

RELIANCE STANDARD

Life Insurance Company

a DELPHI company

SECTION 1
EMPLOYER'S STATEMENT
DISABILITY CLAIM
GROUP LONG TERM DISABILITY
GROUP LIFE-WAIVER OF PREMIUM

P O. Box 8330
Philadelphia, PA 19101-8330

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		3. Indicate under which coverage benefits are being applied on employee's behalf:			
2. ADDRESS (STREET, CITY, STATE, ZIP)		<input type="checkbox"/> Long Term Disability		Group Policy Number _____	
		<input type="checkbox"/> Life-Waiver of Premium		_____	
4. 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					
<input type="checkbox"/> HOURLY (RATE: _____) <input type="checkbox"/> UNION <input type="checkbox"/> EXEMPT <input type="checkbox"/> FULL-TIME <input type="checkbox"/> COMMISSIONED					
<input type="checkbox"/> SALARIED <input type="checkbox"/> NON-UNION <input type="checkbox"/> NON-EXEMPT <input type="checkbox"/> PART-TIME <input type="checkbox"/> RECEIVES BONUSES					
7. IF SALARIED, BASIC MONTHLY EARNINGS AS OF LAST DAY WORKED			8. EFFECTOVE 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? <input type="checkbox"/> YES <input type="checkbox"/> NO					
A. IF YES, WHAT IS THE WEEKLY AMOUNT? _____		B. WHAT TYPE OF BENEFIT? _____			
C. WHEN DO BENEFITS BEGIN? _____		END? _____			
10. IS EMPLOYEE CONDITION WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO			11. HAS CLAIM BEEN FILED WITH WORKER'S COMPENSATION? <input type="checkbox"/> YES <input type="checkbox"/> NO		
			IF YES, SEND INITIAL REPORT OF ILLNESS OR INJURY AWARD NOTICE		
12. NAME AND ADDRESS OF YOUR WORKER'S 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					
1. DOES EMPLOYEE CONTRIBUTE TOWARDS THE PREMIUM? <input type="checkbox"/> YES <input type="checkbox"/> NO					
2. IF YES, WHAT PERCENT IS PAID BY THE EMPLOYEE? ON A PRE TAX BASIS _____% ON A POST TAX BASIS _____%					
IF YOU LEAVE THIS SECTION BLANK, WE WILL ASSUME IT IS 100% EMPLOYER CONTRIBUTION AND CALCULATE FICA TAXES 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? _____
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 FULLY 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

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 SHARING 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

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 SALARY IS BASED ON W-2, K1, 1099, OR SIMILAR DOCUMENT, ATTACH A COPY OF THE DOCUMENT.
IF YOU HAVE MEDICAL INFORMATION FROM THE EMPLOYEE'S FILE RELATING TO DISABILITY, PLEASE ATTACH COPIES.
IF A WORKER'S 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

 TITLE

 E-MAIL ADDRESS

 DATE

() _____
 TELEPHONE

() _____
 FAX

RELIANCE STANDARD

Life Insurance Company

a DELPHI company P.O. Box 8330
Philadelphia, PA 19101-8330

SECTION 2
OCCUPATION ANALYSIS
GROUP LONG TERM DISABILITY
GROUP LIFE-WAIVER OF PREMIUM

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? YES NO IF YES, HOW MANY PEOPLE ARE SUPERVISED? _____
DESCRIBE OCCUPATION DUTIES.

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WRITTEN AND VERBAL COMMUNICATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REASONING, MATH AND LANGUAGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MAKE INDEPENDENT JUDGEMENTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="checkbox"/> UNPROTECTED HEIGHTS	<input type="checkbox"/> CHANGES IN TEMPERATURE OR HUMIDITY
<input type="checkbox"/> EXPOSURE TO DUST, FUMES, AND GASES	<input type="checkbox"/> BEING NEAR MOVING MACHINERY
<input type="checkbox"/> DRIVING AUTOMOTIVE EQUIPMENT	<input type="checkbox"/> OTHER HAZARDS

IS THE EMPLOYEE REQUIRED TO TRAVEL? YES NO
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 ASPECT 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WALKING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SITTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BALANCING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STOOPING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KNEELING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CROUCHING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CRAWLING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REACHING/WORKING OVERHEAD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLIMBING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STAIRS Number of Stairs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LADDER Height of Ladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Describe Activity				
PUSHING. _____ LBS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PULLING. _____ LBS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LIFTING/CARRYING. _____ LBS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?

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

TO BE COMPLETED BY THE EMPLOYER

C. 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

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

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

X _____
SIGNATURE

DATE

() _____
TELEPHONE

TITLE

() _____
FAX

E-MAIL ADDRESS

RELIANCE STANDARD

Life Insurance Company

a DELPHI company

P.O. Box 8330
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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. <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	8. MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED
9. YOUR EMPLOYER (INCLUDE DIVISION IF APPLICABLE)			
10. OCCUPATION	11. DOMINANT HAND RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/>		
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 <input type="checkbox"/> YES <input type="checkbox"/> NO		
4. DO YOU HAVE ANY CHILDREN UNDER AGE 18? <input type="checkbox"/> YES <input type="checkbox"/> NO			
5. DO YOU HAVE HANDICAPPED CHILDREN (REGARDLESS OF AGE) <input type="checkbox"/> YES <input type="checkbox"/> NO			
6. DO YOU HAVE ANY CHILDREN AGE 18-19, WHO ARE FULL TIME STUDENTS IN ELEMENTARY OR SECONDARY SCHOOLS? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> NO			
6. HAVE YOU FILED, OR DO YOU INTEND TO FILE A WORKER'S COMPENSATION CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, EXPLAIN.			
4. HAVE YOU RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO PART TIME (DATE) _____ FULL TIME (DATE) _____			
5. IF YOU HAVE NOT RETURNED TO WORK, DO YOU EXPECT TO? <input type="checkbox"/> YES <input type="checkbox"/> NO PART TIME DATE _____ FULL TIME DATE _____			

