How to Complete Reliance LTD Packet

West Chester Area School District **Spellman Administration** **Benefits Office** **782 Springdale Drive** **Exton, PA 19341** **Phone: 484-266-1011 Fax: 484-266-1180**	**Return the Forms Marked with an "X" to Debbie Baker in the Benefits Office**
1.**Employee's Statement – 5 pages long** Complete with your information	**X**
2.**Physician's Statement** Your physician is required to complete these forms. The physician can fax or email them to the Benefits Office	**X**
3. **Notice of Privacy Practices** Keep for your records	
Once you have all forms completed, please forward them to my attention for further processing. Do Not send them directly to Reliance Standard as this will slow the process	

ALL ABOVE FORMS WITH AN "X' SHOULD BE SUBMITTED

RELIANCE STANDARD
Life Insurance Company
a DELPHI company

SECTION 3
EMPLOYEE'S STATEMENT
DISABILITY CLAIM
GROUP LONG TERM DISABILITY
GROUP LIFE-WAIVER OF PREMIUM

TO BE COMPLETED BY THE EMPLOYEE

A. INFORMATION ABOUT YOU

1. LAST NAME FIRST MIDDLE INITIAL
2. ADDRESS CITY STATE/PROVINCE ZIP
3. TELEPHONE: AREA CODE ( )
4. SOCIAL SECURITY NUMBER
5. DATE OF BIRTH (MONTH, DAY, YR)
6. HEIGHT WEIGHT
7. ☐ MALE ☐ FEMALE
8. MARITAL STATUS ☐ SINGLE ☐ WIDOWED ☐ MARRIED ☐ DIVORCED
9. YOUR EMPLOYER (INCLUDE DIVISION IF APPLICABLE)
10. OCCUPATION
11. DOMINANT HAND ☐ RIGHT ☐ LEFT

B. INFORMATION ABOUT YOUR FAMILY

(REQUIRED TO DETERMINE YOUR ELIGIBILITY FOR SOCIAL SECURITY BENEFITS)

1. SPOUSE'S NAME (LAST, FIRST)
2. DATE OF BIRTH (MONTH, DAY, YR)
3. IS YOUR SPOUSE EMPLOYED ☐ YES ☐ NO
4. DO YOU HAVE ANY CHILDREN UNDER AGE 18? ☐ YES ☐ NO
5. DO YOU HAVE HANDICAPPED CHILDREN (REGARDLESS OF AGE)? ☐ YES ☐ NO
6. DO YOU HAVE ANY CHILDREN AGE 18-19, WHO ARE FULL TIME STUDENTS IN ELEMENTARY OR SECONDARY SCHOOLS? ☐ YES ☐ NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE LIST NAMES. (LAST, FIRST) DATE OF BIRTH

(LAST, FIRST)	DATE OF BIRTH

C. INFORMATION ABOUT THE CONDITION CAUSING YOUR DISABILITY

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. WHAT WERE YOUR FIRST SYMPTOMS?
2. WHEN DID YOU NOTICE THEM?
3. DATE YOU WERE FIRST TREATED BY A PHYSICIAN? (MONTH, DAY, YR)
4. WHY ARE YOU UNABLE TO WORK?
5. BEFORE YOU STOPPED WORKING, DID YOUR CONDITION REQUIRE YOU TO CHANGE YOUR OCCUPATION OR THE WAY YOU DID YOUR OCCUPATION? ☐ YES ☐ NO
6. HAVE YOU FILED, OR DO YOU INTEND TO FILE A WORKERS COMPENSATION CLAIM? ☐ YES ☐ NO

FOR AN INJURY, ANSWER THE FOLLOWING QUESTIONS:

7. WHERE AND HOW DID THE INJURY OCCUR?
8. DATE THE INJURY OCCURRED (MONTH, DAY, YR)
9. DATE YOU WERE FIRST TREATED FOR THIS INJURY BY A PHYSICIAN (MONTH, DAY, YR)

