

**IMPORTANT INFORMATION REGARDING APPLICATION FOR GROUP INTEGRATED  
DISABILITY BENEFITS**

**PLEASE READ THESE INSTRUCTIONS BEFORE COMPLETING THE ATTACHED FORMS**

This is a multi-purpose form that requires completion in full by all parties concerned. This information *must be provided immediately following the employee's last day worked*. In order to allow sufficient processing time, each responsible party should complete their section as soon as possible. The entire claim forms should be sent immediately upon completion to: Reliance Standard Life Insurance Company, P.O. Box 7749, Philadelphia, PA 19101-7749. If you have any questions, please call our Customer Service Department at 1-800-351-7500.

**THE EMPLOYER IS RESPONSIBLE FOR COMPLETING THE FOLLOWING SECTIONS:**

Section 2           Employer's Statement  
Section 3           Job Description and Requirements

**THE EMPLOYEE IS RESPONSIBLE FOR COMPLETING THE FOLLOWING SECTIONS:**

Section 1           Employee's Statement  
Section 4           Sign and Date the Authorization for Use in Obtaining Information

**THE ATTENDING PHYSICIAN IS RESPONSIBLE FOR COMPLETING THE FOLLOWING:**

Section 5           Physician's Statement

**Please be sure that all responsible parties completing and filing a claim for benefits are aware of the following statements which concern claim fraud and abuse:**

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 fines and confinement in prison.

**State of California**

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in prison.

**State of New Jersey**

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**State of New York**

Any person who knowingly and with intent to defraud any insurance company or other person, file sand 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 such violation.

**State of Oregon**

Any person who, with an intent to knowingly 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, may be subject to prosecution for insurance fraud.

**State of 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.

# RELIANCE STANDARD

Life Insurance Company

a DELPHI company

Integrated Disability Benefits  
Initial Statement of Claim  
Group Life Waiver of Premium

|   |   |  |  |
|---|---|--|--|
| <b>Section 1 – To be completed by Claimant (Please print or type)</b>   |   |  |  |
| Name  |   | Social Security Number   | Date of Birth  |
| Street Address  |   | City   | State  |
| Home Phone<br>( )   |   | E-mail Address   |  |
| Sex<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female   | Type of Disability<br><input type="checkbox"/> Accident <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy |  | Date of Accident   |
| Dominant Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left   |   | Date first unable to work  |  |
| Spouse's Name (Last, First)   |   |  |  |
| Spouse's Date of Birth (Month, Day, Year)   |   | Is your Spouse Employed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Child's Name (Last, First)  | Date of Birth (M/D/Y)   | Is Child Handicapped?<br><input type="checkbox"/> Yes <input type="checkbox"/> No    | Is Child a Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, where? _____ |
| Child's Name (Last, First)  | Date of Birth (M/D/Y)   | Is Child Handicapped?<br><input type="checkbox"/> Yes <input type="checkbox"/> No    | Is Child a Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, where? _____ |
| Child's Name (Last, First)  | Date of Birth (M/D/Y)   | Is Child Handicapped?<br><input type="checkbox"/> Yes <input type="checkbox"/> No    | Is Child a Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, where? _____ |
| Child's Name (Last, First)  | Date of Birth (M/D/Y)   | Is Child Handicapped?<br><input type="checkbox"/> Yes <input type="checkbox"/> No    | Is Child a Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, where? _____ |
| Describe how and where accident occurred or list symptoms of illness and diagnosis.   |   |  |  |
| Name and Address of Primary Physician   |   |  |  |
| Name and Address of other Physician(s) or other medical provider(s) (attach additional sheets if necessary)   |   |  |  |
| Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No      If "Yes," on what date: _____ Part-time _____ Full-time  |   |  |  |
| If you have not returned to work, on what date do you expect to return to work: _____ Part-time _____ Full-time   |   |  |  |
| Check if you are receiving or are entitled to receive benefits from any of the following sources:   |   |  |  |
| <input type="checkbox"/> Salary, Wages or Commissions   | <input type="checkbox"/> Social Security Disability   |  |  |
| <input type="checkbox"/> State Disability   | <input type="checkbox"/> Social Security Retirement   |  |  |
| <input type="checkbox"/> Worker's Compensation  | <input type="checkbox"/> Railroad Retirement Act  |  |  |
| <input type="checkbox"/> Retirement or Pension Plan   | <input type="checkbox"/> Other Sources  |  |  |
| <b>For each source indicated, please provide the following information as well as copies of applications and any award or denial notices:</b>   |   |  |  |
| Source  | Amount  | Frequency  | Date Application Filed   |
|   |   |  | Benefit Effective Date   |
|   |   |  |  |
|   |   |  |  |
| <b>Computer Usage Information</b>   |   |  |  |
| Do you use a computer at home? <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |
| If yes, check all uses that apply: <input type="checkbox"/> Word Processing <input type="checkbox"/> Spreadsheets <input type="checkbox"/> Data-entry <input type="checkbox"/> E-mail <input type="checkbox"/> Internet |   |  |  |
| <input type="checkbox"/> Other (specify): _____   |   |  |  |

