## 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

Reset

# Proof of Loss Claim Statement
# VAI Dismemberment Benefits

## EMPLOYER/ADMINISTRATOR INSTRUCTIONS

The Employer/Administrator must complete PART A in its entirety. The Employee should complete, sign and date the Authorization for Use in Obtaining Information form and PART B. PART C must be completed by the attending physician.

**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 | Voluntary Accident Policy Number | Employee Name |
| Employee Social Security Number | Date of Birth | Date of Hire |
| Date of Accident | Employee Occupation/Title/Position | Insurance Class (Refer to Policy Schedule of Benefits) |

Other Names by which the Employee may have been known (maiden name, hypothetical name, nickname, derivative form of first/middle name, alias)

| | | |
|---|---|---|
| Plan Elected (Refer to Policy Schedule of Benefits) ☐ A ☐ B ☐ C | Type of Coverage Elected ☐ Employee Only ☐ Employee & Child(ren) ☐ Employee & Spouse ☐ Family | Date Voluntary Accident Coverage First Elected |
| Usual Number of Hours Employee Works(ed) Per Week | Date Employee Last Worked Usual Number of Hours | Reason Employee Did Not Return to Work (if applicable) |

Did Accident Happen at Work? ☐ Yes ☐ No Explain:

Percentage of premium paid by employer:_____% Was Employee taxed on this amount? ☐ Yes ☐ No
Percentage of premium paid by employee:_____% ☐ Pre-tax dollars ☐ Post tax dollars

Percentages must total 100%. **If left blank, we will assume that 100% of premium is paid by employer and that employee was not taxed.**

## IF CLAIM IS FOR A DEPENDENT, PROVIDE THE FOLLOWING:

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

Other Names by which the Dependent may have been known (maiden name, hypothetical name, nickname, derivative form of first/middle name, alias)

## AUTHORIZED EMPLOYER/ADMINISTRATOR SIGNATURE

**Any person who knowingly and with intent to injure, defraud or deceive Reliance Standard Life Insurance Company, files a statement of claim or submits any information in conjunction with a claim containing fraudulent, false, misleading, incomplete or deceptive information commits a fraudulent insurance act, which is a crime. These actions will result in the denial of the claim, and are subject to prosecution under state and/or federal law. Reliance Standard Life Insurance Company will cooperate fully with any prosecution and will seek any and all appropriate legal remedies.**

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

**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

P.O. Box 7307
Philadelphia, PA 19101-7307

# 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 B: CLAIMANT INFORMATION (USE EXTRA SHEETS 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 SHEETS 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) | Email Address |
|---|---|
| | |

## PART C: 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)

| Date of Accident | When did patient first consult you for this condition? |
|---|---|
| | |

### DID THE ACCIDENTAL INJURY RESULT IN:

| Loss of Hand(s) Including surgical reattachment? ☐ Left ☐ Right | Loss of Foot (feet) Including surgical reattachment? ☐ Left ☐ Right | Loss of Arm(s) Including surgical reattachment? ☐ Left ☐ Right |
|---|---|---|
| Loss of Leg(s) Including surgical reattachment? ☐ Left ☐ Right | Loss of Sight? ☐ Left Eye ☐ Right Eye | Loss of Hearing? ☐ Left Ear ☐ Right Ear |
| Loss of Finger(s) Including surgical reattachment? How many? | Loss of Thumb(s) Including surgical reattachment? ☐ Left Thumb ☐ Right Thumb | Loss of Toe(s) Including surgical reattachment? How many? |

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 RELEVANT TREATMENT RECORDS FOR THIS PATIENT.**

| Date of First Visit | Dates of Subsequent Visits | | | |
|---|---|---|---|---|
| | | | | |

**Any person who knowingly and with intent to injure, defraud or deceive Reliance Standard Life Insurance Company, files a statement of claim or submits any information in conjunction with a claim containing fraudulent, false, misleading, incomplete or deceptive information commits a fraudulent insurance act, which is a crime. These actions will result in the denial of the claim, and are subject to prosecution under state and/or federal law. Reliance Standard Life Insurance Company will cooperate fully with any prosecution and will seek any and all appropriate legal remedies.**

| 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.**