

Laborers National Health & Welfare Fund

5565 Sterrett Place, Suite 210
Columbia, MD 21044
(800)-235-5805

SHORT TERM DISABILITY INFORMATION

Attached you will find several forms that must be completed and returned to the Laborers' National Health and Welfare Fund Office in order for you to received your Short Term Disability benefit.

FORMS:

- 1) Short Term Disability, Employee's Statement.
Please complete this form, sign and date the bottom.
- 2) Authorization to Release Information to ReliaStar Life Insurance Company.
Please review this form, sign and date the bottom.
- 3) Authorization for Release of Health-Related Information to:
Please complete this form, sign and date the bottom.
- 4) Short Term Disability, Attending Physician's Statement of Impairment.
Please have your physician complete and sign this form.

Once you have completed and signed all of the above forms send them together in the enclosed envelope to:

**Laborers' National H & W Fund
Short Term Disability
5565 Sterrett Place, Suite 210
Columbia, MD, 21044**

Once received at the Fund Office each package of forms will be reviewed, the Fund Office will Certify if you are eligible for the benefit at the time of disability and forward to "ING Employee Benefits" for processing.

If your forms have not been properly completed and signed they will be returned to you. Benefits cannot begin until all completed forms are received.

SHORT TERM DISABILITY

Employee's Statement

To be completed by the participant (employee) and returned to the employer.

Employee's name			Employee's home address		
Date of birth	Sex	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Number of dependent children	Social Security number	Employee's phone number () -
Employer		Occupation		Date employed	
Cause of disability			Date last worked	Date disability began	
Is this condition due to injury or illness arising out of your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			Has employment been terminated? _____ If so, why? _____ Date _____		
Is injury due to accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" date _____ Where _____ How _____					
Name of treating physician(s)			Address(es)		
On what date did you first see a physician for this sickness or injury?		If hospitalized for this sickness or injury, give name of hospital?		Date admitted: Date released:	
Have you ever had the same kind of sickness or injury before? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "yes" give date and physician's name and address			

Are you eligible for or receiving:

- Workers' compensation benefits?
- Unemployment compensation disability?
- Sick pay?
- Salary continuance benefits?
- Social Security benefits?
- Retirement income (current or past employers)?
- Other (Vacation or Holiday)?

Date benefit began	Date benefit paid through	Amount	Paid Weekly	Paid Monthly
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

Are you working? Yes No

If "yes" give date you returned to work (including year) _____ How many hours a day are you working? _____

If "no" when do expect to return to work? _____

I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse ReliaStar Life Insurance Company to the extent of any overpayment which is in excess of the amounts payable under this group plan.

Date

Employee's signature

Please return this authorization with your claim.

**Authorization to Release Information to
ReliaStar Life Insurance Company**

Participant's name	Contract holder number
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For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, Inc. (MIB), Social Security Administration, employer or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative acting on its behalf (including ChoicePoint or any consumer reporting agency), ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information, including Social Security benefits or earnings information and other employment-related information, as they apply to me. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life and its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This authorization will be valid for the duration of my claim for benefits. I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice and Insurance Information Practices Notice.

Patient's signature <i>(parent or guardian's signature if patient is a minor)</i>	Date
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Authorization for Release of Health-Related Information to:

- | | |
|---|---|
| <input type="checkbox"/> ING USA Annuity and Life Insurance Company | <input type="checkbox"/> ReliaStar Life Insurance Company of New York |
| <input type="checkbox"/> Midwestern United Life Insurance Company | <input type="checkbox"/> Security Life of Denver Insurance Company |
| <input type="checkbox"/> ReliaStar Life Insurance Company | <input type="checkbox"/> Southland Life Insurance Company |

This authorization complies with the HIPAA Privacy Rule

Name of Patient (please print)

Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to Patient or on Patient's behalf within the past 10 years ("Providers") to disclose Patient's entire medical record and any other protected health information concerning Patient to "THE COMPANY" and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict Patient's protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose Patient's entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that "THE COMPANY" may: 1) underwrite Patient's application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage Patient has or has applied for with "THE COMPANY."

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to "THE COMPANY" at 20 Washington Avenue South, Minneapolis, MN 55401, Attention: Privacy Official. I understand that a revocation is not effective to the extent that any Providers have relied on this Authorization or to the extent that "THE COMPANY" has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the signing of this authorization is not a condition for obtaining treatment or payment for services. I further understand that if I refuse to sign this authorization to release Patient's complete medical record, "THE COMPANY" may not be able to process Patient's application, or if coverage has been issued may not be able to make a claim determination. I acknowledge that I have received a copy of this authorization.