D. INFORMATION ABOUT THE DISABILITY

1. DATE YOU WERE FIRST UNABLE TO WORK ON A FULL TIME BASIS (MONTH, DAY, YR)
2. LAST DAY YOU WORKED BEFORE THE DISABILITY (MONTH, DAY, YR)
3. DID YOU WORK A FULL DAY? ☐ YES ☐ NO IF NO, EXPLAIN.
4. HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO PART TIME (DATE) ____________ FULL TIME (DATE) ____________
5. IF YOU HAVE NOT RETURNED TO WORK, DO YOU EXPECT TO? ☐ YES ☐ NO
   PART TIME DATE FULL TIME DATE

DISABILITY CLAIM EMPLOYEE'S STATEMENT

TO BE COMPLETED BY THE EMPLOYEE

E. INFORMATION ABOUT PHYSICIANS AND HOSPITALS

DATE YOU WERE FIRST TREATED FOR THE CURRENT ILLNESS OR INJURY:

LIST ALL MEDICAL PRACTITIONERS CONSULTED FOR THIS CONDITION:

DOCTOR'S NAME | TELEPHONE ( ) | FAX ( ) | SPECIALTY:

ADDRESS (STREET, CITY, STATE, ZIP) | DATES SEEN

DOCTOR'S NAME | TELEPHONE ( ) | FAX ( ) | SPECIALTY:

ADDRESS (STREET, CITY, | DATES SEEN

PLEASE ATTACH ADDITIONAL INFORMATION ON SEPARATE SHEET IF MORE DOCTORS WERE CONSULTED

HOSPITAL

ADDRESS (STREET, CITY, STATE, ZIP) | DATES OF CONFINEMENT FROM ______ TO ______

F. INFORMATION ABOUT OTHER DISABILITY INCOME

CHECK THE OTHER INCOME BENEFITS YOU ARE RECEIVING OR ARE ELIGIBLE TO RECEIVE AS A RESULT OF YOUR DISABILITY AND COMPLETE THE INFORMATION REQUESTED

SOURCE OF INCOME	AMOUNT (WK. MONTH)	DATE CLAIM WAS FILED	DATE PAYMENTS BEGAN	DATE PAYMENTS ENDED
SALARY CONTINUANCE	$____/____			
SHORT TERM DISABILITY	$____/____			
STATE DISABILITY	$____/____			
WORKERS COMPENSATION	$____/____			
SOCIAL SECURITY/RETIREMENT	$____/____			
SOCIAL SECURITY/DISABILITY	$____/____			
SOCIAL SECURITY FOR DEPENDENTS	$____/____			
CANADIAN PENSION PLAN	$____/____			
PENSION/RETIREMENT	$____/____			
PENSION/DISABILITY	$____/____			
UNEMPLOYMENT	$____/____			
NO-FAULT INSURANCE	$____/____			
JONES ACT	$____/____			
RAILROAD RETIREMENT	$____/____			
OTHER (INCLUDE INDIVIDUAL OR GROUP)	$____/____			

G. INFORMATION ABOUT INCOME TAX WITHHOLDING

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 may 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 Tax to be Withheld ______ ($88.00 Minimum per month, whole dollars only)

State Tax to be Withheld ______ ($10.00 Minimum per month, whole dollars only)

H. SIGNATURE (REQUIRED FOR ALL CLAIMS)

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.

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

SIGNATURE ______ DATE ______ E-MAIL ADDRESS ______

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SECTION 4
EMPLOYEE'S STATEMENT

TO BE COMPLETED BY THE EMPLOYEE

EMPLOYMENT AND EDUCATION INFORMATION

PLEASE PRINT ALL INFORMATION

1. CLAIMANT'S NAME:
2. POLICY NUMBER:
3. SOCIAL SECURITY NUMBER:

PLEASE COMPLETE THE FOLLOWING INFORMATION AS ACCURATELY AS POSSIBLE. THIS DATA IS NEEDED TO HELP MAKE A THOROUGH EVALUATION OF YOUR CLAIM.

