RELIANCE STANDARD

LIFE INSURANCE COMPANY

#### A MEMBER OF THE TOKIO MARINE GROUP

## 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 PART B and PART C

	Dian Administration
Return this form to:	Plan Administration
	580 Hazard Ave
	Enfield, CT 06082
	Ph 860-272-1135
	Fax 860-272-1137.

In addition to the Proof of Loss Claim Statement, the following items are required:

1. Certified Death Certificate (with raised or colored seal) providing the final cause and manner of death.

- 2. Original enrollment forms and any subsequent changes, including all beneficiary designations. 3. Payroll records for at least two (2) pay periods 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. If the benefit is based on Earnings, please provide us with the appropriate Earnings Records (as defined in the Group Policy).
- 5. Additional documents are required if the beneficiary is a Minor or an Estate-See next page for additional information.
- 6. If Accidental Death Benefits are being claimed, provide any police report, autopsy report and/or relevant newspaper clippings (Note: in some instances, RSL may need to request these documents directly from the source before a determination can be made on the claim).

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.

	PA	RT A: EMPL	OYER/AD	VINISTF	ATOR I	NFOR	MATION			
Employer Name and Address						All F	SL Policy Num	nbers Und	er Which Claim is Being Made	
Division Name and Address						Employee Occupation/Title/Position				
Employee Name and Address						Emp	loyee Social S	ecurity Nu	mber	
Other Names By Which The Er	m <b>ployee M</b> ay Have	Been Known (	Malden Name	, Hypothe	tical Name,	Nicknar	ne, Derivative	Form Of F	irst/Middie Name, Allas)	
Date Employed (Date of Hire)				urance Class (Refer to Policy hedule of Benefits Page)			Employee's Date of B		Employee's Date of Death	
Was Insurance in Effect on Date of Loss?	If No, Terminatio Coverage	n Date of	Salary on Li \$	0	Change Da Hourty Monthly		Policy Weekty Annualiy		ast Salary Change	
Life Benefit Amount Claimed \$		· · · · · · · · · · · · · · · · · · ·					efit Increase	Date To	Which Premium Was Paid loyee's Behalf	
Status of Employee on Date of Active Retired App		aiver for Disabil	ity 🗆 Approv	ved Leave	of Absence		•		Other (Explain)	
				lace Where the Job is V			Date Employee Last Worked		Reason Employee Stopped Working	
Employee Was: Fu (Check All That Apply)	ll-time □Unio rt-time □Non	on 🛛 Hour -Union 🗆 Sala	rly 🔲 Exem		Commis Other (E					
If Claim is For Dependent	, Provide the Fo						Dependent's	Relation	ship to Employee:	
Dependent's Name Social Security Nu			urity Number	umber Relationship to Emplo			Date of Death		Dependent Life Benefit	
									\$	
Dependent's Address Other Names By Which The Dependent May Have Been Known (Maiden Name, Hypothetical Name, Nickname, Derivative Form Of First/Middle Name, Alias)										
			ER/ADMIN							
Any person who knowingly a submits any information in c fraudulent insurance act, whi law. Reliance Standard Life in	onjunction with a Ich is a crime. The	ciaim containi see actions wil	ing fraudulen I result in the	t, false, m denial of	isleading, the claim.	incomp and an	lete or decept subject to pr	tive inform	nation commits a	
Phone Number		Fax Number				Email	Address			
Employer/Administrator Name	(Please Print)	( )	Empl	oyer/Admi	nistrator Si	gnature			Date	
Be Sure the Author	orization For I	lse in Ohtal	•	-		_	d C are Co	mploted		
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PART C: BENEFICIARY INFORMATION           In order to assure prompt processing, please be sure to provide the IMPORTANT TAX INFORMATION above. Be contain the Authorization for Use Obtaining Information is signed by the next of kin or authorized representative of the deceased. The completed and signed daim form along with the 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.           Name of Beneficiary (Please Print)         Relationship of Beneficiary To Employee         Beneficiary's Date of Birth         Address of Beneficiary's (Please provide your email address, if an email address.           Note: If any designated beneficiary is deceased, submit that beneficiary's certificate of death. If beneficiary is the deceased's Estate, provide certified daministration or Letters Testamentary along with the Estate's Tax ID Number. If beneficiary is a minor, provide certified tenters of Guardinanhip minor's Estate and the minor's social security number. The Guardian should sign Part B (IMPORTANT TAX INFORMATION) above, and should a where indicated below in his/mer capacity on behaf of the Estate's Tax ID Number. If beneficiary is a minor, provide certified Latters of Guardinanhip minor's Estate and the minor's social security number. The Guardian should sign Part B (IMPORTANT TAX INFORMATION) above, and should a where indicated below in his/mer capacity on behaf of the Estate's Tax ID Number. If beneficiary is a minor, provide certified Latters of Guardinanhip minor's Estate and the minor's escale security number. The Guardian should sign Part B (IMPORTANT TAX INFORMATION) above, and should a damine state objew in his/mer capacity on behaf of the Estate's Tax ID Number. If beneficiary is a minor, provide certified testate objew in his/mer capacity on behaf of the Estate's Tax ID Number.			PA	RT B: IMP	ORTANT	TAX	NFORMAT	10N				
as well as any accompanying information.       Deat Signed (month, day, year):         PART C: BENEFICIARY INFORMATION       In order to assure prompt processing, please be sure to provide the INFORMATION above. Be certain the Authorization for Us         Obtaining information is algoed by the next of kin or authorized representative of the decessed. The completed and algoing datin form along, with it         Death Certificate dames should be returned to the Employer/Administrator for submission. If you are interested in an optional Me         Settlement rather than a lump aum payment, please contact us all the address or telephone number on this form for the plans that are available.         Name of Beneficiary (Please Print)       Relationable of Beneficiary's Date of Birth       Address of Beneficiary's Date of Birth         Companies       Policy Number       Beneficiary's Date of Birth       Address of Beneficiary (No., Street, City, (Please provide your email address, if an order of the decessed's Date of Birth       Companies         Enail address:       Nome of Beneficiary is decessed, submit hat beneficiary a contribute of death. If Speeficiary is the decessed's Estate, provide order of the Estate of Trob Date Dir Intervenced contactive is a final enaity is afformation. Social security number. The Guardian shocki sign PAH B (MPORTANT TAX INFORMATION) above, and should a were indicated below in Inform capacity on heading the Estate of Trob Date Dir Information containing fraudulers, falae, melaseding, incomplete or deceptive information containing fraudulers, falae, melaseding, incomplete or deceptive information or only and the monor.         Liet Other Insurance Coverage in Force At the	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						n 	Social Security Number/Tax ID Number				
