RESET FORM

DISABILITY AND LEAVE OF ABSENCE MEDICAL CERTIFICATION
EMPLOYEE'S OWN SERIOUS HEALTH CONDITION

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya® family of companies
(the "Company")
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INSTRUCTIONS FOR EMPLOYEE

Checklist Before Submission:

- ☐ Complete **Section 1: Employee Information**
- ☐ Ensure **Treatment Provider** completes **Sections 2 and 3 (if applying for short-term disability benefits)**
- ☐ Notify your manager about your leave per company/FMLA policies.
- ☐ Provide certification to Voya within **the timeframe outlined in your letter**
- ☐ Follow up with your provider to confirm timely submission.
- ☐ Submit completed form via the contact options above.

Important: *You may need to authorize your provider to release complete, sufficient certification. A formal diagnosis is not required for FMLA qualification. If you are applying for both STD and Leave benefits, please make sure your treating provider completes ALL sections of the form.*

SECTION 1: EMPLOYEE INFORMATION

Employee's Name _____ Claim ID _____

Employee Phone Number _____ Last 4 digits of Social Security Number: _____ Date of Birth _____

Employer's Name _____ Employee's Job Title _____

Regular Work Schedule _____ Employee's Essential Job Functions _____

Employee Signature _____ Date _____

INSTRUCTIONS FOR TREATING PROVIDER

Your patient has required time out of work under FMLA and/or Short-Term Disability. Please complete this form thoroughly and sign/date at the end. Several questions seek a response as to the frequency and duration of a medical condition, treatment, etc. Your answers should be your best estimate based on your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime", "unknown", or "as needed" may not be sufficient to determine coverage. Limit your responses to the condition for which the employee is seeking leave.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact than an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

IMPORTANT NOTE: *The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.*

SECTION 2: MEDICAL FACTS & AMOUNT OF LEAVE FOR LEAVE & DISABILITY *(To be completed by treating provider.)*

Family and Medical Leave of Absence (*Select all reasons that indicates that the patient has a serious health condition.*)

☐ Inpatient care (hospital, hospice, residential)

Facility Name _____

Dates: Admission _____

Discharge

☐ Pregnancy related incapacity

Expected date of delivery: _____

☐ Incapacity of more than three consecutive full calendar days, and any subsequent period of incapacity relating to the same condition, plus treatment

- ☐ Two (2) or more treatments within 30 days of first day of incapacity, with the first visit within seven (7) days of the first day of incapacity, **or**
- ☐ One (1) examination, plus continuing treatment under the supervision of a healthcare provider

☐ Chronic condition, plus treatment at least twice per year

☐ Permanent or long-term conditions (i.e., incapacity is permanent or long term) under the continuing supervision of a health care provider

☐ Conditions requiring multiple treatments (i.e., it is medically necessary for the patient to receive and recover from multiple treatments)

☐ None of the above apply. The patient does not have a serious health condition causing medically necessary absence(s) from work

A. Confirm employee cannot perform the essential functions of the job.

Were you provided a written copy of the employee's job duties? . . . . . ☐ Yes ☐ No

Is the employee unable to perform any of his/her job functions due to the condition? . . . . . ☐ Yes ☐ No

If so, identify the job function(s) the employee is unable to perform: _____

B. Describe Appropriate Medical Facts (*Do not provide a diagnosis for California residents.*)

Was the patient referred to other health care provider(s)? . . . . . ☐ Yes ☐ No

If yes, please list: _____

Was the patient prescribed medication not available over the counter?. . . . . ☐ Yes ☐ No

Physical Capacity – Please describe _____

If the patient is treating with a Chiropractor, were X-Rays performed? . . . . . ☐ Yes ☐ No

Based on the patient's medical history and your knowledge of the medical condition, consider all dates the patient has been or will be unable to work by completing either of the below sections that apply. **All applicable sections must be completed.**

Answers of "unknown," "indeterminate" or "lifelong" may not be sufficient to support the leave request.

☐ **Continuous Leave: Provide any single, continuous period of incapacity.**

Start date of incapacity (this may or may not be the first day absent from work) _____

Estimated end date of incapacity _____

Release to return to work date with restrictions _____

Specific restrictions and limitations include: _____

_____

Release to return to work date without restrictions _____

Will the employee require follow-up appointments? . . . . . ☐ Yes ☐ No

If yes, provide past and future appointment dates _____

If intermittent leaves or a reduced work schedule are applicable, identify ALL absence needs below.