EDUCATION/TRAINING

HIGH SCHOOL:

1. COURSE OF STUDY:
2. HIGHEST GRADE COMPLETED:
3. DID YOU OBTAIN YOUR GED IF YOU DID NOT GRADUATE FROM HIGH SCHOOL? ☐ YES ☐ NO
   IF YES, WHEN? ______________
   IF NO, DO YOU PLAN TO OBTAIN YOUR GED IN THE FUTURE?: ☐ YES ☐ NO

COLLEGE:

1. DID YOU ATTEND COLLEGE? ☐ YES ☐ NO
2. WHERE?
3. COURSE OF STUDY:
4. DEGREE? ☐ YES ☐ NO
5. NUMBER OF YEARS COMPLETED:
6. TYPE OF DEGREE: WHEN?

VOCATIONAL TRAINING:

1. WHERE?
2. WHAT TYPE?
3. CERTIFICATE OR LICENSE OBTAINED?
4. WHAT SPECIALIZED TRAINING HAVE YOU HAD INCLUDING EQUIPMENT/MACHINERY USED?

____
____
____
____

5. DO YOU HAVE KNOWLEDGE OR PROFICIENCY WITH PERSONAL COMPUTERS? ☐ YES ☐ NO
6. IF YES, PLEASE LIST SOFTWARE PROGRAMS YOU HAVE USED:

____
____
____
____

TO BE COMPLETED BY THE EMPLOYEE

EMPLOYMENT HISTORY

STARTING WITH PRESENT EMPLOYER, PLEASE LIST AND DESCRIBE ALL OCCUPATIONS YOU HAVE HELD IN THE PAST 15 YEARS. IF MORE THAN 1 OCCUPATION WITH ANY EMPLOYER, PLEASE LIST EACH. ATTACH RESUME OR ADDITIONAL PAPER AS NECESSARY.

1. NAME OF EMPLOYER:

2. START DATE:	3. END DATE:	4. OCCUPATION TITLE:	5. MONTHLY SALARY:

6. REASON FOR LEAVING:

7. DETAIL YOUR DUTIES: ______

8. WHAT WERE THE PHYSICAL/MENTAL REQUIREMENTS?

9. DID YOU USE A COMPUTER? ☐ NO ☐ YES (IF YES, CHECK ALL USES THAT APPLY): ☐ WORD PROCESSING ☐ SPREADSHEETS ☐ DATA-ENTRY ☐ E-MAIL ☐ OTHER (SPECIFY):

10. NAME OF EMPLOYER:

11. START DATE:	12. END DATE:	13. OCCUPATION TITLE:	14. MONTHLY SALARY:

15. REASON FOR LEAVING:

16. DETAIL YOUR DUTIES: ______

17. WHAT WERE THE PHYSICAL/MENTAL REQUIREMENTS?

18. DID YOU USE A COMPUTER? ☐ NO ☐ YES (IF YES, CHECK ALL USES THAT APPLY): ☐ WORD PROCESSING ☐ SPREADSHEETS ☐ DATA-ENTRY ☐ E-MAIL ☐ OTHER (SPECIFY):

19. NAME OF EMPLOYER:

20. START DATE:	21. END DATE:	22. OCCUPATION TITLE:	23. MONTHLY SALARY:

24. REASON FOR LEAVING:

25. DETAIL YOUR DUTIES: ______

26. WHAT WERE THE PHYSICAL/MENTAL REQUIREMENTS?

27. DID YOU USE A COMPUTER? ☐ NO ☐ YES (IF YES, CHECK ALL USES THAT APPLY): ☐ WORD PROCESSING ☐ SPREADSHEETS ☐ DATA-ENTRY ☐ E-MAIL ☐ OTHER (SPECIFY):

