

**PROOF OF LOSS CLAIM STATEMENT
IMPORTANT INFORMATION REGARDING APPLICATION FOR GROUP LONG TERM
DISABILITY AND GROUP LIFE-WAIVER OF PREMIUM BENEFITS**

PLEASE READ THESE INSTRUCTIONS BEFORE COMPLETING THE ATTACHED FORMS

THE EMPLOYER IS RESPONSIBLE FOR COMPLETING THE FOLLOWING SECTIONS:

- Section 1 Employer's Statement, both sides
- Section 2 Occupation Analysis, both sides

THE EMPLOYEE IS RESPONSIBLE FOR COMPLETING THE FOLLOWING SECTIONS:

- Section 3 Employee's Statement, both sides
- Section 4 Employment and Education Information, both sides
- Section 5 Sign and date the Authorization for Use in Obtaining Information

THE ATTENDING PHYSICIAN IS RESPONSIBLE FOR COMPLETING THE FOLLOWING:

- Section 6 Physician's Statement
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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 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, 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.

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.

TO BE COMPLETED BY EMPLOYER

THIS CLAIM IS FOR (EMPLOYEE NAME)	SOCIAL SECURITY NUMBER	DATE OF BIRTH
A. INFORMATION ABOUT THE EMPLOYER		
1. COMPANY'S NAME IBEW, c/o Group Benefit Associates	PROVIDE APPLICABLE POLICY NUMBER(S): Group Policy Number _____	
2. ADDRESS (STREET, CITY, STATE, ZIP)	Long Term Disability _____ Life-Waiver of Premium _____	
3. NAME AND ADDRESS OF DIVISION WHERE EMPLOYEE WORKS (IF DIFFERENT FROM ABOVE)		
B. INFORMATION ABOUT THE EMPLOYEE		
1. DATE EMPLOYEE WAS HIRED? (MTH, DAY, YR)	3. DATE EMPLOYEE BECAME INSURED UNDER THIS PLAN?	LTD _____ LIFE _____ MTH DAY YR MTH DAY YR
2. WHAT WAS THE EMPLOYEE'S REGULARLY SCHEDULED WORK WEEK? _____ hrs/wk.	UNDER YOUR PRIOR PLAN?	_____ MTH DAY YR _____ MTH DAY YR
4. PLEASE IDENTIFY THE CLASS OF THIS EMPLOYEE: (Refer to Policy Schedule of Benefits)		LTD _____ LIFE _____
5. DATE TO WHICH PREMIUM IS PAID FOR THIS EMPLOYEE		_____ MTH DAY YR _____ MTH DAY YR
		LIFE BENEFIT IN FORCE \$ _____
6. THE EMPLOYEE IS (CHECK ALL THAT APPLY). PROVIDE COPY OF PAYROLL RECORD AS OF LAST DAY WORKED		
HOURLY (RATE: _____) UNION EXEMPT FULL-TIME COMMISSIONED SALARIED NON-UNION NON-EXEMPT PART-TIME RECEIVES BONUSES		
7. IF SALARIED, BASIC MONTHLY EARNINGS AS OF LAST DAY WORKED	8. EFFECTIVE DATE OF CURRENT SALARY OR HOURLY RATE	
	_____ / _____ / _____ MTH DAY YR	
9. WILL EMPLOYEE FILE FOR DISABILITY BENEFITS PROVIDED BY ANY EMPLOYER/EMPLOYEE LABOR MANAGEMENT, STATE DISABILITY OR UNION WELFARE PLAN? YES NO		
A. IF YES, WHAT IS THE WEEKLY AMOUNT? _____ B. WHAT TYPE OF BENEFIT? _____		
C. WHEN DO BENEFITS BEGIN? _____ END? _____		
10. IS CONDITION WORK RELATED? YES NO	11. HAS CLAIM BEEN FILED WITH WORKERS COMPENSATION? YES NO	
	IF YES, SEND INITIAL REPORT OF ILLNESS OR INJURY AWARD NOTICE	
12. NAME AND ADDRESS OF YOUR WORKERS COMPENSATION CARRIER: (Include Policy Number)		
Contact Name: _____		Phone Number: _____
13. NAME AND ADDRESS OF YOUR MEDICAL INSURANCE CARRIER OR ADMINISTRATOR IF SELF FUNDED: (Include Policy Number)		
Contact Name: _____		Phone Number: _____
C. INFORMATION NEEDED FOR WITHHOLDING AND REPORTING TAXES		
PERCENTAGE OF PREMIUM PAID BY EMPLOYER: _____% IS EMPLOYEE TAXED ON THIS AMOUNT? YES NO		
PERCENTAGE OF PREMIUM PAID BY EMPLOYEE: _____% PRE-TAX DOLLARS POST-TAX DOLLARS		
PERCENTAGES MUST TOTAL 100%. IF LEFT BLANK WE WILL ASSUME 100% OF PREMIUM IS PAID BY EMPLOYER AND THAT EMPLOYEE IS NOT TAXED ON THIS AMOUNT. FICA TAXES WILL BE CALCULATED ACCORDINGLY		