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We are required to withhold federal income tax from any benefit payments upon your request. If benefits are taxable by your state, we will also withhold state income tax upon your request. We must also send a report to your employer at the end of each calendar year showing your name, social security number, any benefits paid and any taxes withheld. If you would like us to withhold any taxes, please indicate the dollar amount to be withheld each week:

|   |    |     |
|---|----|-----|
| Federal Taxes to be withheld (\$20.00 minimum per week, whole dollars only) | \$ | .00 |
| State Taxes to be withheld (\$2.00 minimum per week, whole dollars only)    | \$ | .00 |

Any person who knowingly and with intent to injure, defraud or deceive Reliance Standard Life Insurance Company, files a statement of claim or submits any information in conjunction with a claim containing fraudulent, false, misleading, incomplete or deceptive information commits a fraudulent insurance act, which is a crime. These actions will result in the denial of the claim, and are subject to prosecution under state and/or federal law. Reliance Standard Life Insurance Company will cooperate fully with any prosecution and will seek any and all appropriate legal remedies.

Employee's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Telephone Number (\_\_\_\_\_) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

| Section 2 – To be completed by Employer   |   |   |  |
|---|---|---|--|
| Short Term Disability Policy Number   | Long Term Disability Policy Number (if applicable)  | Life-Waiver of Premium Policy Number (if applicable)  |  |
| Claimant's Name   |   | Date Employed   | Eff. Date of insurance under this plan |
| Has claimant made prior claim for benefits?<br><input type="checkbox"/> Yes <input type="checkbox"/> No When? _____   | Was insurance effective when disability began?<br><input type="checkbox"/> Yes <input type="checkbox"/> No Termination date _____   | Occupation, title or position   |  |
| Describe the claimant's job duties. If available, attach a formal job description.  |   | Did this disability occur as a result of the claimant's employment?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently disputed |  |
| Date last worked _____<br>No. of hours worked that day _____  | How is Claimant paid?<br><input type="checkbox"/> Hourly <input type="checkbox"/> Salary + Commission<br><input type="checkbox"/> Salaried <input type="checkbox"/> Commission only<br><input type="checkbox"/> Salary + Bonus <input type="checkbox"/> Other _____ | Weekly earnings (as defined in policy)  | Class                                  |
| Work schedule at time of disability _____ day/week _____ hrs./day   |   |   |  |
| Has claimant returned to work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", on what date: _____<br><input type="checkbox"/> With restrictions <input type="checkbox"/> Full capacity   | Was Claimant covered under your prior disability plan? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Effective date under prior plan _____<br>Termination date under prior plan _____   |   |  |
| Percentage of premium paid by employer: _____ % Is claimant taxed on this amount? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Percentage of premium paid by claimant: _____ % <input type="checkbox"/> Pre-tax dollars <input type="checkbox"/> Post-tax dollars<br><b>Percentages must total 100%. If left blank, we will assume 100% of premium is paid by employer and that claimant is not taxed on this amount. FICA taxes will be calculated accordingly.</b> |   |   |  |
| Is there any reason why FICA taxes should not be withheld from claimant's benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain:  |   |   |  |
| Date Laid Off (if applicable)   |   | Date Retired (if applicable)  |  |
| Employer's Name   |   | Your name and title   |  |
| Telephone ( ) _____   | Ext. _____  | Fax Number ( ) _____  | E-mail Address _____                   |

