

LONG TERM DISABILITY

Claim Notice Employer's Statement

ING Employee Benefits
 P.O. Box 1290 • Minneapolis, MN 55440-1290
 800-328-4090



ReliaStar Life Insurance Company of New York
 (outside NY)
 ReliaStar Life Insurance Company
 Members of the ING family of companies

To be completed by the Benefits Representative:

Plan number		Contract division/location			Employee's name	
Social Security Number		Employee's home address		City	State	ZIP
Date of birth	Sex	<input type="checkbox"/> Married <input type="checkbox"/> Single	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Hire Date	Occupation	
Cause of disability					Effective date of LTD coverage	
Date last worked	Date disability began	Is disability work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes has Workers' Compensation been paid? <input type="checkbox"/> Yes <input type="checkbox"/> No			Has Employee been laid off? (If so, when?)	
Has employment been terminated? (If so, why?) Give date.						
List prior periods of disability in the last two years:						
Has employee returned to work before submission of this claim? <input type="checkbox"/> Yes (Give date.) <input type="checkbox"/> No				How many hours per week did the employee normally work?		

Attach copy of participant's signed enrollment card.

Is participant eligible for:	Yes	No
Unemployment compensation disability?	<input type="checkbox"/>	<input type="checkbox"/>
Sick Pay?	<input type="checkbox"/>	<input type="checkbox"/>
Salary continuance benefits?	<input type="checkbox"/>	<input type="checkbox"/>
Social security benefits?	<input type="checkbox"/>	<input type="checkbox"/>
Retirement income-current or past employers?	<input type="checkbox"/>	<input type="checkbox"/>
Auto no-fault?	<input type="checkbox"/>	<input type="checkbox"/>
Other?	<input type="checkbox"/>	<input type="checkbox"/>
Workers' Compensation benefits?	<input type="checkbox"/>	<input type="checkbox"/>
Include Work Compensation carrier information _____		

Date benefit terminates	Amount	Paid weekly	Paid monthly

Please check appropriate box and complete spaces:

<input type="checkbox"/> Basic monthly earnings	Monthly rate	\$ _____	Length of contract _____
<input type="checkbox"/> Basic yearly earnings	Annual rate	\$ _____	
<input type="checkbox"/> Basic contract earnings	Contract amount	\$ _____	
<input type="checkbox"/> Basic weekly earnings	Weekly rate	\$ _____	
<input type="checkbox"/> Basic hourly earnings	Hourly rate	\$ _____	
<input type="checkbox"/> Commissions (Please attach list of commissions paid for each of last 12 months.)			

Date of last increase	Earnings prior to increase \$ _____ per
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Please complete the attached Occupational Demands form for description of employee job duties.

Was employee late enrollee? Yes No
 Is there a layoff planned at employee's division/location? Yes No

Certification

The undersigned certifies that the above statements as to the participants are correct as reported on its records.

 Name Title

 Address Phone number Date



Fraud Warnings

Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, New Mexico, Ohio, Oklahoma, Oregon, 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 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 insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

Kentucky: Any person who knowingly and 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.

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.

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.

LONG TERM DISABILITY

Occupational Demands

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This form should be completed by the employee's immediate supervisor (who may request assistance from the employee) or by another individual possessing comprehensive knowledge regarding the occupational demands of the employee's job. This form is then submitted to the treating physician for review in completing the Attending Physician's Statement. Both forms are returned to the employer.

