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

Short-Term Disability Benefits
Initial Statement of Claim

HOW TO FILE A CLAIM

Please follow the instructions listed below to avoid unnecessary delays in processing your claim. This form must be fully completed for each disability claim. If the claim form is not fully completed, the processing of the claim may be delayed.

Employer: 1) Complete and sign Part I answering all questions;
2) Attach job description; and
3) Attach proof of earnings as defined by applicable policy (example: payroll records, W-2, K1, 1099, etc.)

Insured: 1) Complete and sign Part II answering all questions; and
2) Complete and sign the AUTHORIZATION FOR USE IN OBTAINING INFORMATION form, and
3) Have the attending physician complete and sign the ATTENDING PHYSICIAN STATEMENT. **IMPORTANT: PLEASE ATTACH ALL MEDICAL RECORDS FROM THREE (3) MONTHS PRIOR TO DATE OF DISABILITY TO PRESENT.**

"Please mail completed claim forms and attachments (only) to Bay Bridge Administrators, LLC, P.O. Box 161690, Austin, TX 78716 "

PART I **FOR EMPLOYER TO COMPLETE**

Name of Insured (Last, First, Middle Initial)	Date of Birth	Social Security No.	Policy No.

Job Title	Insurance Class	Hire Date	Date Enrollment Card Signed	Effective Date of Insurance

Date Laid Off (If Applicable)	Date Retired (If Applicable)	Weekly Earnings ☐ Weekly ☐ Bi-weekly	Date Last Worked	Numbers of Hours Worked 2 Weeks Preceding the Last Day Worked	Date Returned to Work

Work schedule at time of disability____day/week_____hrs./day

How is Claimant Paid? ☐ Hourly ☐ Salaried ☐ Salary & Bonus ☐ Salary & Commission ☐ Commission Only ☐ Other:

Did the employee receive sick pay after ceasing work? ☐ Yes ☐ No	Date Began	Dated Ended	Reason For Stopping Work

Was sick pay exhausted? ☐ Yes ☐ No Date exhausted?	If they did not exhaust their sick pay, provide number of remaining sick days or hours
Did the employee receive salary continuation? ☐ Yes ☐ No Date Began Date Ended	Work State
Is disability work related? ☐ No ☐ Yes If "Yes," Explain	Brief Description of Duties

Percentage of premium paid by: Claimant_____% Employer_____% If claimant pays any portion of the premium, please indicate whether the claimant's portion of the premium is paid with: ☐ Pre-tax dollars ☐ Post-tax dollars

Is there any reason why FICA taxes should not be withheld from claimant's benefits? ☐ Yes ☐ No If yes, please explain:

Employer Name & Address	Employer's Telephone Number Ext.

Authorized Signature Date	Fax Number	Email Address

PART II **FOR INSURED TO COMPLETE**

Home Address (Street, City, State, Zip)	Gender ☐ Male ☐ Female	Dominant Hand ☐ Right ☐ Left Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Mailing Address if different than Home Address (Street, City, State Zip)	Do you wish to receive communications by Email or Mail Email ☐ Mail ☐	Email Address

Is this Claim Based on an accident? Yes ☐ No ☐	Did injury occur at work? If "Yes," for whom were you working? Yes ☐ No ☐	Date you were first unable to work because of this disability

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Short-Term Disability Benefits
Initial Statement of Claim

Date of Accident (if any)	Time ☐ AM ☐ PM	How and where did accident happen?

Name and Address of Attending Physician	Date you returned to work

Are you now receiving Unemployment Compensation benefits? ☐ Yes ☐ No

Are you now receiving or eligible to receive as a result of this disability:
Social Security ☐ Yes ☐ No
Worker's Compensation ☐ Yes ☐ No

State Disability ☐ Yes ☐ No
No Fault Disability ☐ Yes ☐ No
Other _____ ☐ Yes ☐ No

If "Yes" give name and address of insurer, amount of income, date benefits began and ended.