TO BE COMPLETED BY THE EMPLOYER

DISABILITY CLAIM EMPLOYER'S STATEMENT

D. INFORMATION ABOUT THE CLAIM

1. WERE THERE ANY CHANGES TO THE EMPLOYEE'S OCCUPATIONAL RESPONSIBILITIES DUE TO THE DISABLING CONDITION BEFORE THE EMPLOYEE BECAME FULLY DISABLED? YES NO IF YES, WHAT WERE THE CHANGES AND WHEN WERE THEY MADE? (please attach)
2. WHAT WAS THE EMPLOYEE'S PERMANENT OCCUPATION ON HIS OR HER LAST DAY AT WORK? _____
3. HOW LONG HAS THE EMPLOYEE BEEN IN THIS OCCUPATION? _____
4. LAST DAY EMPLOYEE ACTUALLY WORKED (MONTH, DAY, YR.) _____ / _____ / _____
5. ON THAT DAY, DID THE EMPLOYEE WORK A FULL DAY? YES NO IF NO, HOW MANY HOURS WERE WORKED? _____
6. WHY DID EMPLOYEE STOP WORKING?
LAYOFF TERMINATION FOR CAUSE FAMILY MEDICAL LEAVE ACT RESIGNATION RETIRED DISABILITY

E. INFORMATION ABOUT YOUR PENSION PLAN (DO NOT COMPLETE FOR MATERNITY CLAIM)

1. DO YOU HAVE A PENSION PLAN? YES NO
2. IF YES, WHAT TYPE?
DEFINED BENEFIT 401K DEFINED CONTRIBUTION PROFIT SHARING
OTHER (EXPLAIN)
3. IS THE EMPLOYEE ELIGIBLE FOR YOUR PENSION PLAN? YES NO
4. IF ELIGIBLE, DOES THE EMPLOYEE CONTRIBUTE? YES NO
5. IF YES, WHAT PERCENTAGE?
6. IF THE EMPLOYEE IS PARTICIPATING, WHEN IS HE OR SHE ELIGIBLE FOR BENEFITS UNDER THE PLAN? (Month, Day, Year) _____
7. IS THE EMPLOYEE RECEIVING ANY OTHER INCOME RELATED TO THIS DISABILITY? YES NO
SOURCE AMOUNT PER WEEK/MONTH?

F. INFORMATION ABOUT YOUR REHIRE OR RETURN-TO-WORK POLICIES

1. DOES YOUR COMPANY HAVE A REHIRE OR RETURN-TO-WORK POLICY FOR DISABLED EMPLOYEES? YES NO
2. DO YOU HAVE FULL OR PART-TIME POSITIONS AVAILABLE THAT THIS EMPLOYEE WOULD BE SUITED FOR UNDER A SUPERVISED REHABILITATION PROGRAM? YES NO
3. WHAT IS THE NAME, TITLE AND TELEPHONE NUMBER OF THE INDIVIDUAL WE SHOULD CONTACT IF WE IDENTIFY A REHABILITATION OR RETURN-TO-WORK OPTION?

G. REQUIRED ATTACHMENTS AND SIGNATURE

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

NAME/TITLE OF PERSON COMPLETING THIS FORM

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.

X _____
SIGNATURE DATE

_____ () _____
TITLE TELEPHONE EXT.

_____ () _____
E-MAIL ADDRESS FAX

TO BE COMPLETED BY THE EMPLOYER

THIS CLAIM IS FOR (EMPLOYEE'S NAME)	SOCIAL SECURITY NUMBER	DATE OF DISABILITY (MONTH, DAY, YEAR)
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A. GENERAL INFORMATION ABOUT THE EMPLOYEE'S OCCUPATION

OCCUPATION TITLE	DOT CODE (DICTIONARY OF OCCUPATIONAL TITLES)	MINIMUM EDUCATION OR TRAINING REQUIRED
DOES THE EMPLOYEE PERFORM SUPERVISORY FUNCTIONS? NO YES IF YES, HOW MANY PEOPLE ARE SUPERVISED? _____		
Describe Major Tasks 1. _____		
Describe Major Tasks 2. _____		
Describe Major Tasks 3. _____		

CHECK THE ITEMS BELOW THAT RELATE TO THE EMPLOYEE'S OCCUPATION, USE THESE DEFINITIONS FOR THE FREQUENCY OF OCCURRENCE.