Plan number	Employee's name	Job title
Job Location		

Please attach a copy of the employee's job description and complete the following:

PHYSICAL DEMANDS

Indicate the number of times per day the listed activity is performed:

	Lifting*	Carrying**
1-5 pounds	_____	_____
6-10 pounds	_____	_____
11-25 pounds	_____	_____
26-50 pounds	_____	_____
51-100 pounds	_____	_____
100 pounds or more	_____	_____

*Includes pushing and pulling effort while stationary

**Includes pushing and pulling effort while walking

What are the average hours per day worked on this job? _____

What are the average days per week worked on this job? _____

Is overtime required? Yes No If yes, how often? _____ hours/day; _____ days/week

Indicate percent of day each activity is performed:

Sitting _____ %	Inside work _____ %	Working with others _____ %
Standing _____ %	Outside work _____ %	Working around others _____ %
Walking _____ %		Working alone _____ %

Indicate extent of performance of each of the following:

	Often	Significant	Seldom	Never
Ascending and descending stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ascending and descending ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching below shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Occupational requirements:

- Far vision
- Near vision
- Hearing
- Talking
- Depth perception
- Other (Explain _____)

Employee's Name _____

EMOTIONAL STRESS

Does the employee have to answer to customer complaints?

- Often
- Sometimes
- Not at all

The employee is expected to perform the job at a normal, somewhat leisurely, pace . . .

- Most of the time
- Some of the time
- Occasionally
- ____% of the time

The employee is expected to perform the job at a rapid pace . . .

- Most of the time
- Some of the time
- Occasionally
- ____% of the time

Must this employee depend upon the assistance of others in order to accomplish his/her daily tasks? Yes No
If so, how often?

- Most of the time
- Occasionally
- ____% of the time

And how closely must the employee work with his/her fellow workers?

- Very closely
- Significant contact
- Minor contact

How many employees does this employee supervise? _____

Is this employee routinely subject to close supervision? Yes No

Does the employee's job consist primarily of prescheduled activities, or of tasks that arise randomly during the day?

- Primarily prescheduled
- Primarily random

What percentage of the employee's time is spent meeting deadlines set by others? _____%

How much responsibility does the employee have for the overall performance of his/her particular department:

- 100 percent
- Great deal
- Significant
- Minor

In your opinion, what degree of emotional stress is this employee subject to during the performance of his/her job?

- Great
- Significant
- Some
- Very little

The above questions, both those involving physical demands and those involving emotional stress, require primarily objective answers. Your subjective and/or supplementary comments would also be appreciated.

Completed by	Title	Phone
Address		Date

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To be completed by the employee and returned to the employer.

Plan number		Division/location			
Employee's name			Social Security Number		Employee's phone ()
Date of birth	Sex	<input type="checkbox"/> Married <input type="checkbox"/> Divorced	Dependent Children and birthdate(s)		Employee's home address
		<input type="checkbox"/> Single <input type="checkbox"/> Widowed			
Cause of disability			Date employed		Occupation
Has employment been terminated? (If so, why?) Give date.				Date last worked	Date disability began

On what date did you first see a physician for this sickness or injury? _____

Name of treating physician		Address			
If hospitalized for this sickness or injury, give name and address of hospital				Date admitted	Date Released

Are you bed confined? Yes No Are you house confined? Yes No
Have you ever had the same kind of sickness or injury before? Yes No
If yes, give date and physician's name and address: _____

If disability resulted from accident or sickness, answer these questions:

On what date were you first able to leave your home for any purpose? _____
On what date were you first able to do any part of your work, supervisory or otherwise? _____

If disability resulted from sickness only, answer this question:

When did you first note symptoms? _____
Have you had any medical or surgical advice during the past five years for any other condition? Yes No
For what? _____
When? _____ Physician's name and address: _____

If disability resulted from accident only, answer these questions:

Where did accident occur? _____ Date of accident? _____
What time? _____ Was accident work-related? Yes No

What was your basic weekly or monthly salary or wage (excluding any commissions, overtime, bonus, etc.) immediately prior to your stopping work because of your disability? _____
State the amount of your weekly or monthly salary or wage (including overtime, bonus, etc.) that your employer is paying while disabled. _____ How long is this amount payable? _____

Are you eligible for or receiving:

- Workers' compensation benefits?
- Unemployment compensation disability?
- Sick pay?
- Salary continuance benefits?
- Social Security benefits?
- Retirement income (current or past employers)?
- Other?

