

# Waiver of Premium Disability Claim



Complete and sign the Employer's Statement. The Insured's Statement must be completed by the Insured. The Attending Physician's Statement must be completed by the Insured's attending physician. The completed forms, along with a copy of the Insured's enrollment form, must be sent to: ING Employee Benefits, P.O. Box 1548, Minneapolis, Minnesota 55440.

## Employer's Statement

Insured employee's full name		Date of birth	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Never married <input type="checkbox"/> Widow(er)	
Residence (number, street, city, state, zip code)		Telephone #	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security number
Policyholder's name		Group policy number	Account number	Job title
Amount of employee's insurance	Effective date of coverage	Date First entered our employment		Date last worked
Basic \$ _____	_____	Salary \$ _____ per <input type="checkbox"/> hour <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year		
Optional \$ _____	_____	Status <input type="checkbox"/> Full time <input type="checkbox"/> Part time		<input type="checkbox"/> Union <input type="checkbox"/> Nonunion
Supplemental \$ _____	_____	If part time, average hours per week _____		Date of last salary change
Other \$ _____	_____			

## Employer Certification

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

Name of employer		Date (month, day, year)
Employer's address (number, street, city, state, zip code)		Telephone number
Authorized signature	Print Name and Title	

## Insured's Statement

Describe condition or illness

Name and address of attending physician(s): Use reverse side of form to provide additional information.

Doctor	Complete Address	Cause	Date

Date you last worked preceding claim _____	Date you became totally disabled _____
Are you receiving any other disability benefits? _____	If yes, what type? _____
Are you house confined? _____	Are you bed confined? _____
Are you receiving any wages or salary? _____	If yes, what type? _____
Have you returned to work? _____	If yes, what date? _____
Do you expect to return to work? _____	If yes, what date? _____

EDUCATIONAL BACKGROUND: (Please circle grade completed.)

1 2 3 4 5 6 7 8 9 10 11 12 GED

College: 1 2 3 4 AA/AS/BA/BS/MA/Ph.D/Other: \_\_\_\_\_

I hereby certify that the above statements are complete and accurate to the best of my knowledge.

I hereby authorize any physician who has attended me or any hospital where I have been a patient to release to ING Employee Benefits, Minneapolis, Minnesota, or its authorized representative, all information regarding my medical history or treatment. A reproduction of this authorization is as valid as the original.

Signature	Date
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**Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.**

Use this side if you wish to provide us with additional information.

**Name and address of attending physician(s)**

Doctor	Complete Address	Cause	Date

Describe condition or illness

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