IMPORTANT INFORMATION REGARDING APPLICATION FOR BENEFITS

This form is to be attached to the proof of Loss Claim Statement when a claim is submitted to Reliance Standard Life. Please be sure that all responsible parties completing and filing a claim for benefits are aware of the following statements which concern claim fraud and abuse:

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 fines and confinement in prison.

State of California
For your protection, California law requires the following to appear on this form: Any person who knowingly presents a 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.

State of Florida
Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

State of New Jersey
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

State of New York
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.

State of Ohio
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

State of Oregon
Any person who, with an intent to knowingly 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, may be subject to prosecution for insurance fraud.

State of 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.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Proof of Loss Claim Statement
Accidental Dismemberment Benefits

EMPLOYER/ADMINISTRATOR INSTRUCTIONS

The Employer/Administrator must complete PART A in its entirety. The Claimant should complete, sign and date PART B, the Authorization for Use in Obtaining Information form and PART C in their entirety. PART D must be completed by the attending physician without expense to RSL.

Return this form to: **Reliance Standard Life Insurance Company**
Attn: Group Life Claims
P.O. Box 7307
Philadelphia, PA 19101-7307
Phone 1-800-351-7500

In addition to the claim form, the following items are required:
1. A copy of the original enrollment forms and any subsequent changes;
2. Payroll records showing premium deduction, if the employee is required to pay all or part of the premiums for this insurance.
3. Information on other insurance carriers, including company name, address, phone number, policy number and type of coverage for each.

On a small number of cases, additional information may be required. Submission of the above information does not waive our right to request additional information, or waive any of our rights or defenses, or admit liability.

PART A: EMPLOYER/ADMINISTRATOR INFORMATION

Employer Name and Address				List all Applicable RSL Policy Numbers Under Which a Claim is Being Made
Division Name and Address				Employee Social Security Number
Employee Name and Address				Bill Group Number (if applicable)
Is Employee's Insurance Currently in Force? ☐Yes ☐ No	Date Coverage Terminated	Date of Birth	Date Employed	Employee Occupation/Title/Position
Effective Date of Coverage for Employee	Insurance Class (Refer to Policy Schedule of Benefits)	Salary on Last Benefit Change Date $ ☐Hrly ☐ Wkly ☐Mthly ☐ Annly		Date Premium Paid To On Employee's Behalf
Accidental Death Benefit In Force $	Date of Last Benefit Increase (Refer to Policy Schedule of Benefits)	Is Employee receiving Workers Comp. Benefits? ☐Yes ☐ No		Is Employee receiving LTD Benefits? ☐Yes ☐ No
If either answer is Yes, indicate:	Name of Company(ies)	Address of Company(ies)		
Policy Number(s)	Phone Number(s)	Type(s) of Benefit(s), Benefit Amount(s), Effective Date(s)		

Current Status of Employee
☐Active ☐ Retired ☐ Premium Waiver of Disability ☐ Approved Leave of Absence (Explain)
☐ Other (Explain)

Number of Hours Employee Scheduled to Work Per Week	Is Employee Still Working? ☐ Yes ☐ No	Date Employee Last Worked	Reason Employee Did Not Return to Work

Employee Is (Was): ☐ Full-time ☐ Union ☐ Hourly ☐ Exempt ☐ Commissioned
(Check All That Apply) ☐ Part-time ☐ Non-Union ☐ Salaried ☐ Non-Exempt ☐ Other (Explain)

If Claim is For Dependent, Provide the Following:

Dependent's Name and Address	Social Security Number	Relationship	Amount of Benefit

AUTHORIZED EMPLOYER/ADMINISTRATOR SIGNATURE

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Phone Number ( )	Fax Number ( )	Email Address	
Employer/Administrator Name (Please Print)		Employer /Administrator Signature	Date

PART B: IMPORTANT TAX INFORMATION

To Be Completed By Claimant

Under penalties of perjury, I certify (1) that the Social Security Number shown on this form is my correct Social Security Number or Taxpayer Identification Number and (2) that I am not subject to backup withholding as a result of a failure to report all interest or dividends; or the Internal Revenue Service has notified me that I am no longer subject to backup withholding. (Strike out clause (2) if you are currently under notification that you are subject to backup withholding.)
By signing this form the claimant has read and agrees with the terms of the statement as well as any accompanying information.

