RESET FORM

Employee Benefits

SHORT TERM DISABILITY
CLAIM NOTICE EMPLOYER'S STATEMENT

☑ ReliaStar Life Insurance Company, Minneapolis, MN
☐ ReliaStar Life Insurance Company of New York, Woodbury, NY (outside NY)
Members of the ING family of companies
(the "Company")
ING Employee Benefits: One Riverfront Plaza, Westbrook, ME 04092
Phone: 800-328-4090, Fax: 888-305-0605
Disability RMS is the claims administrator on behalf of the insurance company.

GROUP INFORMATION

Group Policyholder/Plan Sponsor City of Laredo

Group Policy/Plan Number 680729 Division/Location/Account Number n/a

EMPLOYEE INFORMATION *(Attach copy of Employee's signed enrollment form and job description.)*

Employee Name _____ Phone (_____) _____

Birth Date _____ SSN _____

Address _____

City _____ State _____ ZIP _____

Marital Status: ☐ Married ☐ Domestic Partner/Civil Union ☐ Never Married ☐ Divorced ☐ Widow(er) Gender: ☐ Male ☐ Female

Employment Start Date _____ Occupation/Duties _____

Cause of Disability _____

Coverage Effective Date _____ Date Last Worked _____ Date Disability Began _____

Is disability work-related? . . . . . ☐ Yes ☐ No

If "Yes," has a Workers' Compensation claim been filed? . . . . . ☐ Yes ☐ No

If "Yes," have benefits been paid? . . . . . ☐ Yes ☐ No

Has Employee been laid off? . . . . . ☐ Yes ☐ No

If "Yes," when? _____

Has employment been terminated? . . . . . ☐ Yes ☐ No

If "Yes," why? *(Include date.)* _____

Has Employee returned to work before submission of this claim? . . . . . ☐ Yes ☐ No

If "Yes," give date. _____

How many hours per week did the Employee normally work? _____ What type of shift? _____

			Benefits			Paid	
Is Employee eligible for, or receiving:			Date Began	Date Paid Through	Amount	Weekly	Monthly
Workers' Compensation Benefits?	☐ Yes	☐ No			$	☐	☐
Unemployment Compensation Disability?	☐ Yes	☐ No			$	☐	☐
Sick Pay?	☐ Yes	☐ No			$	☐	☐
Salary Continuance Benefits?	☐ Yes	☐ No			$	☐	☐
Social Security Benefits?	☐ Yes	☐ No			$	☐	☐
Retirement Income (Current or Past Employers)?	☐ Yes	☐ No			$	☐	☐
Other (Vacation, Holiday)?	☐ Yes	☐ No			$	☐	☐

Employee Name _____ SSN _____ Group Number 680729

EMPLOYEE INFORMATION *(Continued)*

Was Employee late enrollee? . . . . . ☐ Yes ☐ No

Salary $ _____ per: ☐ Hour ☐ Week ☐ Month ☐ Year

☐ Commissions *(Please attach list of commissions.)*

Last Salary Change Date _____ Earnings Prior to Increase _____

Is a layoff planned at Employee's location? . . . . . ☐ Yes ☐ No

Does the employee pay for any part of the premium? *(If "Yes," attach a copy of signed Enrollment form.)* . . . . . ☐ Yes ☐ No

REMARKS

APPROVED FMLA DATES

Begin Date _____ Approved Through Date _____

EMPLOYER CERTIFICATION

The undersigned certifies that the above statements as to the Employee are correct as reported on its records.

