- ☐ The Attending Physician must complete Sections 3 - 11. ***** Include copies of patient's most recent office visit notes. *****

SECTION 1. GROUP OR POLICY INFORMATION

Group or Association Name [1] *(If applicable)* _____

Group or Association Policy Number [1] _____ **OR** Insurance Policy Number (s) _____

Claim Number *(if available)* _____

[1] ***Group or Association Name*** *and* ***Group or Association Policy Number*** *apply ONLY if coverage was obtained through an Employer or Association.*

SECTION 2. INSURED/PATIENT INFORMATION

Select, if applicable.: ☐ International / Foreign Address

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

Birth Date _____ SSN _____

Address _____

Address _____

City _____ Province / State _____ ZIP _____

Country _____ Email _____

Phone (_____) _____ International Phone _____

SECTION 3. PRESENT CONDITION

When did symptoms first appear or accident happen? _____

Date you advised patient to cease work because of disability. _____

Has patient ever had the same or similar condition? ☐ Yes ☐ No *(If "yes," provide the date and description.)* _____

Subjective Symptoms _____

Objective Findings *(Provide results of current X-rays, EKGs or any other special tests.)* _____

Patient is: ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

Diagnosis ICD-10 Code(s) _____

SECTION 4. TREATMENT AND PROGRESS *(Include copies of the most recent office visit notes.)*

Date of First Visit _____ Date of Last Visit _____ When did you last examine the patient? _____

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other _____

Describe Patient Progress: ☐ Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed

Order #171893 (e) 05/11/2023

Group Number _____ Policy Number _____

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

SECTION 5. EXTENT OF DISABILITY

Please describe the nature of any medical impairments (i.e., loss of function): _____

_____

Description of corresponding symptoms: _____

_____

Please describe the patient's cognitive and/or physical restrictions and limitations related to their disabling condition: _____

_____

Remarks: _____

_____

SECTION 6. MENTAL CONDITION

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

SECTION 7. 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 8. 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 *(mm/dd/yyyy)* _____

Without Glasses: O.D. _____ O.S. _____ Date *(mm/dd/yyyy)* _____

Date corrected vision was irrecoverably reduced to 20/200 or less in the better eye _____ ☐ O.D. ☐ O.S.

Vision can be restored in whole or in part by:

O.D. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

O.S. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

SECTION 9 PHYSICAL CAPACITIES EVALUATION

Functional Capacity: This is your estimate of your patient's functional capacity based on your knowledge of the patient. This information is important to assess your patient's eligibility for disability benefits.

Patient's ability to: (*Please check*)

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Walk	☐	☐	☐	☐

Patient's ability to perform: (*Please check*)

	Never 0%		Occasionally 1-33%		Frequently 34-66%		Continuously 67-100%	
	R	L	R	L	R	L	R	L
Fine Finger Movements	☐	☐	☐	☐	☐	☐	☐	☐
Hand/eye coordinated movements	☐	☐	☐	☐	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐	☐	☐	☐	☐

Dominant Hand ☐ Right ☐ Left

Patient's ability to: (*Please check*)

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Climb	☐	☐	☐	☐
Twist/bend/stoop	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Operate heavy machinery	☐	☐	☐	☐

Patient's ability to lift/carry: (*Please check*)

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Up to 10 lbs.	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐
21 to 50 lbs.	☐	☐	☐	☐
51 to 100 lbs.	☐	☐	☐	☐

SECTION 10. REMARKS

Group Number _____ Policy Number _____

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

SECTION 11. 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.