RELIANCE STANDARD
LIFE INSURANCE COMPANY

A MEMBER OF THE TOKIO MARINE GROUP

BAY BRIDGE ADMINISTRATORS
"Your solutions begin at the Bridge"™

Bay Bridge Administrators, P.O. Box 161690, Austin, Texas 78716
Telephone: 800-845-7519
Fax: 512-329-5463

STATEMENT OF CLAIMAINT
FOR MEDICAL TREATMENT BENEFIT FOR INJURY OR SICKNESS ONLY
(Do NOT use this form when filing for Disability)

Name of Employee_____ Social Security Number _____-_____-_____
Last Name First Name Middle Initial

Policy Number_____ Date of Birth _____
Month Day Year

Employee's Residence Address

_____
Street City State Zip Code

Telephone Number(s): (Day) _____ (Evening) _____

I am employed at _____ Occupation _____

_____
Street City State Zip Code

1. Date of accident or illness began? _____
2. Nature of illness or accident? _____
3. Was the accident or illness work related? Yes or No
4. If accident, where and how did it happen? Explain fully _____
5. Dates of all Treatment Office _____

   What date(s) were you unable to work a full day? _____
   Hospital _____
   Admit. Date_____
   Discharge Date_____
6. Were you scheduled to work on the day of medical treatment? Yes or No
   If no, explain (Semester break, holiday, week-end, etc.)
   _____

   If yes, were you totally disabled and unable to work one full day on the date of medical treatment? Yes or No
   Date unable to work _____

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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_____

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To be completed by Employer (Please Print)

Name of Employee_____
Last Name First Name Middle Initial

Social Security Number _____-_____-_____

Occupation_____

Date of Hire_____
Month Day Year

Did employee miss a day of work? Yes or No

If yes,

a. Date employee was actually last at work? _____

b. Has employee returned to work? If yes, please indicate date _____

Amount of Salary Monthly or Annually_____

Name of Employer_____

Address_____

Signature of Employee Representative_____Date_____

Printed Name & Title or Position_____

Employer's Telephone Number_____Fax Number_____

Email Address_____

Fax or mail the claim to the following address with a bill or medical documentation which list the date of service and the medical reason for your visit:

Bay Bridge Administrators, LLC
PO Box 161690
Austin TX 78716
Fax (512) 275-9350