Employer Name _____

Employer Address _____

City _____ State _____ ZIP _____

Authorized Signature _____ Date _____

Title _____ Phone (_____)_____

E-mail _____ Fax (_____)_____

EMPLOYEE STATEMENT *(Use separate sheet to provide additional information if needed.)*

Employee Name _____ Group Number _____

Birth Date _____ SSN _____

Address _____

City _____ State _____ ZIP _____

Marital Status: ☐ Married ☐ Domestic Partner/Civil Union ☐ Never Married ☐ Divorced ☐ Widow(er) Gender: ☐ Male ☐ Female

Employee Phone (_____)_____ Number of Dependent Children _____

Cause of Disability _____ Hand Dominance: ☐ Right-hand ☐ Left-hand

Date Last Worked _____ Date of Disability _____

Is this condition due to injury or illness arising out of your employment? . . . . . ☐ Yes ☐ No

Is injury due to accident? . . . . . ☐ Yes ☐ No

If "Yes," give date, where and how. _____

Attending Physician Name *(Please print.)* _____ Date First Treated _____

Phone (_____)_____ Address _____

City _____ State _____ ZIP _____

If hospitalized for this sickness or injury, give hospital name. _____

Date Admitted _____ Date Released _____

Have you ever had the same kind of sickness or injury before? *(If "Yes," give date, physician's name and address.)* . . . . . ☐ Yes ☐ No

Physician Name *(Please print.)* _____ Date Treated _____

Phone (_____)_____ Address _____

City _____ State _____ ZIP _____

			Benefits			Paid	
Is Employee eligible for, or receiving:			Date Began	Date Paid Through	Amount	Weekly	Monthly
Workers' Compensation Benefits?	☐ Yes	☐ No			$	☐	☐
Unemployment Compensation Disability?	☐ Yes	☐ No			$	☐	☐
Sick Pay?	☐ Yes	☐ No			$	☐	☐
Salary Continuance Benefits?	☐ Yes	☐ No			$	☐	☐
Social Security Benefits?	☐ Yes	☐ No			$	☐	☐
Retirement Income (Current or Past Employers)?	☐ Yes	☐ No			$	☐	☐
Other (Vacation, Holiday)?	☐ Yes	☐ No			$	☐	☐

Are you working? . . . . . ☐ Yes ☐ No

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

If "No," when do you expect to return to work? _____ Next Office Visit _____

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

Employee Signature _____ Date _____

Employee Name _____ SSN _____ Group Number 680729

AUTHORIZATION AND ACKNOWLEDGMENT

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, MIB, Inc., Social Security Administration or employer to give ReliaStar Life Insurance Company ("the Company") or its agents, employees and authorized representatives 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 non-medical information regarding Social Security benefits or earnings information and other employment-related information, as they apply to me. I give my permission to the Company to get consumer or investigative consumer reports about me.

I give my permission to the Company 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 the Company and its affiliates and may be sent to MIB. This information may be made available to any Company affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with the Company 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 or my authorized representative 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 the Company's Consumer Privacy Notice and Insurance Information Practices Notice.

Employee Signature _____ Date _____

Home Phone (_____)_____ Home E-mail _____

Employee Name _____ SSN _____ Group Number 680729

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 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.

Employee Benefits

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Security Life of Denver Insurance Company, Denver, CO
Midwestern United Life Insurance Company, Fort Wayne, IN
ING USA Annuity and Life Insurance Company, Des Moines, IA
A member of the ING family of companies
("the Company")

ING
Your future. Made easier.®

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION TO:

- ☐ ING USA Annuity and Life Insurance Company
- ☐ Midwestern United Life Insurance Company
- ☐ ReliaStar Life Insurance Company
- ☐ ReliaStar Life Insurance Company of New York
- ☐ Security Life of Denver Insurance Company

This authorization complies with the HIPAA Privacy Rule.

Patient Name *(Please print.)* _____ Birth Date _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefits manager, 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, unless otherwise provided by state law, ("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 24 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, including the reporting of protected health information or personally identifiable information to MIB, Inc., and is no longer covered by federal rules governing privacy and confidentiality of health information. Any re-disclosure continues to be covered by any applicable state privacy laws, state insurance privacy rules and by the security standards of the listed carrier(s).

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.

Patient or
Personal Representative Signature _____ Date _____

Description of Personal Representative's
Authority or Relationship to Patient _____

Order #127182 02/25/2013