Long Term Disability
Employee's Statement

COUNTY OF SAN MATEO
ATTN: LTD ADMINISTRATOR
455 COUNTY CENTER, 5TH FLOOR
REDWOOD CITY, CA 94063

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

Plan number	Division/location			
Employee's name			Social Security number	Employee's phone ( )
Date of birth	Sex	❒ Married ❒ Divorced ❒ Single ❒ Widowed	Number of dependent children	Employee's home address
Cause of disability		Date employed	Occupation	
Has employment been terminated? If so, Why? Give date.			Date last worked	Date disability began

On what date did you first see a physician for this sickness or injury? _____

Name of treating physician	Address	
If hospitalized for this sickness or injury, give name and address of hospital	Date admitted	Date Released

Are you bed confined? ❒ Yes ❒ No Are you house confined? ❒ Yes ❒ No
Have you ever had the same kind of sickness or injury before? ❒ Yes ❒ No
If yes, give date and physician's name and address: _____

_____

If disability resulted from accident or sickness, answer these questions:
On what date were you first able to leave your home for any purpose? _____
On what date were you first able to do any part of your work, supervisory or otherwise? _____

If disability resulted from sickness only, answer this question:
When did you first note symptoms? _____
Have you had any medical or surgical advice during the past five years for any other condition? ❒ Yes ❒ No
For what? _____
When? _____ Physician's name and address: _____

If disability resulted from accident only, answer these questions:
Where did accident occur? _____ Date of accident? _____
What time? _____ Was accident work related? ❒ Yes ❒ No

What was your basic weekly or monthly salary or wage (excluding any commissions, overtime, bonus, etc.) immediately prior to your stopping work because of your disability? _____
State the amount of your weekly or monthly salary or wage (including overtime, bonus, etc.) that your employer is paying while disabled. _____ How long payable? _____

Are you eligible for or receiving:

	Date benefit began	Date benefit terminates	Amount	Paid weekly	Paid monthly
❒ Worker's compensation benefits?				❒	❒
❒ Unemployment compensation disability?				❒	❒
❒ Sick pay?				❒	❒
❒ Salary continuance benefits?				❒	❒
❒ Social Security benefits?				❒	❒
❒ Retirement income (current or past employers)?				❒	❒
❒ Other?				❒	❒

Have you returned to work? ❒ No ❒ Yes At what date? _____

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.

Any person who knowingly and with intent to defraud, files a statement of claim containing any materially false or misleading information, commits a fraudulent act which is a crime.

_____ _____
Date Employee's Signature

FURNISHING OF FORMS BY THE COMPANY DOES NOT CONSTITUTE AN ADMISSION THAT THERE IS ANY COVERAGE IN FORCE NOR DOES IT CONSTITUTE AN ACKNOWLEDGEMENT OF ANY LIABILITY
PLEASE COMPLETE THE BACK OF THIS FORM

Education

Last year completed	Name of school	
Last year in school	Degree/certificate	Additional training
Attitude towards school ❒ Like ❒ Dislike	Favorable courses	

Military service

Branch	Dates From: To:	Discharge ❒ Honorable ❒ General ❒ Other _____
Rank	Special training	
Duties/responsibilities		
Service connected disabilities		

Vocational history

List most recent first.

1.

Employer		Supervisor
Job title(s)		
Dates From: To:	Salary	Duties
Union		Representative

2.

Employer		Supervisor
Job title(s)		
Dates From: To:	Salary	Duties
Union		Representative

3.

Employer		Supervisor
Job title(s)		
Dates From: To:	Salary	Duties
Union		Representative

4.

Employer		Supervisor
Job title(s)		
Dates From: To:	Salary	Duties
Union		Representative