

# LONG TERM DISABILITY

## Claim Notice Employer's Statement

One Riverfront Plaza • Westbrook, ME 04092-9700  
 Phone: 1-888-305-0602 • Fax: 1-888-305-0605



ReliaStar Life Insurance Company of New York (outside NY)  
 ReliaStar Life Insurance Company  
 Members of the ING family of companies

All questions must be answered by the benefits representative to avoid delay.

Group Policyholder Name			Group Number				
Employee Name			Birth Date		SSN		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single		<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Occupation		
Employee Address							
Has the Employee also applied for Short Term Disability Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				Is disability due to employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date employed	Date insured	Date last worked		Reason for stopping work <input type="checkbox"/> Disability <input type="checkbox"/> Dismissed <input type="checkbox"/> Resigned <input type="checkbox"/> Layoff <input type="checkbox"/> Retired <input type="checkbox"/> Family Medical Leave of Absence <input type="checkbox"/> Other Leave of Absence <input type="checkbox"/> Other Reason _____			
Date returned to work <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	If part-time, number of hours worked per week	If employee has not returned to work, estimated return to work date		Date employment terminated	Date disability insurance terminated		
Required number of hours per week _____ hrs.		Gross Annual Salary: (During the 12 months just prior to your employee's disability) \$ _____		Please indicate how the employee is paid (check all that apply): <input type="checkbox"/> hourly <input type="checkbox"/> salaried <input type="checkbox"/> other _____ <input type="checkbox"/> includes commissions? <input type="checkbox"/> includes bonuses?			
Is employee subject to FICA tax? <input type="checkbox"/> Yes <input type="checkbox"/> No			If "Yes," is employee subject to <input type="checkbox"/> Full FICA tax? <input type="checkbox"/> Medicare portion only?				
Percentage of employee/employer contribution to premium for this disability plan (As of policy year of disability)							
Employee <input type="checkbox"/> 100% <input type="checkbox"/> Other _____%	is employee contribution:		<input type="checkbox"/> Pre-tax deduction?				
Employer <input type="checkbox"/> 100% <input type="checkbox"/> Other _____%	<input type="checkbox"/> After-tax deduction?						
Employee Eligible For:							
Yes	No	Type	Amount	Date Began	Date Term.	Paid Weekly	Paid Monthly
<input type="checkbox"/>	<input type="checkbox"/>	Sick Pay	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Salary Continuance Benefits	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Workers' Compensation	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Local, State or National Association or Society Disability Income Plan	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	No Fault	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Compensation disability	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Benefits (disability or retirement)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Retirement income (normal, early, or disability)	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other LTD/STD Benefits	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other (describe) _____	\$ _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Please return this completed form to the employee.



# Fraud Warnings

**Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, New Mexico, Ohio, Oklahoma, Oregon, 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 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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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.

**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.