28. PROJECTED RETURN TO WORK DATE?	29. HAVE YOU CONTACTED YOUR FORMER EMPLOYER? ☐ YES ☐ NO

30. HAVE YOU BEEN LOOKING FOR EMPLOYMENT? ☐ YES ☐ NO

31. ARE YOU FAMILIAR WITH YOUR LTD POLICY'S RETURN TO WORK INCENTIVES AND REHABILITATION SERVICES? ☐ YES ☐ NO

32. DO YOU USE A COMPUTER AT HOME? ☐ YES ☐ NO	33. DO YOU HAVE INTERNET ACCESS? ☐ YES ☐ NO

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SECTION 5

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 (including but not limited to the Social Security Administration), 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 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 6
PHYSICIAN'S STATEMENT
DISABILITY CLAIM
GROUP LONG TERM DISABILITY
GROUP LIFE-WAIVER OF PREMIUM

This form should be completed by the physician who was treating the claimant when he or she last worked.

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

A. GENERAL INFORMATION

This claim is for (Patient's Name)				Policy Number
Date of Birth (Month, Day, Year)	Height (Ft., Inches)	Weight (Lbs.)	Blood Pressure	Patient's Social Security Number
Primary Diagnosis including ICD9 code				

B. PREGNANCY: PHYSICIAN COMPLETES THIS SECTION FOR NORMAL PREGNANCY

1. DATE OF LAST MENSTRUAL PERIOD	2. EXPECTED DATE OF DELIVERY	3. TYPE OF DELIVERY EXPECTED	4 DATE OF DELIVERY
5. INITIAL VISIT FOR THIS PREGNANCY	6. LAST DATE OF TREATMENT	7. EXPECTED LENGTH OF POSTPARTUM RECOVERY	

C. PHYSICIAN COMPLETES THIS SECTION FOR ALL CONDITIONS EXCEPT NORMAL PREGNANCY

1. PRIMARY DIAGNOSIS (INCLUDING ICD-9 CODE):

2. SYMPTOMS (subjective)

3. OBJECTIVE FINDINGS: **(PLEASE PROVIDE COPIES OF TEST RESULTS AND OFFICE NOTES)**

4. ARE THERE ANY SECONDARY CONDITIONS CONTRIBUTING TO DISABILITY? IF YES, WHAT ARE THEY? (INCLUDING ICD-9 OR DSMIII R CODE):

5. WHEN DID SYMPTOMS FIRST APPEAR ____/____/____ MTH DAY YR	6. DATE OF PATIENT'S FIRST VISIT ____/____/____ MTH DAY YR	7. DATE OF PATIENT'S LAST VISIT ____/____/____ MTH DAY YR	8. FREQUENCY OF VISITS

9. WAS THE PATIENT REFERRED BY ANOTHER MEDICAL PRACTITIONER?	10. IF SO, FURNISH THE NAME AND ADDRESS.

11. IS THE PATIENT'S CONDITION WORK RELATED? ☐YES ☐ NO IF YES, EXPLAIN:

12. HAS THE PATIENT UNDERGONE A SURGICAL PROCEDURE? ☐ YES ☐ NO IF NO, SKIP TO 13.

12a. PROCEDURE:	12b. DATE:	12c. FACILITY (NAME/ADDRESS)

13. DO YOU EXPECT SURGERY IN THE NEAR FUTURE? ☐YES ☐ NO IF NO, SKIP TO 14.

13a. PROCEDURE:	13b. DATE:	13c. FACILITY (NAME/ADDRESS)

