

# ATTENDING PHYSICIAN'S STATEMENT OF IMPAIRMENT AND FUNCTION

ReliaStar Life Insurance Company, Minneapolis, MN  
ReliaStar Life Insurance Company of New York, Woodbury, NY (outside NY)  
Members of the *Voya®* family of companies  
(the "Company")



**Submit at [voya.com/claims](http://voya.com/claims)** (select Upload Documents);  
Disability Reinsurance Management Services, Inc.  
is the claims administrator on behalf of the Company.  
P.O. Box 9757, Portland, ME 04101-9757  
Phone: 888-305-0602; Fax: 888-305-0605

The patient is responsible for the completion of this form without expense to the Company.

## CLAIM CHECKLIST

- This completed form must be submitted using one of the above methods.
- The Insured must complete Sections 1 and 2.
- The Attending Physician must complete Sections 3 - 14.

## SECTION 1. GROUP INFORMATION *(This information is mandatory and can be obtained from the Employer.)*

Group Name Clermont Board of County Commissioners Group Policy Number 708054

## SECTION 2. INSURED / PATIENT INFORMATION

Select, if applicable.:  International / Foreign Address

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

Patient Birth Date \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province / State \_\_\_\_\_ ZIP \_\_\_\_\_

Country \_\_\_\_\_ Email \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ International Phone \_\_\_\_\_

## SECTION 3. DIAGNOSIS AND TREATMENT INFORMATION

Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. Blood Pressure \_\_\_\_\_ Date of Reading \_\_\_\_\_

Primary Diagnosis \_\_\_\_\_

List All Additional Diagnoses in Order of Severity \_\_\_\_\_

Subjective Symptoms \_\_\_\_\_

Objective Findings Supported by Testing \_\_\_\_\_

Diagnostic Tests Performed (Include dates and results.) \_\_\_\_\_

Procedure(s) \_\_\_\_\_

Date you first saw the patient for this condition. \_\_\_\_\_

Date you advised the patient to cease working due to this condition. \_\_\_\_\_

Date you last saw the patient for this condition. \_\_\_\_\_

Is this condition due to an accident? . . . . .  Yes  No

If "yes," was the accident work related? . . . . .  Yes  No

Has the patient ever had the same or similar condition? . . . . .  Yes  No

Has the patient been hospitalized for this condition? . . . . .  Yes  No

If "yes," When (from, to)? \_\_\_\_\_ Where? \_\_\_\_\_

Group Policy Number 708054

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

**SECTION 4. CURRENT PLAN OF TREATMENT**

Frequency of Visits:  Weekly  Monthly  Other \_\_\_\_\_

Medications (Include name and dosage.) \_\_\_\_\_

Therapy Prescribed:  Physical Therapy  Occupational Therapy  Speech Therapy

Frequency of Therapy \_\_\_\_\_

Is the patient compliant with therapy?  Yes  No Tolerance to therapy:  Good  Poor

**SECTION 5. PROGRESS**

Has patient:  Recovered?  Improved?  Unchanged?  Retrogressed?

Is patient:  Ambulatory?  House confined?  Bed confined?  Hospital confined?

If "Hospital confined," provide Name and Address of hospital. \_\_\_\_\_

Dates Confined (from) \_\_\_\_\_ (through) \_\_\_\_\_

**SECTION 6. FOR PREGNANCY DISABILITY ONLY**

Are there any present complications or anticipated difficulties in connection with:

(a) Pregnancy:  Yes  No Date of last menstrual period \_\_\_\_\_ Expected date of delivery \_\_\_\_\_

(b) Delivery:  Yes  No Actual date of delivery \_\_\_\_\_ Type of Delivery:  Vaginal  C-Section

(c) Post Partum:  Yes  No

If "yes," to any of these, specify in detail. \_\_\_\_\_

**SECTION 7. COMPETENCY**

Is the Patient competent to endorse checks and direct the use of the proceeds? . . . . .  Yes  No

**SECTION 8. PHYSICIAN REFERRAL INFORMATION**

Have you referred this patient to another Physician? . . . . .  Yes  No

If "yes," provide the name and address of that Physician. \_\_\_\_\_

Did another Physician refer this patient to you? . . . . .  Yes  No

If "yes," provide the name and address of that Physician. \_\_\_\_\_

**SECTION 9. PHYSICAL CAPACITIES EVALUATION**

In an 8 hour day, what is the maximum number of hours your patient could perform each of these levels of activity? (Indicate appropriate number of hours.):

\_\_\_\_\_ Hours Sedentary Activity (10 lbs. maximum lifting or carrying articles. Walking/standing on occasion. Sitting 6 to 8 hours.)

\_\_\_\_\_ Hours Light Activity (20 lbs. maximum lifting, carrying 10 lbs. articles frequently, most jobs involving standing with a degree of pushing and pulling. Standing 6 to 8 hours.)

\_\_\_\_\_ Hours Medium Activity (50 lbs. maximum lifting with frequent lifting/carrying of up to 25 lbs. Frequent walking and standing.)

\_\_\_\_\_ Hours Heavy Activity (100 lbs. maximum lifting, frequent lifting/carrying of up to 50 lbs. Frequent walking/standing.)

Patient is able to:	Occasionally 0% to 33%	Frequently 33% to 66%	Continuously 66% to 100%
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/Pull	Number of lbs. _____	Number of lbs. _____	Number of lbs. _____
Lift	Number of lbs. _____	Number of lbs. _____	Number of lbs. _____

What is this assessment based on?  Observed Activity  Measured Capacity  Physical Therapy Report

Group Policy Number 708054

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

**SECTION 9. PHYSICAL CAPACITIES EVALUATION** (Continued)

List current restrictions (activities which should not be performed) and limitations (activities which can not be performed) from activities not addressed above (i.e. driving, working at heights, etc.) Be specific.

\_\_\_\_\_

Upper Extremity Function - Indicate upper extremity functional capabilities:	Left	Right	Comments
Simply Grasping	<input type="checkbox"/>	<input type="checkbox"/>	
Pinching	<input type="checkbox"/>	<input type="checkbox"/>	
Fine Manipulation	<input type="checkbox"/>	<input type="checkbox"/>	
Power Grip	<input type="checkbox"/>	<input type="checkbox"/>	
Repetitive Motion	<input type="checkbox"/>	<input type="checkbox"/>	

**SECTION 10. MENTAL HEALTH ABILITY** (If applicable.)

What behavior, attitudes or functional impairments are contributing to any restrictions and/or limitations related to a mental health condition?

\_\_\_\_\_

**SECTION 11. CARDIAC FUNCTIONAL CAPACITY** (If applicable.)

American Heart Association Classification:  Class 1 (no limitation)  Class 2 (slight limitation)  Class 3 (marked limitation)  Class 4 (complete limitation)

**SECTION 12. ESTIMATED RETURN TO WORK INFORMATION**

Estimated Return to Work Date \_\_\_\_\_ Status:  Full-Time  Part-Time Number of Hours Per Week \_\_\_\_\_

With NO Physical Limitations  With Physical Limitations Describe Limitations \_\_\_\_\_

Has this patient reached Maximum Medical Improvement (MMI)? . . . . .  Yes  No

If "no," anticipated date of MMI? \_\_\_\_\_

**SECTION 13. REMARKS**

**SECTION 14. 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 \_\_\_\_\_ Degree \_\_\_\_\_

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

Email \_\_\_\_\_

Address \_\_\_\_\_

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

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

---

## 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 information to obtain or amend insurance coverage or to make a 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.