OCCASIONALLY MEANS THE PERSON DOES THE ACTIVITY 1% TO 33% OF THE TIME
FREQUENTLY MEANS THE PERSON DOES THE ACTIVITY 34% TO 66% OF THE TIME
CONTINUOUSLY MEANS THE PERSON DOES THE ACTIVITY 67% TO 100% OF THE TIME

OCCASIONALLY FREQUENTLY CONTINUOUSLY

RELATE TO OTHERS
WRITTEN AND VERBAL COMMUNICATIONS
REASONING, MATH AND LANGUAGE
MAKE INDEPENDENT JUDGMENTS

WHICH OF THE FOLLOWING DESCRIBE THE EMPLOYEE'S WORKING ENVIRONMENT? CHECK ALL THAT APPLY.

UNPROTECTED HEIGHTS	CHANGES IN TEMPERATURE OR HUMIDITY
EXPOSURE TO DUST, FUMES, AND GASES	BEING NEAR MOVING MACHINERY
DRIVING AUTOMOTIVE EQUIPMENT	OTHER HAZARDS

IS THE EMPLOYEE REQUIRED TO TRAVEL? NO YES (IF YES, COMPLETE THE FOLLOWING INFORMATION)		
HOW DOES THE EMPLOYEE TRAVEL? (AUTOMOBILE, PLANE, ETC.)	WHERE DOES THE EMPLOYEE TRAVEL?	WHAT PERCENT OF THE TIME DOES THE EMPLOYEE TRAVEL?

B. INFORMATION ABOUT THE PHYSICAL ASPECTS OF THE EMPLOYEE'S OCCUPATION

CHECK THE ITEMS BELOW THAT RELATE TO THE EMPLOYEE'S OCCUPATION AND COMPLETE THE INFORMATION REQUESTED. USE THESE DEFINITIONS FOR THE FREQUENCY OF OCCURRENCE:

OCCASIONALLY MEANS THE PERSON DOES THE ACTIVITY 1% TO 33% OF THE TIME
FREQUENTLY MEANS THE PERSON DOES THE ACTIVITY 34% TO 66% OF THE TIME
CONTINUOUSLY MEANS THE PERSON DOES THE ACTIVITY 67% TO 100% OF THE TIME

ACTIVITY	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
STANDING				
WALKING				
SITTING				
BALANCING				
STOOPING				
KNEELING				
CROUCHING				
CRAWLING				
REACHING/WORKING OVERHEAD				
CLIMBING				
STAIRS Number of Stairs:				
LADDER Height of Ladder				
Describe Activity				
PUSHING. _____ LBS.				
PULLING. _____ LBS.				
LIFTING/CARRYING. _____ LBS.				

CAN THE OCCUPATION BE PERFORMED BY ALTERNATING SITTING AND STANDING? YES NO

DOES THE OCCUPATION REQUIRE USING FEET TO OPERATE FOOT CONTROLS? YES NO IF YES, ON WHAT TYPE OF EQUIPMENT:
--

IS GOOD VISUAL ACUITY REQUIRED IN THE OCCUPATION? YES NO
--

WHAT ARE THE MAJOR TASKS REQUIRING USE OF ONE OR BOTH HANDS ONE HAND BOTH HANDS		

RELIANCE STANDARD

Life Insurance Company

a DELPHI company

TO BE COMPLETED BY THE EMPLOYER

C. COMPUTER USAGE INFORMATION

IS USE OF A COMPUTER REQUIRED? NO YES (IF YES, CHECK ALL USES THAT APPLY): WORD PROCESSING SPREADSHEETS
DATA-ENTRY E-MAIL OTHER (SPECIFY): _____

PERCENTAGE OF TIME SPENT WORKING ON COMPUTER _____ %

HAS ANY NECESSARY COMPUTER TRAINING BEEN PROVIDED? YES NO

D. INFORMATION ABOUT THE OCCUPATION AS IT RELATES TO THE DISABILITY

CAN THE OCCUPATION BE MODIFIED TO ACCOMMODATE THE DISABILITY EITHER TEMPORARILY OR PERMANENTLY?

YES NO IF YES, EXPLAIN

IS IT POSSIBLE TO OFFER THE EMPLOYEE ASSISTANCE IN DOING THE OCCUPATION (THROUGH USE OF TECHNOLOGY OR PERSONAL ASSISTANCE FOR EXAMPLE)? YES NO

E. ATTACHMENTS AND SIGNATURE (ATTACH COPY OF THE EMPLOYEE'S OCCUPATION DESCRIPTION

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.

X _____
SIGNATURE

DATE

TITLE

() _____
TELEPHONE EXT.