| REQUIRED ATTACHMENTS  |
|---|
| <p><b>PROOF OF EARNINGS AS DEFINED BY APPLICABLE POLICY (EXAMPLE: PAYROLL RECORDS, W-2, K1, 1099, ETC.)</b></p> <p><b>IF EMPLOYEE WAS COVERED UNDER A PRIOR PLAN, INCLUDE COPY OF PRIOR PLAN.</b></p> <p><b>IF THE EMPLOYEE CONTRIBUTES TO THE PREMIUMS, ATTACH A COPY OF THE ENROLLMENT FORM.</b></p> <p><b>IF YOU HAVE MEDICAL INFORMATION FROM THE EMPLOYEE'S FILE RELATING TO DISABILITY, PLEASE ATTACH COPIES.</b></p> <p><b>IF A WORKER'S COMPENSATION CLAIM IS FILED, SEND INITIAL REPORT OF INJURY OR ILLNESS AND AWARD NOTICE.</b></p> |

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Date \_\_\_\_\_ By AUTHORIZED SIGNATURE \_\_\_\_\_

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## SECTION 3 – TO BE COMPLETED BY EMPLOYER

### Job Description and Requirements

|  |         |
|--|---------|
| Policyholder                             | Insured |
| Signature of Employer: _____ Date: _____ |         |
| Title: _____                             |         |

**To be completed by Employer:**

Job Title: \_\_\_\_\_

Detailed Description of Job Duties: (Disregard if detailed job description previously submitted)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Required Education and Training: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### PHYSICAL REQUIREMENTS

In an eight hour work day, employee is required to: (Circle daily requirement for each activity.)

|          |                 |   |   |   |   |   |   |   |   |
|----------|-----------------|---|---|---|---|---|---|---|---|
| 1. Sit   | Number of Hours | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 2. Stand | Number of Hours | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 3. Walk  | Number of Hours | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 4. Drive | Number of Hours | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

**INTERMS OF AN 8 HOUR WORKDAY,**

| On the job, employee must:    | Not at all               | Occasionally<br>(1/4-2 1/2 hours) | Frequently<br>(2 1/2 - 5 1/2 hours) | Continuously<br>(5 1/2 - 8 hours) |
|-------------------------------|--------------------------|-----------------------------------|-------------------------------------|-----------------------------------|
| A. Bend/Stoop                 | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>            | <input type="checkbox"/>          |
| B. Climb                      | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>            | <input type="checkbox"/>          |
| C. Reach above shoulder level | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>            | <input type="checkbox"/>          |
| D. Kneel                      | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>            | <input type="checkbox"/>          |
| E. Balance                    | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>            | <input type="checkbox"/>          |
| F. Push/Pull                  | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>            | <input type="checkbox"/>          |
| G. Squat                      | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>            | <input type="checkbox"/>          |
| H. Crawl                      | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>            | <input type="checkbox"/>          |
| I. Crouch                     | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>            | <input type="checkbox"/>          |

During work the employee must lift:

| On the job, employee must:   | Not at all               | Occasionally<br>(1/4-2 1/2 hours) | Frequently<br>(2 1/2 - 5 1/2 hours) | Continuously<br>(5 1/2 - 8 hours) |
|------------------------------|--------------------------|-----------------------------------|-------------------------------------|-----------------------------------|
| A. Usual amount _____ lbs.   | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>            | <input type="checkbox"/>          |
| B. Maximum amount _____ lbs. | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>            | <input type="checkbox"/>          |