Social Security Number/Tax ID Number
___ ___ ___ ___ ___ ___ ___ ___ ___

Signature of the Claimant: _____

Date Signed (month, day, year): _____

Be Certain Authorization for Use in Obtaining Information form and Part C are Completed.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF INSURED: _____
INSURED'S DATE OF BIRTH: _____
POLICYHOLDER: _____

To all physicians and other health care professionals, hospitals, other health care institutions, insurers, medical, hospital and prepaid health plans, pharmacies, pharmacy benefit managers, employers, group policyholders, contract holders, governmental agencies (including but not limited to the Internal Revenue Service and the Social Security Administration), private and/or public benefit plan administrators, and/or attorney representatives, including but not limited to covered entities and business associates under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the accompanying regulations:

You are authorized to provide Reliance Standard Life Insurance Company and/or its authorized administrators including but not limited to Matrix Absence Management, with information concerning medical care, advice, and/or treatment provided to me, the above named Insured, and/or any employment, salary, tax and/or benefit-related information concerning me, the above named Insured. I understand that the disclosure of information may include disclosure of protected health information under HIPAA and the accompanying regulations, information regarding treatment for mental illness, the human immunodeficiency virus (HIV) and/or the use of drugs and alcohol. I also understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be subject to protection under HIPAA and the accompanying regulations. A statement of Reliance Standard Life Insurance Company's privacy policy is available at www.rsli.com or upon request.

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, and may be revoked by me at any time upon written request to the address above. A reproduction of this Authorization shall be considered as valid as the original.

_____ _____
Date Insured's Signature

(If the Insured is unable to sign, an authorized person may sign.)

_____ _____
Date Authorized Person's Signature

Description of Authorized Person's authority to sign on behalf of Insured:

_____

PART C: CLAIMANT INFORMATION (USE EXTRA SHEET IF NECESSARY)

Describe fully how the accident happened:	What was the date of the accident?

List all medical providers (e.g. physicians, surgeons etc.) providing care, consultation and/or treatment as a result of the above injuries:

Name	Address	Phone Number

List all witnesses to accident. USE EXTRA SHEET IF NEEDED.

Name	Address	Phone Number

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Signature of Claimant Date	Home Phone No. ( )	Business Phone No. ( )

Address of Claimant (No., Street, City, State, Zip)

PART D: ATTENDING PHYSICIAN'S STATEMENT

Instructions to Physician: Please complete each applicable section of this form and provide all reports and treatment records requested pertaining to this patient. The Claimant is responsible for the completion of this Statement without expense to the Company.

Name of Patient	Address (Street, City, State, Zip Code)

Nature of Injury (describe complications, if any)

When did the accident happen?	When did patient first consult you for this condition?

Did the accidental injury result in:

Loss of Hands? ☐ Right ☐ Left	Was severance at or above wrist joint? ☐ Yes ☐ No	Date of severance	Extent of severance (attach supporting documentation)	
Loss of thumb and index finger of same hand? ☐ Right ☐ Left	Was severance through or above metacarpophalangeal joint? ☐ Yes ☐ No	Date of severance	Extent of severance (attach supporting documentation)	
Loss of Feet? ☐ Right ☐ Left	Was severance at or above ankle joint? ☐ Yes ☐ No	Date of severance	Extent of severance (attach supporting documentation)	

Total and Irrecoverable Loss of Sight of:	Right Eye ☐ Yes ☐ No Left Eye ☐ Yes ☐ No	Date of Loss _____ Date of Loss _____	Was Eye Removed? ☐ **Yes** ☐ **No** Was Eye Removed? ☐ Yes ☐ No	Date Removed _____ Date Removed _____

Total and Irrecoverable Loss of Hearing in both ears? ☐ Yes ☐ No Date of Loss:_____ Does your patient suffer from Total and Irrecoverable Loss of the function of Speech? ☐ Yes ☐ No Date of Loss: _____

In your opinion, was any disease, infection, or bodily or mental infirmity an underlying cause in the loss(es) indicated above?
☐ Yes ☐ No If "Yes", please explain.

Was an operation performed in conjunction with the treatment of the loss(es) indicated above?
☐ Yes ☐ No If "Yes, please describe briefly. (Attach surgery records)

In your opinion, did the loss(es) result from any self-inflicted injury or attempted self-destruction? ☐ Yes ☐ No

If the indicated loss(es) include loss of sight, please answer the following questions.

If the loss of sight is partial, but irrecoverable, please state amount of vision in each eye with Snellen notations, or Jaeger scale, if pertinent.

Uncorrected O.D. O.S.	Corrected O.D. O.S.	Date of Examination (attach copies of examination records)

Do you believe vision can be restored in whole or part by treatment or operation? ☐ Yes ☐ No

If an operation is contemplated, give approximate date.

Was patient confined to a hospital? ☐ Yes ☐ No If "Yes" give name and address of hospital

Treatment - PLEASE ATTACH COPIES OF ALL TREATMENT RECORDS FOR THIS PATIENT.

Date of First Visit	Dates of Subsequent Visits			

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Physician's Specialty	Tax Identification Number	
Physician's Name (please print or type)	Address (No., Street, City, State, Zip Code)	
Physician's Signature Date	Phone Number ( )	Fax Number ( )

REMINDER: PLEASE PROVIDE ALL REPORTS AND TREATMENT RECORDS PERTAINING TO THIS PATIENT.