RELIANCE STANDARD
LIFE INSURANCE COMPANY

A MEMBER OF THE TOKIO MARINE GROUP

Please mail original form to: Bay Bridge Administrators, LLC PO Box 161690
Austin, TX 78716
Fax (512) 275-9355

DISABILITY CONTINUANCE REPORT

Please return completed report before:

INSURED'S STATEMENT

*Note: This statement must be made by the insured. Every question must be fully answered. The Company reserves the right to ask for additional statements if deemed necessary for proper disposition of the claim.

Insured's Full Name:		Social Security #:
Policy No.:	Claim No.:	
Are you presently working? ☐ Yes ☐ No	If "Yes", on what date did you resume? Full Duties / Partial Duties	If "No", when do you think you will be able to return to work? (Give Approx. date)
Did you perform any work since last report? (Other than stated above) ☐ Yes ☐ No	If "Yes", Name of Employer: Dates Worked: Total Earnings Since Last Report: (Please attach payroll documentation)	
What is your current condition?		
What is status of your application for Social Security or other Federal or State disability or Workers' Compensation Benefits? Please advise your current benefit amount and the date benefits commenced.		
Are you receiving income from any other source? Source:	Date you began receiving income:	Monthly Amount:
On what dates were you treated since last report? Doctor's Office	Hospital	Home
****If you have been referred to another physician(s) since last report please provide name, address, and phone number on separate sheet of paper****		
Are you in any rehabilitation program? ☐ Yes ☐ No	If "Yes", give details:	

AUTHORIZATION

To All physicians, hospitals, medical service providers, druggists, employers, consumer reporting agencies, law enforcement agencies and any other agencies or organizations including other insurance companies, Blue Cross-Blue Shield, self-insured and prepaid health plans? And specifically

_____
Hospital(s), and Dr.(s)

You are authorized to permit Reliance Standard Life Insurance Company and its authorized representatives to view and obtain a copy of ALL RECORDS including employment, law enforcement, tax, financial, insurance claim records and medical records as to examination, history, diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric, drug or alcohol treatment and disease of;

_____
Print Name of Insured

I understand the information obtained will be used only by Reliance Standard Life Insurance Company to determine eligibility for insurance and benefits claimed under the Insured's policy. I consent to re-disclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred or relayed to any other person not specified in this form without my written consent.

I understand this authorization may be revoked by written notice to Reliance Standard Life Insurance Company, but this will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below.

I know I may request to receive a copy of this authorization. I also agree a photographic copy of this authorization shall be as valid as the original.

By signing below, I certify that the facts as indicated are true to the best of my knowledge and belief. I acknowledge that I have read the Claim Fraud Warning Statements pages. on the following pages.
I also acknowledge and agree that Reliance Standard Life Insurance Company has the right to seek reimbursement from me, as necessary to collect benefit overpayments made by Reliance Standard Life Insurance Company, or by its Administrator: Bay Bridge Administrators, LLC in reliance on information requested or required under the provisions of my policy or in connection with this claim.

Date:	Signature of Insured:	Telephone No.:
Address: (Street, City, State, Zip Code)		

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

ATTENDING PHYSICIAN'S STATEMENT OF CONTINUING DISABILITY

It will be a service to your patient if will please answer ALL questions completely. Any charge required for completion of this form is the responsibility of the patient.

Patients Name:

What is the present diagnosis?

Physical Limitations:

Is Patient still under your care for this condition? ☐ Yes ☐ No

If "No", give date your services terminated:

Has patient been referred to another physician or specialist? ☐ Yes ☐ No

If "Yes", please provide name, address, and phone number

Frequency of visits:
☐ Daily ☐ Monthly
☐ Weekly ☐ Other, Explain:

Date of last visit:

Enclose copy of office notes for:
-

Have any complications developed? ☐ Yes ☐ No

If "Yes", what:

Has any operation been: ☐ Performed? ☐ Scheduled? ☐ Recommended?

What?

When?

Since last report, has the patient been hospital confined? ☐ Yes ☐ No

Where?

When?

PROGNOSIS FOR REGULAR WORK

Is patient disabled and unable to perform his/her regular work? If "No", please give date released to return to work? ☐ Yes ☐ No

Do you expect a fundamental or marked change in the future relating to patient's job?
☐ Yes-Improvement
☐ Yes-Deterioration
☐ No

If "No", please explain.

If improvement is expected, when will patient recover sufficiently to perform duties of his/her regular work? (Do not respond with undetermined)

Is patient a suitable candidate for trial employment or job training?
Regular Work: ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time

PROGNOSIS FOR ANY GAINFUL WORK

Is patient disabled and unable to perform any gainful occupation? If "No", please give date released to return to any work? ☐ Yes ☐ No

Do you expect a fundamental or marked change in the future relating to any occupation? ☐ Yes-Improvement ☐ Yes-Deterioration ☐ No

If "No", please explain.

If improvement is expected, when will patient recover sufficiently to perform duties of any gainful occupation? (Do not respond with undetermined)

Is patient a suitable candidate for trial employment or job training?
Any Work: ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time

To your knowledge, does patient have other disability income insurance? ☐ Yes ☐ No

If "Yes", which Company:

Treatment Plans and Comments:

Name of Attending Physician **(Please print)**:

Degree/Specialty:

Telephone No.:

Physician's Address (Street, City, State, Zip)

Fax No.:

Date Signed

Signature of Attending Physician

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

CLAIM FRAUD WARNING STATEMENTS

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.

Employee's Signature _____ Date Signed_____