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## SECTION 3 CONTINUED

During work the employee must carry:

| On the job, employee must:   | Not at all               | Occasionally<br>(1/4-2 1/2 hours) | Frequently<br>(2 1/2 - 5 1/2 hours) | Continuously<br>(5 1/2 - 8 hours) |
|------------------------------|--------------------------|-----------------------------------|-------------------------------------|-----------------------------------|
| A. Usual amount _____ lbs.   | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>            | <input type="checkbox"/>          |
| B. Maximum amount _____ lbs. | <input type="checkbox"/> | <input type="checkbox"/>          | <input type="checkbox"/>            | <input type="checkbox"/>          |

On the job, employee uses feet for repetitive movements as in operating foot controls:

Right:  Yes  No      Left:  Yes  No      Both:  Yes  No

I. On the job, employee uses hands for repetitive action such as:

|          | Simple Grasping          | Firm Grasping            | Fine Manipulation        |
|----------|--------------------------|--------------------------|--------------------------|
| A. Right | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Left  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

II. Does Job Require:

|   |  |
|---|--|
| A. Working at heights   | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____<br>_____ |
| B. Operating heavy machinery  | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____<br>_____ |
| C. Operating heavy machinery  | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____<br>_____ |
| D. Precise manual dexterity   | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____<br>_____ |
| E. Exposure to marked changes in temperature and humidity or extremes thereof | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____<br>_____ |
| F. Exposure to dust, fumes, gases, chemicals                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____<br>_____ |

Can the occupation be modified to accommodate the disability either temporarily or permanently:  Yes  No If "Yes," please explain.

Is it possible to offer the employee assistance in doing the occupation (through use of technology or personal assistance for example)  Yes  No  
 If "Yes," please explain. \_\_\_\_\_

### (ATTACH COPY OF THE EMPLOYEE'S OCCUPATION DESCRIPTION)

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I CERTIFY THAT THE FACTS AS INDICATED ABOVE ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

X \_\_\_\_\_  
 SIGNATURE DATE

**AUTHORIZATION FOR USE IN OBTAINING INFORMATION**

NAME OF INSURED: \_\_\_\_\_  
 INSURED'S SSN: \_\_\_\_\_  
 POLICYHOLDER: \_\_\_\_\_

To all physicians and other health care professionals, hospitals, other health care institutions, insurers, medical, hospital and prepaid health plans, pharmacies, employers, group policyholders, contract holders, governmental agencies, private and/or public benefit plan administrators, and/or attorney representatives, including but not limited to covered entities and business associates under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the accompanying regulations:

You are authorized to provide Reliance Standard Life Insurance Company and/or its authorized administrators with information concerning medical care, advice, and/or treatment provided to me, the above named Insured, and/or any employment, salary and/or benefit-related information concerning me, the above named Insured. I understand that the disclosure of information may include disclosure of protected health information under HIPAA and the accompanying regulations, information regarding treatment for mental illness, the human immunodeficiency virus (HIV) and/or the use of drugs and alcohol. I also understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be subject to protection under HIPAA and the accompanying regulations. A statement of Reliance Standard Life Insurance Company's privacy policy is available at [www.rsli.com](http://www.rsli.com) or upon request.

I understand that any such information will be used for the purpose of evaluating my claim for benefits. Upon request, I understand that I am entitled to receive a copy of this Authorization. This Authorization is valid from the date signed for the duration of the claim, and may be revoked by me at any time upon written request to the address below. A reproduction of this Authorization shall be considered as valid as the original.