Date benefit began	Date benefit terminates	Amount	Paid weekly	Paid monthly
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

Have you returned to work? No Yes On what date? _____

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse the insurance company to the extent of any overpayment which is in excess of the amounts payable under this group plan.

Date
35366k

Employee's Signature
Page 1 of 4

E-Ship: 115165 6/20/2007

Employee's Name _____

Education

Last year completed	Name of school	
Last year in school	Degree/certificate	Additional training
Attitude towards school <input type="checkbox"/> Like <input type="checkbox"/> Dislike	Favorable courses	

Military service

Branch	Dates From: _____ To: _____	Discharge <input type="checkbox"/> Honorable <input type="checkbox"/> General <input type="checkbox"/> Other _____
Rank	Special training	
Duties/responsibilities		
Service connected disabilities		

Vocational history

List most recent first.

1.

Employer	Supervisor	
Job title(s)		
Dates From: _____ To: _____	Salary	Duties
Union		Representative

2.

Employer	Supervisor	
Job title(s)		
Dates From: _____ To: _____	Salary	Duties
Union		Representative

3.

Employer	Supervisor	
Job title(s)		
Dates From: _____ To: _____	Salary	Duties
Union		Representative

4.

Employer	Supervisor	
Job title(s)		
Dates From: _____ To: _____	Salary	Duties
Union		Representative

Please return this authorization with your claim.

**Authorization to Release Information to
ReliaStar Life Insurance Company**

Employee's name	Plan number
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For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, Inc. (MIB), Social Security Administration or employer to give ReliaStar Life Insurance Company (ReliaStar Life) or its agents, employees and authorized representatives acting on its behalf (including ChoicePoint or any consumer reporting agency), ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or non-medical information regarding Social Security benefits or earnings information and other employment-related information, as they apply to me. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life and its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I or my authorized representative have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This authorization will be valid for the duration of my claim for benefits. I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice and Insurance Information Practices Notice.

Employee's signature	Date
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Authorization for Release of Health-Related Information to:

- ING USA Annuity and Life Insurance Company ReliaStar Life Insurance Company of New York
 Midwestern United Life Insurance Company Security Life of Denver Insurance Company
 ReliaStar Life Insurance Company

This authorization complies with the HIPAA Privacy Rule

Name of Patient (please print)

Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to Patient or on Patient's behalf within the past 10 years ("Providers") to disclose Patient's entire medical record and any other protected health information concerning Patient to "THE COMPANY" and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict Patient's protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose Patient's entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that "THE COMPANY" may: 1) underwrite Patient's application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage Patient has or has applied for with "THE COMPANY."

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to "THE COMPANY" at 20 Washington Avenue South, Minneapolis, MN 55401, Attention: Privacy Official. I understand that a revocation is not effective to the extent that any Providers have relied on this Authorization or to the extent that "THE COMPANY" has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the signing of this authorization is not a condition for obtaining treatment or payment for services. I further understand that if I refuse to sign this authorization to release Patient's complete medical record, "THE COMPANY" may not be able to process Patient's application, or if coverage has been issued may not be able to make a claim determination. I acknowledge that I have received a copy of this authorization.

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient

ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York Consumer Privacy Notice and Insurance Information Practices Notice

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your application or claim form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from the Medical Information Bureau (MIB). See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request called an Amendment.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc. (Medical Information Bureau)

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112. MIB's phone number is (617) 426-3660. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Attending Physician's Statement of Impairment and Function

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

Patient Name (Please print)		Claim #	Group #	
Date of Birth / /		Sex	Social Security Number	
Patient's Full Home Address (P.O. Box Number or Street, City, State, ZIP)				

DIAGNOSIS and TREATMENT INFORMATION

Primary Diagnosis	List All Additional Diagnoses in Order of Severity 1. 2. 3.		
Subjective Symptoms	Objective Findings Supported by Testing		
Diagnostic Tests Performed (include dates and results)			
Procedure(s)			
Date you first saw your patient for this condition.	Date you advised your patient to cease working due to this condition.	Date you last saw your patient for this condition.	
Is this condition due to an accident? If yes, is it work-related?	Has your patient ever had the same or similar condition?	Has your patient been hospitalized for this condition? If yes, when? From: To: Where?	