DISABILITY CLAIM EMPLOYEE'S STATEMENT

TO BE COMPLETED BY THE EMPLOYEE

E. INFORMATION ABOUT PHYSICIANS AND HOSPITALS

1. 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, 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	\$ _____ / _____	_____	_____	_____
WORKER'S COMPENSATION	\$ _____ / _____	_____	_____	_____
SOCIAL SECURITY/RETIREMENT	\$ _____ / _____	_____	_____	_____
SOCIAL SECURITY/DISABILITY	\$ _____ / _____	_____	_____	_____
SOCIAL SECURITY FOR DEPENDANTS	\$ _____ / _____	_____	_____	_____
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

IF YOUR REQUEST FOR BENEFITS IS APPROVED, SHOULD INCOME TAXES BE WITHHELD FROM YOUR BENEFIT CHECKS? YES NO

IF YES, HOW MUCH SHOULD BE WITHHELD FROM EACH CHECK. FEDERAL TAXES (MINIMUM IS \$87.00 PER MONTH) \$ _____ .00
STATE TAXES (MINIMUM IS \$10.00 PER MONTH) \$ _____ .00

H. SIGNATURE (REQUIRED FOR ALL CLAIMS)

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

X _____

SIGNATURE

DATE

E-MAIL ADDRESS:

RELIANCE STANDARD

Life Insurance Company

SECTION 4
EMPLOYEE'S STATEMENT

a DELPHI company

P.O. Box 8330
Philadelphia, PA 19101-8330

TO BE COMPLETED BY THE EMPLOYEE

I. 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: 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.		
1. NAME OF EMPLOYER:		
2. START DATE:	3. OCCUPATION TITLE:	4. MONTHLY SALARY:
5. REASON FOR LEAVING:		
6. DETAIL YOUR DUTIES: _____ _____		
7. WHAT WERE THE PHYSICAL/MENTAL REQUIREMENTS? _____ _____		
8. NAME OF EMPLOYER:		
9. START DATE:	10. OCCUPATION TITLE:	11. MONTHLY SALARY:
12. REASON FOR LEAVING:		
13. DETAIL YOUR DUTIES: _____ _____		
14. WHAT WERE THE PHYSICAL/MENTAL REQUIREMENTS? _____ _____		
15. NAME OF EMPLOYER:		
16. START DATE:	17. OCCUPATION TITLE:	18. MONTHLY SALARY:
19. REASON FOR LEAVING:		
20. DETAIL YOUR DUTIES: _____ _____		
21. WHAT WERE THE PHYSICAL/MENTAL REQUIREMENTS?		
22. WHAT IS YOUR PROJECTED RETURN TO WORK DATE?		
23. HAVE YOU CONTACTED YOUR FORMER EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO		
24. HAVE YOU BEEN LOOKING FOR EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. ARE YOU FAMILIAR WITH YOUR LTD POLICY REGARDING RETURN TO WORK INCENTIVES AND REHABILITATION SERVICES?		

AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF CLAIMANT: _____

CLAIMANT'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, government agencies, private and/or public benefit plan administrators, and/or attorney representatives:

You are authorized to provide Reliance Standard Life Insurance Company or any of its agents or representatives information concerning medical care, advise, treatment provided to me, the claimant, and any employment, salary or benefit related information concerning me, the claimant. I understand that the disclosure of information may include disclosure of information regarding treatment for mental illness and/or the human immunodeficiency virus (HIV) and/or the use of drugs and alcohol.

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. A copy of this Authorization is as valid and as effective as the original.

Date_____
Claimant's Signature**(If the claimant is unable to sign, then another authorized person may sign.)**_____
Relationship of Authorized Person to Claimant_____
Authorized Person's Signature

Reliance Standard Life Insurance Company
P.O. Box 8330, Philadelphia, PA 19101-8330

RELIANCE STANDARD

Life Insurance Company

a DELPHI company

SECTION 6
PHYSICIAN'S STATEMENT
DISABILITY CLAIM
GROUP LONG TERM DISABILITY
GROUP LIFE-WAIVER OF PREMIUM

P.O. Box 8330
Philadelphia, PA 19101-8330

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 or DSM 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 OR DSMIII R 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	6. DATE OF PATIENT'S FIRST VISIT	7. DATE OF PATIENT'S LAST VISIT	8. FREQUENCY OF VISITS	
MTH / DAY / YR	MTH / DAY / YR	MTH / DAY / YR		
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	Right	<input type="checkbox"/> Yes <input type="checkbox"/> No	B. Pushing/Pulling	Right	<input type="checkbox"/> Yes <input type="checkbox"/> No	C. Fine Manipulation	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
A. Bend (at waist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Squat (at waist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Reach above Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Use Feet (foot controls)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 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? Yes No

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

Functional Capacity Class 1 (no limitation) Class 2 (slight limitation)

(American Heart Association) 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?

<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?

FULL RECOVERY IMPROVED OVER CURRENT BUT NOT FULL 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.