We are required to withhold federal income tax from any benefit payments upon your request. If benefits are taxable by your state, we will also withhold state income tax upon your request. We must also send a report to your employer at the end of each calendar year showing your name, social security number, any benefits paid and any taxes withheld. If you would like us to withhold any taxes, please indicate the dollar amount to be withheld each week:

Federal Tax to be Withheld _____ ($20.00 Minimum per week, whole dollars only)
State Tax to be Withheld _____ ($ 2.00 Minimum per week, whole dollars only)

I authorize RSL to send my disability payments to the Bank designated below for electronic deposit in my Account. I understand that I may terminate this arrangement at any time by writing to the RSL address above.

☐ Yes Set-up Direct Deposit

Bank/Financial Institution Information

Name of Bank (Print)		
Address of Bank		
City,	State	Zip

Choose Type of Account

☐ Checking ☐ Savings

Bank Transit/Routing Number (9 Digits)
Personal Account Number
Or Attach a Voided Check imprinted with your name.

Any person who knowingly and with intent to injure 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 pursue any and all appropriate legal remedies arising from such fraudulent insurance acts.

Insured's Signature	Date	Telephone Number ( )	E-Mail Address

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Bay Bridge Administrators, LLC,
P.O. Box 161690, Austin, TX 78716

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.

Reliance Standard Life Insurance Company will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on the provision of this Authorization, except that this Authorization may be required to allow a covered entity to disclose protected health information where such disclosure is necessary to evaluate my claim for benefits.

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:

_____

IMPORTANT: PLEASE ATTACH ALL MEDICAL RECORDS FROM THREE (3) MONTHS PRIOR TO DATE OF DISABILITY TO PRESENT.

PART III ATTENDING PHYSICIAN'S STATEMENT (PLEASE ANSWER ALL QUESTIONS AND SIGN)

Patient's Name

Diagnosis and Concurrent Conditions (including ICD-9 or ICD-10 codes)

Surgical or Obstetrical Procedure

Current Medications

Frequency of Treatment ☐ Weekly ☐ Other ☐ Monthly

Is condition due to injury or sickness arising from patient's employment? ☐ Yes ☐ No	Has patient ever had same or similar symptoms? ☐ Yes ☐ No If Yes, when	
Date symptoms first appeared or accident happened	Date patient first consulted you for this condition	Is patient still under your care for this condition? ☐ Yes ☐ No
If condition is due to pregnancy, give LMP and expected date of delivery. LMP_____ Expected Date of delivery _____	If patient hospitalized, give name of hospital Admission Date _____ Discharge Date _____	
Is patient able to perform his/her job? ☐ Yes ☐ No	Date patient was continuously unable to work From_____ To	
Estimate date patient should be able to return to work.	Patient will be partially disabled From: To:	

Physical Impairment

☐ Class 1 – No limitation of functional capacity; capable of heavy work* …. .No restrictions (0-10%)
☐ Class 2 – Medium manual activity* ……..(15-30%)
☐ Class 3 – Slight limitation of functional capacity; capable of light work* ……...(35-55%)
☐ Class 4 – Moderate limitation of function capacity; incapable of clerical or administrative (sedentary*) activity ……..(60-70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity ……(75-100%)
☐ Remarks
*As defined in the Federal Dictionary of Occupational Titles

Psychiatric Impairment -Complete only if applicable.

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations *(no limitations)*.
☐ Class 2 – Patient is able to function in most stress situations and engage in only limited interpersonal relations *(slight limitations)*.
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations *(moderate limitations)*.
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations *(marked limitations)*.
☐ Class 5 – Patient has significant loss of psychological, physiological, personal, and social adjustments *(severe limitations)*.
☐ Remarks

Please define stress as it applies to this patient.
What stress and problems in interpersonal relations has patient had on the job?
Do you believe a legal guardian or conservator should be appointed for this problem? ☐ Yes ☐ No
Is the patient competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

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Physician's Name, Address, ZIP (Please Print or Type)

Telephone Number ( )	Fax Number ( )	Specialty

Physician's Signature	Date	Degree	Physician's Tax ID No.