RELIANCE STANDARD
Life Insurance Company

Proof of Loss Claim Statement
Group Life/Accidental Death Insurance

EMPLOYER/ADMINISTRATOR INSTRUCTIONS

The Employer/Administrator must complete PART A in its entirety. The Beneficiary must complete The Authorization for Use in Obtaining Information and PARTS B and C.

Return this form to: **Bay Bridge Administrators, LLC**
P.O. Box 161690
Austin, TX 78716

In addition to the claim form, the following items are required:
1. Certified Death Certificate (with raised or colored seal) providing the final cause of death.
2. Original enrollment forms and any subsequent changes, including all beneficiary designations.
3. Payroll records for two (2) months prior to the date last worked confirming premium deduction (if the employee was required to pay any portion of the premiums for this insurance).
4. Additional documents are required if the beneficiary is a Minor or an Estate-See next page for additional information.
5. If Accidental Death Benefits are being claimed, provide any police report, autopsy report and/or relevant newspaper clippings.

Any benefit payments of $5,000 or more will be deposited into an RSL Asset Account ®. RSL will establish an interest-bearing account for each Beneficiary and provide him/her with personalized checks and access to the account.

A separate form must be completed and signed by each Beneficiary. In certain instances, we may require completion of the Attending Physician's Statement (Part D). Also, 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	Policy Number
Division Name and Address	Employee Social Security Number
Employee Name and Address	Date Employment Commenced

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

Was Insurance in Effect on Date of Loss? ☐ Yes ☐ No	If No, Termination Date of Coverage	Date of Birth	Date of Death	Employee Occupation/Title/Position
Effective Date of Coverage for Employee	Insurance Class (Refer to Policy Schedule of Policy)	Salary on Last Benefit Change Date $ ☐ Hrly ☐ Wkly ☐ Mthly ☐ Annly		Date Premium Paid To On Employee's Behalf
Life Benefit in Force	Are Accidental Death Benefits Being Claimed? ☐ Yes ☐ No Amount Claimed $ _____	Date of Last Salary Increase		Date of Last Benefit Increase

Status of Employee on Date

☐ Active ☐ Retired ☐ Premium Waiver for Disability ☐ Approved Leave of Absence (Explain) ☐ Other (Explain)

Usual Number of Hours Employee Worked Per Week	Date Employee Last Worked Usual Number of Hours	Reason Employee Did Not Return to Work

Employee 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

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

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 Sure the Authorization For Use in Obtaining Information and Parts B and C are Completed

RELIANCE STANDARD
Life Insurance Company

LIFE CLAIM AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF DECEDENT: _____
DECEDENT'S SSN: _____
DATE OF DEATH: _____
BENEFICIARY: _____
NEXT OF KIN OR LEGAL REPRESENTATIVE OF
DECEDENT'S ESTATE: _____
RELATIONSHIP: _____
(*If Executor, Administrator etc., Provide Appropriate Court Order)*

To all physicians and other health care professionals, hospitals, other health care institutions, insurers, medical, hospital and prepaid health plans, pharmacies, employers, group policyholders, contract holders, governmental agencies (including but not limited to 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 with information concerning medical care, advice, and/or treatment provided to the above named Decedent, and/or any employment, salary and/or benefit-related information concerning the above named Decedent. 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 below. A reproduction of this Authorization shall be considered as valid as the original.

_____ _____
Date Beneficiary's Signature

If the Beneficiary is not the Decedent's next of kin or legal representative, the next-of-kin or authorized legal representative of the Decedent's Estate must sign below:

_____ _____
Date Authorized Person's Signature

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

PART B: IMPORTANT TAX INFORMATION

To Be Completed By Beneficary

Under penalties of perjury, I certify (1) that the Social Security Number shown on this form is my correct Social Security Number or Taxpayor 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 beneficiary 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 Beneficiary:

_____

If applicable, this signature specimen will be used on the RSL Asset Account ®

Date Signed (month, day, year): _____

PART C: BENEFICIARY INFORMATION

In order to assure prompt processing, please be sure to provide the **IMPORTANT TAX INFORMATION** above. Be certain the Authorization for Use in Obtaining Information is signed by the next of kin or authorized representative of the deceased. The completed and signed claim form along with the Certified Death Certificate and other required items should be returned to the Employer/Administrator for submission. If you are interested in an optional Method of Settlement rather than a lump sum payment, please contact us at the address or telephone number on this form for the plans that are available. Important: Upon approval of this claim, if the benefit amount is $5,000 or more, we will deposit the benefit into an interest bearing account in your name and provide you with access to it.

Name of Beneficiary	Relationship To Employee	Beneficiary's Date of Birth	Address of Beneficiary (No., Street, City, State)

Note: If any designated beneficiary is deceased, submit that beneficiary's certificate of death. If beneficiary is the deceased's Estate, provide certified Letters of Administration or Letters Testamentary along with the Estate's Tax ID Number. If beneficiary is a minor, provide certified Letters of Guardianship for the minor's Estate and the minor's social security number. The Guardian should sign Part B (IMPORTANT TAX INFORMATION) above, and should also sign where indicated below in his/her capacity on behalf of the Estate of the Minor.

List Other Insurance Coverage In Force At the Time of the Insured's Death

Companies	Policy Number	Effective Date	Amount of Insurance

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

PART D: ATTENDING PHYSICIAN'S STATEMENT

Completion of PART D may help to expedite the processing and review of this claim.

Name of Deceased	Names(s)/Address(es) of all Physicians Who Treated Deceased

Cause of Death

Principal Cause		Date of Onset
Contributing Cause		Date of Onset

I Attended Deceased	From (Date)	To (Date)

Was deceased unable to work due to illness or injury prior to date of death? ☐ Yes ☐ No	If **"Yes"** please state date on which such illness or injury prevented the deceased from working: _____

Was Death Due To: ☐ Accident? ☐ Suicide? ☐ Homicide?	If caused by accident, was it associated with his/her occupation? ☐ Yes ☐ No
Name of Physician (Please Print)	Address of Physician

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Date	Phone Number ( )	Fax Number ( )	Physician's Signature	Degree