☐ **Intermittent Leave:**

Leave Begin Date: _____

Leave End Date: _____

Will the patient need to miss work for appointments or treatments?
☐ Yes ☐ No

If yes, complete the estimated treatment schedule:

Frequency:
Up to _____ times per _____ (week/month/year)

Duration:
Lasting up to _____ hours **OR** _____ days
Please include the dates of any scheduled appointments and the time required for each appointment:

_____

Will the patient need to miss work for incapacity/flare-ups of the health condition? ☐ Yes ☐ No

If yes, complete the estimate of absences needed for episodes:

Frequency:
Up to _____ times per _____ (week/month/year)

Duration:
Lasting up to _____ hours **OR** _____ days
List all dates you have already treated the patient for the condition:

_____

☐ **Reduced Schedule Leave:**

Will the patient need a temporary FIXED part-time schedule or require predictable, regularly scheduled absences?

☐ Yes ☐ No

If yes, complete the period the reduced schedule will be needed.

Start date of modified schedule: _____

Estimated end date of modified schedule: _____

In the table below, indicate the hours of time the patient will need to miss each day.

Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

STEP 3 – SHORT-TERM DISABILITY – ADDITIONAL MEDICAL FACTS

Note: To be completed ONLY if the employee is also applying for STD benefits

PRESENT CONDITION

Height :_____ft._____in. **Weight**:_____lbs **Hand Dominance**: ☐ Right-Hand ☐ Left-Hand

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

When did symptoms first appear or accident happen? _____

On what date did you advise the patient to cease work because of disability? _____

Is condition due to an illness or an injury that is work related? . . . . . ☐ Yes ☐ No

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

Did another Physician refer this Patient to you? . . . . . ☐ Yes ☐ No

If yes, provide the name and address of the referring Physician. _____

Subjective Symptoms _____

Objective Findings _____

Primary Diagnosis _____ ICD-10 Code(s _____

Initial Diagnosis Date _____ Any subsequent diagnosis dates _____

Secondary Conditions _____

Has Patient confined to a hospital? . . . . . ☐ Yes ☐ No

If yes, provide date(s): _____

Has Patient had surgery? . . . . . ☐ Yes ☐ No

If yes, provide date(s): _____

Surgery Type _____ CPT Code(s) _____

Prognosis _____

CURRENT PLAN OF TREATMENT

Date of first visit: _____ Date of last visit: _____ Next office visit: _____

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other

Treatment Plan _____

FOR PREGNANCY RELATED DISABILITY ONLY

Date first treated: _____ Estimate date of confinement (EDC) _____

Has the patient delivered? . . . . . ☐ Yes ☐ No

If yes, provide delivery date(s): _____

Frequency of visits: ☐ Vaginal ☐ C-Section Post Partum Recover Weeks: ☐ 6 ☐ 8

EXTENT OF DISABILITY

Is Patient totally disabled from performing the duties of their own occupation? . . . . . ☐ Yes ☐ No

If the disability is not considered total and permanent, do you anticipate a release to their OWN occupation? . . . . . ☐ Yes ☐ No

If yes, when? _____

If "no", do you anticipate a release to a less physically and/or emotionally demanding occupation? . . . . . ☐ Yes ☐ No

If yes, when? _____

If the Patient cannot perform the duties of their own occupation, would you feel it appropriate to consider Vocational and/or Medical Rehabilitation?
☐ Yes ☐ No

If the Patient is disabled from their own occupation but appropriate for rehabilitation or a release to a less demanding occupation, complete the **Physical Capacity Evaluation** portion of this form. This is used to lend direction in exploring medical/vocational alternatives

COMPETENCY

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

CARDIAC FUNCTIONAL CAPACITY (Complete only if disability is due to a cardiac condition)

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

Blood Pressure: _____

VISUAL IMPAIRMENT (Complete only if disability is due to a visual impairment)

What was vision at last observation? (Snellen Notation)

With Glasses: O.D. _____ O.S. _____ Date _____

Without Glasses: O.D. _____ O.S. _____ Date _____

PHYSICAL CAPACITIES EVALUATION (Important: 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)

Note: *In terms of an 8-hour workday, "Occasionally" = 0-33%, "Frequently" = 34-66%, "Continuously" = 67-100%*

In an eight-hour workday, Patient can:

Sit (hours): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

Stand (hours): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

Walk (hours): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

If any of the above three capabilities require alternating positions, include frequency:

Patient can lift:	Never	Occasionally	Frequently	Continuously
Up to 10 pounds				
11-20 pounds				
21-50 pounds				
51-100 pounds				