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient

SHORT TERM DISABILITY



EMPLOYEE BENEFITS

- ReliaStar Life Insurance Company of New York (outside NY)
- ReliaStar Life Insurance Company

Attending Physician's Statement of Impairment and Function

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

Plan number		Division/location		Employee's name	
Social Security number			Employee's home address		
Date of birth	Sex	<input type="checkbox"/> Married <input type="checkbox"/> Single	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Date employed	Occupation

Under the Short Term Disability Plan, an employee is eligible to receive benefits if medically disabled from performing the duties of his own occupation.

In order to determine benefit eligibility and rehabilitation, please answer the following:

HISTORY

When did symptoms first appear or accident happen? Month _____ Day _____, 20 _____
 Date patient ceased work because of disability: Month _____ Day _____, 20 _____
 Has patient ever had same or similar condition? Yes No

Did another Physician refer this patient to you? Yes No If yes, please provide the name and address of that Physician:

PRESENT CONDITION

Subjective symptoms	Objective findings
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DIAGNOSIS

HOSPITALIZATION

PROGNOSIS

	Hospital Confined <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____ Surgery: _____	
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TREATMENT

Date of first visit: Month _____ Day _____, 20 _____
 Date of last visit: Month _____ Day _____, 20 _____
 Next scheduled appointment: Month _____ Day _____, 20 _____
 Frequency of visits: Weekly Monthly Other

MATERNITY

EDC _____ Delivery Date: _____ Vaginal _____ C-Section _____

EXTENT OF DISABILITY

1. Is the employee totally disabled from performing the duties of their own occupation? Yes No
2. If the disability is not considered total and permanent, do you anticipate a release to their own occupation? Yes No
(If "yes," when? _____)
3. If you answered "no," do you anticipate a release to a less physically and/or emotionally demanding occupation?
 Yes No (If "yes," when? _____)
4. If the employee cannot perform the duties of their own occupation, would you feel it appropriate to consider VOCATIONAL and/or MEDICAL REHABILITATION? _____

If the employee is disabled from his own occupation but appropriate for rehabilitation or a release to a less demanding occupation, please complete the physical capacity evaluation on the back side of this form. This is used to lend direction in exploring medical/vocational alternatives.

MENTAL CONDITION

Is the patient competent to endorse checks and direct the use of the proceeds thereof? Yes No

Complete the appropriate section below if disability is due to **CARDIAC CONDITION** or **VISUAL IMPAIRMENT**.

CARDIAC

Functional capacity (American Heart Association): Class 1 (No limitation)
 Class 2 (Slight limitation)
 Class 3 (Marked limitation)
 Class 4 (Complete limitation)

Blood pressure _____

VISUAL IMPAIRMENT

What was vision at last examination?

	O.D	O.S.	Month	Day	Year
With glasses					
Without glasses					

Patient's Name: _____

Physical Capacities Evaluation

Important: Please complete the following items based on your clinical evaluation, other testing results, patient discussions, and/or job analysis. Any item that you do not believe you can answer should be marked N/A (not available).

NOTE: In terms of an eight hour workday, "occasionally" equals zero to 33 percent; "frequently" equals 34-66 percent; "continuously" equals 67-100 percent.

In an eight hour workday, claimant can: (Circle full hourly capacity for each activity)

Sit	1	2	3	4	5	6	7	8
Stand	1	2	3	4	5	6	7	8
Walk	1	2	3	4	5	6	7	8

If any of the above three require alternating positions, please indicate frequency:

Claimant can lift . . .

	Never	Occasionally	Frequently	Continuously
Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 - 20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 - 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 - 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Claimant can carry . . .

	Never	Occasionally	Frequently	Continuously
Up to 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 - 20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 - 50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 - 100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Claimant can use hands for repetitive action such as:

	Simple grasping	Pushing and pulling	Fine manipulation
Right	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Claimant can use feet for repetitive movements as in operating foot controls:

	Yes	No
Right	<input type="checkbox"/>	<input type="checkbox"/>
Left	<input type="checkbox"/>	<input type="checkbox"/>
Both	<input type="checkbox"/>	<input type="checkbox"/>

Claimant is able to:

	Not at all	Occasionally	Frequently	Continuously
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<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"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Restriction of activities involving:

	None	Mild	Moderate	Total
Unprotected heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being around moving machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to marked changes in temperature and humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving automotive equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to dust, fumes, and gasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Remarks on above, or other functional limitations:

Type or Print Physician's Name

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Signature (attending physician)

Degree

Telephone

Date

Street address

City or town

State (or province)

Zip code