E-MAIL ADDRESS

() _____
FAX

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 MARRIED WIDOWED 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	
_____			_____		
_____			_____		
_____			_____		
_____			_____		

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 () SPECIALTY:
FAX ()

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

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

ADDRESS (STREET, CITY, STATE, ZIP) 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

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	

AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF INSURED: _____

INSURED'S SSN: _____

POLICYHOLDER: IBEW, c/o Group Benefit Associates, 1701 E. Lake Avenue, Suite 400, Glenview, IL 60025

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**(If the Insured is unable to sign, an authorized person may sign.)**_____
Insured's Signature_____
Date

Description of Authorized Person's authority to sign on behalf of Insured:

Authorized Person's Signature_____
Description of Authorized Person's authority to sign on behalf of Insured:

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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, EXPLAIN:				
12. HAS THE PATIENT UNDERGONE A SURGICAL PROCEDURE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, SKIP TO 13.				
12a. PROCEDURE:	12b. DATE:	12c. FACILITY (NAME/ADDRESS)		
13. DO YOU EXPECT SURGERY IN THE NEAR FUTURE? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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	<input type="checkbox"/> None	<input type="checkbox"/> 1-3 Hours	<input type="checkbox"/> 3-5 Hours	<input type="checkbox"/> 5-8 Hours
	sit:	<input type="checkbox"/> None	<input type="checkbox"/> 1-3 Hours	<input type="checkbox"/> 3-5 Hours	<input type="checkbox"/> 5-8 Hours
	walk:	<input type="checkbox"/> None	<input type="checkbox"/> 1-3 Hours	<input type="checkbox"/> 3-5 Hours	<input type="checkbox"/> 5-8 Hours
	drive:	<input type="checkbox"/> None	<input type="checkbox"/> 1-3 Hours	<input type="checkbox"/> 3-5 Hours	<input type="checkbox"/> 5-8 Hours
2. Patient can use upper extremities for repetitive:	A. Simple Grasping	B. Pushing/Pulling	C. Fine Manipulation		
	Right <input type="checkbox"/> Yes <input type="checkbox"/> No	Right <input type="checkbox"/> Yes <input type="checkbox"/> No	Right <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Left <input type="checkbox"/> Yes <input type="checkbox"/> No	Left <input type="checkbox"/> Yes <input type="checkbox"/> No	Left <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Patient is able to:	CONTINUOUS 67-100%	FREQUENT 34-66%	OCCASIONAL 0-33%	NO RESTRICTIONS	
Bend (at waist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Squat (at waist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach above Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use Feet (foot controls)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. In an 8 hour day patient can lift/carry:					
<input type="checkbox"/> 10 lbs. maximum and occasionally carry small objects:	SEDENTARY WORK				
<input type="checkbox"/> 20 lbs. maximum and frequently lift/carry up to 10 lbs.:	LIGHT WORK				
<input type="checkbox"/> 50 lbs. maximum and frequently lift/carry up to 25 lbs.:	MEDIUM WORK				
<input type="checkbox"/> 100 lbs. maximum and frequently lift/carry up to 50 lbs.:	HEAVY WORK				
<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ability to complete and follow instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ability to perform simple and repetitive tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ability to perform complex and varied tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
G. PHYSICIAN COMPLETES ONLY IF THE CONDITION IS CARDIAC IN NATURE					
Functional Capacity	<input type="checkbox"/> Class 1 (no limitation)	<input type="checkbox"/> Class 2 (slight limitation)			
(American Heart Association)	<input type="checkbox"/> Class 3 (marked limitation)	<input type="checkbox"/> Class 4 (complete limitation)			
H. PHYSICIAN COMPLETES FOR ALL CONDITIONS: PROGNOSIS FOR RECOVERY					
1. HAS THE PATIENT ACHIEVED MAXIMUM MEDICAL IMPROVEMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No					
2. IF YES, AS OF WHAT DATE CAN PATIENT RETURN TO WORK? _____ / _____ / _____					
3. IF NO, WHEN DO YOU EXPECT PATIENT WILL ACHIEVE MAXIMUM MEDICAL IMPROVEMENT?					
<input type="checkbox"/> <2 weeks	<input type="checkbox"/> <4 weeks	<input type="checkbox"/> <2 months	<input type="checkbox"/> 3-4 months		
<input type="checkbox"/> 5-6 months	<input type="checkbox"/> 6-8 months	<input type="checkbox"/> <12 months	<input type="checkbox"/> <16 months		
4. WHEN THE ABOVE CHANGE OCCURS, WHAT FUNCTIONAL CAPACITY WILL THE PATIENT RECEIVE?					
<input type="checkbox"/> FULL RECOVERY <input type="checkbox"/> IMPROVED OVER CURRENT BUT NOT FULL <input type="checkbox"/> REMAIN AT PRESENT					
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.					
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.