Waiver of Premium Disability Claim

Complete and sign the Employer's Statement. The Insured's Statement must be completed by the Insured. The Attending Physician's Statemen must be completed by the Insured's attending physician. The completed forms, along with a copy of the Insured's enrollment form, must be sen to: ING Employee Benefits, P.O. Box 1548, Minneapolis, Minnesota 55440.

Employer's Statement

Insured employee's full name	Date of birth	Marital status ☐ Married ☐ Divorced ☐ Never married ☐ Widow(er)	
Residence *(number, street, city, state, zip code)*	Telephone #	Sex ☐ Male ☐ Female	Social Security number
Policyholder's name	Group policy number	Account number	Job title

Amount of employee's insurance	Effective date of coverage	Date First entered our employment	Date last worked
Basic $________	________	Salary $________ per ☐ hour ☐ week ☐ month ☐ year	
Optional $________	________	Status ☐ Full time ☐ Part time	☐ Union ☐ Nonunion
Supplemental $________	________	If part time, average hours per week ______	Date of last salary change
Other $________	________		

Employer Certification

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

Name of employer	Date *(month, day, year)*
Employer's address (number, street, city, state, zip code)	Telephone number
Authorized signature	Print Name and Title

Insured's Statement

Describe condition or illness

Name and address of attending physician(s): Use reverse side of form to provide additional information.

Doctor	Complete Address	Cause	Date

Date you last worked preceding claim________

Date you became totally disabled ________

Are you receiving any other disability benefits? ________

If yes, what type? ________

Are you house confined?________

Are you bed confined? ________

Are you receiving any wages or salary? ________

If yes, what type? ________

Have you returned to work? ________

If yes, what date? ________

Do you expect to return to work? ________

If yes, what date? ________

EDUCATIONAL BACKGROUND: *(Please circle grade completed.)*

1 2 3 4 5 6 7 8 9 10 11 12 GED

College: 1 2 3 4 AA / AS / BA / BS / MA / Ph.D / Other: ________

I hereby certify that the above statements are complete and accurate to the best of my knowledge.

I hereby authorize any physician who has attended me or any hospital where I have been a patient to release to ING Employee Benefits, Minneapolis, Minnesota, or its authorized representative, all information regarding my medical history or treatment. A reproduction of this authorization is as valid as the original.

Signature	Date

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 may be guilty of a criminal act punishable under law.

Use this side if you wish to provide us with additional information.

Name and address of attending physician(s)

Doctor	Complete Address	Cause	Date

Describe condition or illness

042857d-2

Attending Physician's Statement of Disability

RELIASTAR
ReliaStar Life Insurance Company
P.O. Box 1548, Minneapolis, MN 55440-1548

Name of patient *(print)*	Date of birth	Group number
Present address *(number, street, city, state or province, zip code)*		
Group insurance *(give name of policyholder, i.e. employer, union or association through whom insured)*		

The patient is responsible for the completion of this form without expense to the Company. Space is available on the reverse side if you wish to amplify your answers.

1. History

a. When did symptoms first appear or accident happen? *(mo., day, yr.)*	b. Date patient ceased work because of disability *(mo., day, yr.)*
c. Has patient ever had same or similar condition? *(If "yes," state when and describe.)* ❒ Yes ❒ No	

2. Present Condition

a. Subjective symptoms

b. Objective findings *(include results of current X-rays, E.K.G.'s or any other special tests)*

c. Is patient . . .
❒ Ambulatory? ❒ Bed confined? ❒ House confined? ❒ Hospital confined?

3. Diagnosis

4. Treatment

a. Date of first visit *(mo., day, yr.)*	b. Date of last visit *(mo., day, yr.)*
c. Frequency of visits ❒ Weekly ❒ Monthly ❒ Other ____________	d. When did you last examine the patient? *(mo., day, yr.)*

5. Progress

❒ Recovered ❒ Improved ❒ Unimproved ❒ Retrogressed

6. Extent of Disability

a. Is patient totally disabled . . . FOR ANY OCCUPATION? ❒ Yes ❒ No	FOR PATIENT'S REGULAR OCCUPATION? ❒ Yes ❒ No
b. If no, when was patient able to go to work? *(mo., day, yr.)*	c. If yes, when do you think patient will be able to resume work? ❒ Approximate date *(mo., day, yr.)* ____________ ❒ Indefinite date *(mo., day, yr.)* ____________ ❒ Never
d. If yes, is patient a suitable candidate for a rehabilitation program? ❒ Yes ❒ No	

7. Mental Condition

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

Complete appropriate section, IF disability is due to CARDIAC CONDITION or VISUAL IMPAIRMENT.

8. Cardiac

a. Functional capacity *(American Heart Ass'n.)*	b. Blood pressure
☐ Class 1 *(No limit)* ☐ Class 3 *(Marked limitation)* ☐ Class 2 *(Slight limitation)* ☐ Class 4 *(Complete limitation)*	

9. Visual Impairment

a. What was vision at last observation? *(Snellen Notation)*

With glasses O.D. __________ O.S. __________ Mo. __________ Day ________ 19______

Without glasses O.D. __________ O.S. __________ Mo. __________ Day ________ 19______

b. Date *corrected* vision was irrecoverable reduced to 20/200 or less in the better eye *(mo., day, yr.)*

☐ O.D. ☐ O.S.

c. Vision can be restored in whole or in part by:

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

REMARKS:

COMPLETED BY:

Signature *(Attending physician)*	Degree	Date
Attending physician's name *(Please print)*	Address	
Tax I.D. #	Phone # ( )	