

# 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")



Voya Life Claims: PO Box 1548, Minneapolis, MN 55440  
Voya Life Claims Overnight Mailing Address: 20 Washington Ave. South, Minneapolis MN 55401  
Phone: 888-238-4840; Fax: 855-653-5339; Submit at [voya.com](http://voya.com) (select Contact & Services > Claims Center > Upload a Claim)

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 <sup>1</sup> (if applicable) \_\_\_\_\_  
Group or Association Policy Number <sup>1</sup> \_\_\_\_\_ OR Insurance Policy Number (s) \_\_\_\_\_  
Claim Number (if available) \_\_\_\_\_

<sup>1</sup> 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

Patient Name (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last) \_\_\_\_\_  
Birth Date \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ SSN \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

## 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

## SECTION 5. EXTENT OF DISABILITY

Is patient totally disabled FOR ALL OCCUPATIONS? . . . . .  Yes  No

Is patient totally disabled FOR PATIENT'S REGULAR OCCUPATION? . . . . .  Yes  No

If "no," when was patient able to resume work? \_\_\_\_\_

If "yes," is patient a suitable candidate for a rehabilitation program? . . . . .  Yes  No

If "yes," when do you think patient will be able to resume work? \_\_\_\_\_

Approximate Date \_\_\_\_\_  Indefinite Date \_\_\_\_\_  Never

Group Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Patient Name (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ (Last) \_\_\_\_\_

**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 irreversibly 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**

Can patient work full-time? . . . . .  Yes  No

Can patient work part-time? (If "yes," how many hours per day \_\_\_\_\_, and how many days per week \_\_\_\_\_) . . . . .  Yes  No

In a work day, patient can stand/walk:

(Hours at one time)

0-2  2-4  4-6  6-8  8-10

(TOTAL hours during day)

0-2  2-4  4-6  6-8  8-10

In a work day, patient can sit:

(Hours at one time)

0-2  2-4  4-6  6-8  8-10

(TOTAL hours during day)

0-2  2-4  4-6  6-8  8-10

Can patient lift/carry?  Up to 10 pounds  11-20 pounds  21-50 pounds  51-100 pounds

Use of hands for repetitive action:

Manual dexterity (hold, grasp, turn):  Right  Left

Finger dexterity (pinch, pick, use keyboard):  Right  Left

Dominant Hand:  Right  Left

Do you believe these physical capacities to be permanent? . . . . .  Yes  No

**SECTION 10. REMARKS**

**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 (Please print.) \_\_\_\_\_ Degree \_\_\_\_\_

TIN \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

 Attending Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

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## 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 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.