Reset

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

Proof of Loss Claim Statement
Group Life Accelerated Benefit

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. Copies of enrollment forms and any subsequent changes;
2. Proof of earnings (as defined by the applicable policy) and, if the employee is required to pay all or part of the premiums for this insurance, copies of payroll records for a two (2) month period prior to date last worked to confirm premium payments.

Additional medical information may be required from the physician and an independent medical examination may be requested by RSL. A notarized consent must be received from any Irrevocable Beneficiary and any Assignee. RSL must comply with all state regulations. This may delay processing of the claim.

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 N/A	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) Class 1 if act. retirees	Salary on Last Benefit Change Date $ ☐ Hrly ☐ Wkly ☐ Mthly ☐ Annly		Date Premium Paid To On Employee's Behalf
Life Insurance In Force $	Accelerated Benefit Amount Requested (based on the limits stated in the policy) $	Date of Last Benefit Increase (Refer to Policy Schedule of Benefits)		

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

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)

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 ( )	E-mail Address
Name (Please Print)		Employer/Administrator Signature Date

PART B: IMPORTANT TAX INFORMATION To be completed by Employee

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
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AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF INSURED: _____
INSURED'S SSN: _____
POLICYHOLDER: _____

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 me, the above named Insured, and/or any employment, salary 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

In order to assure prompt processing, please be certain the Authorization for Use in Obtaining Information is signed and dated. The completed and signed claim form including PART D below should be returned to the Employer/Administrator. **The payment of the Accelerated Benefit will reduce the Death Benefit under your Life Insurance.**

Important tax information: Accelerated Benefits may be considered taxable income and assistance should be sought from a personal tax advisor. Receipt of these benefits may affect your eligibility for other government programs such as Medicaid and Supplemental Security Income (SSI).

Name of Claimant	Relationship To Employee	Date of Birth	E-mail Address

"I herby request Reliance Standard Life to accelerate the portion of my term life insurance coverage specified on this claim statement. This request is being made voluntarily and without coercion on the part of any third party. I understand that receipt of an accelerated benefit may affect my eligibility for a state or federal program such as Medicaid, and that these benefits may be taxable. I also understand that the death benefit will be reduced if I receive an accelerated benefit."

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Signature of Claimant	Date	Home Phone Number	Business Phone Number
		( )	( )

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

PART D: ATTENDING PHYSICIAN'S STATEMENT

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

Patient's Name	Date of Birth
Principle Diagnosis **INCLUDING ICD-9 CODE**	Date of Onset
Contributing Cause INCLUDING **ICD-9 CODE**	Date of Onset

Objective findings (attach results of x-rays, lab tests, EKGs, MRIs, and scans). Provide most recent lab values and diagnostic test results.

Describe Treatment programs, including surgery or medications (attach copies of treatment records)

I attended patient: From (date of first visit) To (date of treatment) Frequency of visits (treatment)

Is patient now totally and continuously disabled? ☐ Yes ☐ No	If "Yes," please state date on which total and continuous disability began:

Please provide the name(s) and address(es) of any other physician currently treating this patient:

In your opinion, does the patient possess the mental capacity to understand his/her financial affairs and to direct the use of his/her funds?
☐ Yes ☐ No

Based upon this patient's medical condition and your current clinical findings, does this patient have a Life Expectancy of:
Less than 12 months ☐ More than 12 months, but less than 24 months ☐ Greater than 24 months ☐ Cannot be determined ☐

What is this patient's prognosis?

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.