CURRENT PLAN of TREATMENT

Frequency of current visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other Specify: _____	Medications (include name and dosage):
Therapy Prescribed: <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy Frequency: _____	
Is patient compliant with therapy? Yes <input type="checkbox"/> No <input type="checkbox"/>	Tolerance to therapy: Good <input type="checkbox"/> Poor <input type="checkbox"/>

COMPETENCY

Do you believe that this patient is competent to endorse checks and direct the use of proceeds thereof? Yes No

PHYSICIAN REFERRAL INFORMATION

Have you referred this patient to another Physician? Yes No If yes, please provide the name and address of that Physician:

Did another Physician refer this patient to you? Yes No If yes, please provide the name and address of that Physician:

SUSTAINED TOLERANCE TO:

(Please circle appropriate section.)

Indicate what accommodations would increase tolerance to any of these sections:	Sit	None	< 1 Hour	1-2 Hours	3-4 Hours	5-6 Hours	7-8 Hours
	Stand	None	< 1 Hour	1-2 Hours	3-4 Hours	5-6 Hours	7-8 Hours
	Walk	None	< 1 Hour	1-2 Hours	3-4 Hours	5-6 Hours	7-8 Hours

Patient's Name: _____

PATIENT CAN LIFT/CARRY: (Please check appropriate box for each weight range.)

Maximum Pounds	Less Than 10 Pounds	10-19 Pounds	20-49 Pounds	50-99 Pounds	100 or More Pounds
Never					
Occasionally (0-2.5 hrs/day)					
Frequently (2.5-5.5 hrs/day)					
Continuously (5.5+ hrs/day)					

PATIENT CAN USE UPPER EXTREMITIES FOR REPETITIVE TASKS:

	Simple Grasping		Pushing / Pulling		Fine Manipulation	
Right Hand	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Left Hand	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Both Hands	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

PATIENT CAN USE LOWER EXTREMITIES FOR REPETITIVE MOVEMENTS: (ie. Foot Controls)

Both Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Right Foot	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Left Foot	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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PATIENT IS ABLE TO: (Please check appropriate column.)

	Climb	Balance	Stoop	Kneel	Crouch	Crawl	Reach (above shoulders)	Handle	Finger	Feel
Not At All										
Occasionally (0-2.5 hrs/day)										
Frequently (2.5-5.5 hrs/day)										
Continuously (5.5+ hrs/day)										

CARDIAC FUNCTIONAL CAPACITY: (if applicable) American Heart Association

Class 1 <input type="checkbox"/> (No Limitation)		Class 2 <input type="checkbox"/> (Slight Limitation)		Class 3 <input type="checkbox"/> (Marked Limitation)		Class 4 <input type="checkbox"/> (Complete Limitation)	
Height	ft. in.	Weight	lbs.	Blood Pressure		Date of Reading	

ESTIMATED RETURN TO WORK INFORMATION:

Part Time Date: _____ # of hours per week: _____ With These Physical Limitations:	Full Time Date: _____ With These Physical Limitations:
NO Physical Limitations: Part Time Date: _____ # of Hours Per Week: _____	NO Physical Limitations: Full Time Date: _____
Has this patient reached Maximum Medical Improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, anticipated date of MMI: _____ Additional Comments:	

PHYSICIAN INFORMATION:

Attending Physician Name: (please print)	Board Certification:	
Mailing Address:	Phone:	Fax:
City:	State:	ZIP:

Physician's Signature: _____ Specialty: _____ Date: _____



Fraud Warnings

Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, New Mexico, Ohio, Oklahoma, Oregon, 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 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 insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

Kentucky: Any person who knowingly and 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.

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.

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.