RESET FORM

ATTENDING PHYSICIAN'S STATEMENT OF IMPAIRMENT AND FUNCTION

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, New York, 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 - 14.

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 _____

SECTION 3. DIAGNOSIS AND TREATMENT INFORMATION

Height _____ ft. _____ in. Weight _____ lbs. Blood Pressure _____ Date of Reading _____

Primary Diagnosis _____

List All Additional Diagnoses in Order of Severity _____

Subjective Symptoms _____

Objective Findings Supported by Testing _____

Diagnostic Tests Performed *(Include dates and results.)* _____

Procedure(s) _____

Date you first saw the patient for this condition. _____

Date you advised the patient to cease working due to this condition. _____

Date you last saw the patient for this condition. _____

Is this condition due to an accident? . . . ☐ Yes ☐ No

If "yes," was the accident work related? . . . ☐ Yes ☐ No

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

Has the patient been hospitalized for this condition? . . . ☐ Yes ☐ No

If "yes," When *(from, to)*? _____ Where? _____

Group Policy Number _____

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

SECTION 4. CURRENT PLAN OF TREATMENT

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other _____

Medications *(Include name and dosage.)* _____

Therapy Prescribed: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Frequency of Therapy _____

Is the patient compliant with therapy? ☐ Yes ☐ No Tolerance to therapy: ☐ Good ☐ Poor

SECTION 5. PROGRESS

Has patient: ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?

Is patient: ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?

If "Hospital confined," provide Name and Address of hospital. _____

_____

Dates Confined *(from)* _____ *(through)* _____

SECTION 6. FOR PREGNANCY DISABILITY ONLY

Are there any present complications or anticipated difficulties in connection with:

(a) Pregnancy: ☐ Yes ☐ No Date of last menstrual period _____ Expected date of delivery _____

(b) Delivery: ☐ Yes ☐ No Actual date of delivery _____ Type of Delivery: ☐ Vaginal ☐ C-Section

(c) Post Partum: ☐ Yes ☐ No

If "yes," to any of these, specify in detail. _____

SECTION 7. COMPETENCY

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

SECTION 8. PHYSICIAN REFERRAL INFORMATION

Have you referred this patient to another Physician? . . . . . ☐ Yes ☐ No

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

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

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

SECTION 9. PHYSICAL CAPACITIES EVALUATION

In an 8 hour day, what is the maximum number of hours your patient could perform each of these levels of activity? *(Indicate appropriate number of hours.):*

_____ Hours Sedentary Activity *(10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours.)*

_____ Hours Light Activity *(20 lbs. maximum lifting, carrying 10 lbs. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours.)*

_____ Hours Medium Activity *(50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing.)*

_____ Hours Heavy Activity *(100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking/standing.)*

Patient is able to:	Occasionally 0% to 33%	Frequently 33% to 66%	Continuously 66% to 100%
Bend	☐	☐	☐
Climb	☐	☐	☐
Reach	☐	☐	☐
Kneel	☐	☐	☐
Squat	☐	☐	☐
Crawl	☐	☐	☐
Push/Pull	Number of lbs. _____	Number of lbs. _____	Number of lbs. _____
Lift	Number of lbs. _____	Number of lbs. _____	Number of lbs. _____

What is this assessment based on? ☐ Observed Activity ☐ Measured Capacity ☐ Physical Therapy Report

Group Policy Number _____

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

SECTION 9. PHYSICAL CAPACITIES EVALUATION *(Continued)*

List current restrictions (activities which **should not** be performed) and limitations (activities which **can not** be performed) from activities not addressed above (i.e. driving, working at heights, etc.) Be specific.

_____

_____

Upper Extremity Function - Indicate upper extremity functional capabilities:	Left	Right	Comments
Simply Grasping	☐	☐	
Pinching	☐	☐	
Fine Manipulation	☐	☐	
Power Grip	☐	☐	
Repetitive Motion	☐	☐	

SECTION 10. MENTAL HEALTH ABILITY *(If applicable.)*

What behavior, attitudes or functional impairments are contributing to any restrictions and/or limitations related to a mental health condition?

_____

_____

SECTION 11. CARDIAC FUNCTIONAL CAPACITY *(If applicable.)*

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

SECTION 12. ESTIMATED RETURN TO WORK INFORMATION

Estimated Return to Work Date _____ Status: ☐ Full-Time ☐ Part-Time Number of Hours Per Week _____

☐ With NO Physical Limitations ☐ With Physical Limitations Describe Limitations _____

Has this patient reached Maximum Medical Improvement (MMI)? . . . . . ☐ Yes ☐ No

If "no," anticipated date of MMI? _____

SECTION 13. REMARKS

SECTION 14. 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

Alabama, Alaska, 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.