14. WHAT PRESCRIBED MEDICATION IS THE PATIENT CURRENTLY TAKING AND WHAT DOSAGE?

15. HAVE YOU REFERRED THE PATIENT FOR OTHER TYPES OF CONSULTATIONS? ☐ YES ☐ NO IF YES, EXPLAIN.

16. HAVE YOU REFERRED THE PATIENT TO A MEDICAL REHABILITATION OR THERAPY PROGRAM? IF YES, PLEASE IDENTIFY:

D. PHYSICIAN COMPLETES FOR ANY HOSPITAL CONFINEMENTS

1. NAME AND ADDRESS OF HOSPITAL:	2. DATE(S) CONFINED FROM/TO IN THE PRIOR 2 YEARS.

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

E. DESCRIPTION OF PATIENT'S RESTRICTIONS AND LIMITATIONS

1. Over the course of an 8 hour day, with 2 breaks and lunch, the patient can alternately:

stand	☐ None	☐ 1-3 Hours	☐ 3-5 Hours	☐ 5-8 Hours
sit:	☐ None	☐ 1-3 Hours	☐ 3-5 Hours	☐ 5-8 Hours
walk:	☐ None	☐ 1-3 Hours	☐ 3-5 Hours	☐ 5-8 Hours
drive:	☐ None	☐ 1-3 Hours	☐ 3-5 Hours	☐ 5-8 Hours

2. Patient can use upper extremities for repetitive:

	A. Simple Grasping	B. Pushing/Pulling	C. Fine Manipulation
Right	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Left	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3. Patient is able to:

	CONTINUOUS 67-100%	FREQUENT 34-66%	OCCASIONAL 0-33%	NO RESTRICTIONS
Bend (at waist)	☐	☐	☐	☐
Squat (at waist)	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach above Shoulder	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Use Feet (foot controls)	☐	☐	☐	☐
Drive	☐	☐	☐	☐

4. In an 8 hour day patient can lift/carry:

- ☐ 10 lbs. maximum and occasionally carry small objects: SEDENTARY WORK
- ☐ 20 lbs. maximum and frequently lift/carry up to 10 lbs.: LIGHT WORK
- ☐ 50 lbs. maximum and frequently lift/carry up to 25 lbs.: MEDIUM WORK
- ☐ 100 lbs. maximum and frequently lift/carry up to 50 lbs.: HEAVY WORK
- ☐ In excess of 100 lbs. and frequently lift/carry 50 lbs.: VERY HEAVY WORK

F. PHYSICIAN COMPLETES IF LIMITATIONS ARE MENTAL/NERVOUS IN NATURE

TO WHAT DEGREE, IF ANY, ARE THE FOLLOWING CAPACITIES AFFECTED?

CAPACITY	NOT LIMITED	MODERATELY LIMITED	EXTREMELY LIMITED
Ability to relate to other people beyond giving and receiving instructions	☐	☐	☐
Ability to complete and follow instructions	☐	☐	☐
Ability to perform simple and repetitive tasks	☐	☐	☐
Ability to perform complex and varied tasks	☐	☐	☐

In your opinion, does the claimant possess the mental capacity to understand his/her financial affairs and to direct the use of his/her funds? ☐ Yes ☐ No

G. PHYSICIAN COMPLETES ONLY IF THE CONDITION IS CARDIAC IN NATURE

Functional Capacity (American Heart Association)

☐ Class 1 (no limitation) ☐ Class 2 (slight limitation)
☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

H. PHYSICIAN COMPLETES FOR ALL CONDITIONS: PROGNOSIS FOR RECOVERY

1. HAS THE PATIENT ACHIEVED MAXIMUM MEDICAL IMPROVEMENT? ☐ Yes ☐ No
2. IF YES, AS OF WHAT DATE CAN PATIENT RETURN TO WORK? ________/________/________ MTH DAY YR
3. IF NO, WHEN DO YOU EXPECT PATIENT WILL ACHIEVE MAXIMUM MEDICAL IMPROVEMENT?

☐ <2 weeks	☐ <4 weeks	☐ <2 months	☐ 3-4 months
☐ 5-6 months	☐ 6-8 months	☐ <12 months	☐ <16 months

4. WHEN THE ABOVE CHANGE OCCURS, WHAT FUNCTIONAL CAPACITY WILL THE PATIENT RECEIVE?

☐ FULL RECOVERY ☐ IMPROVED OVER CURRENT BUT NOT FULL ☐ REMAIN AT PRESENT

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Your Name (Please Print)	Degree
Specialty	Telephone: ( ) Fax: ( )
Address (Please Print)	
Physician's Signature (no stamp)	Date

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