Patient can carry:	Never	Occasionally	Frequently	Continuously
Up to 10 pounds				
11-20 pounds				
21-50 pounds				
51-100 pounds				

Patient is able to:	Never	Occasionally	Frequently	Continuously
Bend				
Squat				
Crawl				
Climb				
Reach above shoulder level				

Limits on activities involving:	Never	Occasionally	Frequently	Continuously
Unprotected heights				
Being around moving machinery				
Exposure to marked changes in temperature and humidity				
Driving automotive equipment				
Exposure to dust, fumes, or gasses				

Patient can use hands for repetitive action such as:	Right		Left	
	Yes	No	Yes	No
Simple Grasping				
Pushing and Pulling				
Fine Manipulation				

Patient can use feet for repetitive movements, as in operating foot controls:	Yes	No
Right		
Left		
Both		

PHYSICIAN REMARKS

Provider Information and Signature

Provider Signature _____ Date _____

Provider Name (printed): _____ TIN: _____

Type of Practice/Medical Specialty: _____

Email: _____ Phone: _____ Fax: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

AUTHORIZATION FOR RELEASE OF INFORMATION *(Excluding psychotherapy notes. HIPAA Compliant. To be signed and dated by the insured/claimant.)*

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, pharmacy benefits manager, hospital, clinic, other medical or medically related facility, federal, state or local government agency including the Social Security Administration, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, (including any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, State Disability, pension, credit, earnings and employment history) to give any and all such information to authorized representatives of ReliaStar Life Insurance Company *excluding psychotherapy notes,* and including, but not limited to, any other mental or psychiatric records, medical, dental, hospital and pharmacy records (including psychiatric, alcohol, and drug abuse, and **HIV/AIDS*** information) which may have been acquired in the course of examination or treatment. I understand the information obtained by use of this authorization will be used by ReliaStar Life Insurance Company and the above-described representatives to evaluate and adjudicate my current disability claim. The information may be re-disclosed to: (a) any medical, investigative, financial or vocational specialist or entity, or any other organization or person, employed by or representing ReliaStar Life Insurance Company, to assist with the evaluation, management, and adjudication of my current disability claim, (b) a Social Security vendor that may assist me in filing a claim with the Social Security Administration, and (c) other insurance companies or their representatives to help investigate and adjudicate other insurance claims related to me. I understand ReliaStar Life Insurance Company and the above-described representatives may release information to my treating physicians and current or prospective employers relating to restrictions, accommodations and possible return to work. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA's Privacy rules, or any other federal or state law.

This authorization is valid for two (2) years following the date of my signature. A photocopy of this authorization is as valid as the original. I understand my authorized representative or I have the right to request and receive a copy of this authorization and the information to which it pertains.

I understand I have the right to revoke this authorization by notifying ReliaStar Life Insurance Company in writing, of my revocation. However, such revocation is not effective to the extent ReliaStar Life Insurance Company has relied previously upon this authorization for the use or disclosure of my protected health information. I understand ReliaStar Life Insurance Company cannot condition the payment of a claim on my signing this authorization. However, I understand my revocation of, or my failure to sign this authorization may impair ReliaStar Life Insurance Company's ability to evaluate my current disability claim and as a result lack of required information may be a basis for denying that current disability claim for benefits.

*If you reside in **California**: this authorization excludes the release of Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS) information and test results. Separate authorizations signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

If you reside in **Connecticut, Maine, or Massachusetts: this authorization excludes the release of information about Human Immunodeficiency Virus (HIV) and Autoimmune Deficiency Disorder (AIDS). A separate authorization signed by the insured claimant, or employee-claimant (for self-insured business) are required each time results are released.

***If you reside in **Vermont**: this authorization EXCLUDES the release of any information about previously administered HIV-related tests, including but not limited to tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured is NOT AUTHORIZING ReliaStar Life Insurance Company to forward the results from any new test, requested by us, to any outside, non-affiliated company or entity not under specific contract with us to perform underwriting services, and ReliaStar Life Insurance Company shall comply, as applicable with the provisions of Title 8, Section 4724 (20) of the Vermont Statutes.

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.

By typing your name in the box below, you are electronically signing this document. Your electronic signature will be legally binding and enforceable and the legal equivalent of your handwritten signature.

Insured Name _____ Birth Date _____

Insured Signature *(or Authorized Representative [1])* _____ Date _____

Description of Personal Representative's Authority *(If applicable.)* _____

[1] *If signed by Authorized Representative, attach verification of identity*

FRAUD WARNINGS

Alabama, Alaska, 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.