\_\_\_\_\_  
 Date Insured's Signature  
**(If the Insured is unable to sign, an authorized person may sign.)**

\_\_\_\_\_  
 Date Authorized Person's Signature  
 Description of Authorized Person's authority to sign on behalf of Insured:  
 \_\_\_\_\_

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SECTION 5-To be completed by Attending Physician (please print or type)

Patient's Name: \_\_\_\_\_

|                                |   |
|--------------------------------|---|
| <b>History &amp; Prognosis</b> | Patient's symptoms result from ( <i>check all that apply</i> )<br>Employment <input type="checkbox"/> Illness <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident<br><input type="checkbox"/> Pregnancy (expected/actual delivery date) ____/____/____ Type of delivery: _____<br>Has patient had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No First visit for this condition ____/____/____<br>Date symptoms first appeared ____/____/____<br>First date unable to work ____/____/____ Full-time ____/____/____ Part-time ____/____/____<br>Expected/Actual return to work date: Full-time ____/____/____ Part-time ____/____/____<br>Has the patient reached maximum medical improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," when _____ <input type="checkbox"/> Unknown<br>What limitations prevent the patient from returning to gainful employment?<br><br>Would job modifications enable patient to work with impairments? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Most recent visit ____/____/____<br>Name(s) and address(es) of other treating physician(s)<br><br>Hospital name _____<br><br>Confinement dates ____/____/____ thru ____/____/____ |
| <b>Diagnosis</b>               | Diagnoses ( <i>including complications</i> ):<br><br>ICD-9 Code(s):<br><br>Subjective symptoms:<br><br>Objective findings ( <i>including results/copies of x-rays, lab tests, EKGs, MRIs, and scans</i> )   |
| <b>Treatment</b>               | Describe treatment program, including surgery or medications  |
| <b>Physical Impairment</b>     | <input type="checkbox"/> Class 1 – No limitation of functional capacity; capable of heavy work* .....No restrictions (0-10%)<br><input type="checkbox"/> Class 2 – Medium manual activity* .....(15-30%)<br><input type="checkbox"/> Class 3 – Slight limitation of functional capacity; capable of light work* .....(35-55%)<br><input type="checkbox"/> Class 4 – Moderate limitation of function capacity; capable of clerical or administrative (sedentary*) activity .....(60-70%)<br><input type="checkbox"/> Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity .....(75-100%)<br><input type="checkbox"/> Remarks _____ As defined in the Federal Dictionary of Occupational Titles   |
| <b>Psychiatric Impairment</b>  | <b>Complete only if applicable.</b><br><input type="checkbox"/> Class 1 – Patient is able to function under stress and engage in interpersonal relations ( <i>no limitations</i> ).<br><input type="checkbox"/> Class 2 – Patient is able to function in most stress situations and engage in only limited interpersonal relations ( <i>slight limitations</i> ).<br><input type="checkbox"/> Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations ( <i>moderate limitations</i> ).<br><input type="checkbox"/> Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations ( <i>marked limitations</i> ).<br><input type="checkbox"/> Class 5 – Patient has significant loss of psychological, physiological, personal, and social adjustments ( <i>severe limitations</i> ).<br><input type="checkbox"/> Remarks _____<br><br>Please define stress as it applies to this patient.<br>What stress and problems in interpersonal relations has patient had on the job?<br>Do you believe a legal guardian or conservator should be appointed for this problem? <input type="checkbox"/> Yes <input type="checkbox"/> No   |

COMPLETE THIS SECTION ONLY IF DISABILITY IS DUE TO CARDIAC CONDITION

### CARDIAC

|   |  |  |
|---|--|--|
| Functional Capacity<br>(American Heart Association) | <input type="checkbox"/> Class 1 (no limitation)<br><input type="checkbox"/> Class 3 (marked limitation) | <input type="checkbox"/> Class 2 (slight limitation)<br><input type="checkbox"/> Class 4 (complete limitation) |
|---|--|--|

Blood Pressure and Dates: \_\_\_\_\_

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|   |                           |                        |  |
|---|---------------------------|------------------------|--|
| Physician's Name, Address, Zip (Please Print or Type) |                           |                        |  |
| Telephone<br>( ) ( ) ( )                              | Fax Number<br>( ) ( ) ( ) | Physician's SSN or EIN |  |
| Physician's Signature                                 | Degree                    | Date                   |  |

**IMPORTANT: PLEASE ATTACH ALL MEDICAL RECORDS FROM THREE (3) MONTHS PRIOR TO DATE OF DISABILITY TO PRESENT.**