In order to assure prompt processing, please be sure to provide the IMPORTANT TAX INFORMATION above. Be certain the Authorization for Use Optimizing Information is signed by the next of kin or suthorized representative of the deceased. The completed and aligned datin from along with its presentation and the deceased. The completed and aligned datin from along with its please contact us at the address or telephone number on this form for the please that are available.           Name of Beneficiary (Please Print)         Relationship of Beneficiary         Beneficiary's         Address of Beneficiary (No., Street, City, Please provide your email address, if a contact us at the address or telephone number on this form for the please that are available.           Immed and the matching sum payment, please contact us at the address or telephone number on this form for the please that the telephone number on this form for the please that the telephone number on this form for the please that the telephone number on this form for the please that the telephone number on this form for the please that the telephone number on this form for the please that the telephone number on this form for the please that the telephone number on this form for the please that the telephone number on this form for the please that the telephone number on this form for the please that the telephone number on this form for the please that the telephone number on this form for the please that the telephone number on this form for the please that the telephone number of the please provide your email address. If an order telephone number of the please provide your email address. If an order please the please that the telephone number of telese of Beneficiary (No., Street, City, Please the please	By signing this form the beneficlary has read and agrees with the terms of the statement						Date Sig	Date Signed (month, day, year):				
In order for assure prompt processing, please be sure to provide the IMPORTANT TAX INFORMATION above. Be certain the Authorization for Use Oblaming information is agined by the next of is on zubhotzed expressional events. The development and aligned datin form along with the Death Conflicts and other required tiems should be returned to the Employer/Administrator for submission. If you are interested in an optional Me Settlement rather than a lump sum payment, please contact us all the address of telephone number on this form for the plans that are available. Name of Beneficiary (Please Print) Relationship of Beneficiary Det of Birth Relationship of Beneficiary's Address of Beneficiary's Address of Beneficiary (No., Street, City, Please provide your email address, if a Comparise Relationship of Beneficiary's Comparise Companies Relationship of Beneficiary's Comparise Relationship of Beneficiary's Comparise Relationship of Beneficiary's Comparise Relationship of Beneficiary's Comparise Relationship of Beneficiary's Relationship of Beneficiary's Comparise Relationship of Beneficiary's Comparise Relationship of Beneficiary's Comparise Relationship of Beneficiary's Relationship of Beneficiary's Comparise Relationship of Beneficiary's Relationship of Beneficiary's Relationship of Relationship of Relationship of Beneficiary's Relationship of Relationship of Relationship of Beneficiary's Relationship of Relations				PART C: B	BENEFICIA	RY INF	ORMATION	1				
Name of Beneficiary (Please Print)         To Employee         Date of Birth         (Please provide your email address, if and the provide optime of the provide properating proprint provide provide provide provide provide propr	Obtaining Information Death Certificate	ation is signed by the next of and other required items sh	f kin or a ould b <del>e</del> r	uthorized repre	sentative of Employer/A	f the dece dministra	eased. The co itor for submit	ompleted and s ssion, if you a	signed claim re interested	) form along with the Certifie I in an optional Method of		
Noie: If any designated beneficiary is deceased, submit that beneficiary's certificate of death. If beneficiary is the deceased's Estate, provide certified testers of Guardianship minor's Estate and the minor's social security number. The Guardian should sign Part B (MPORTANT TAX INFORMATION) above, and should a 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       Effective Date       Amount of Insurance Coverage In Force At the Time of the Insured's Death         Any person who knowingly and with Intent to Injure, defraud or deceive Reliance Standard Life Insurance Company, files a statement of submits any information in conjunction with a claim containing fraudulent, false, maleading, incomplete or deceptive Information comm fraudulent insurance act, which is a crime. These actions will result in the denial of the claim, and are subject to prosecution under state of the Miner active Reliance Standard Life Insurance Company, files a statement of submits any information in conjunction with a claim containing fraudulent, false, maleading, incomplete or deceptive Information comm fraudulent insurance act, which is a crime. These actions will result in the denial of the claim, and are subject to prosecution under state of the Miner active Reliance Standard Life Insurance Company will cooperate fully with any prosecution and will seek any and all appropriate to remedies.         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. May not be necessary if Employee was on Approve Name of Deceased       Date of Onset         <	Name of	Beneficiary (Please Print)										
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Cause of Death         Principal Cause       Date of Onset         Contributing Cause       Date of Onset         I Attended Deceased       From (Date)       If Decedent Was Hospitalized, Provide the Name of Hospital and Admission and Discharge Date Name of Hospital: Admit (Date)       Discharge (Date)         Was deceased unable to work due to illness or injury prior to date of death?       If "Yes" please state date on which such illness or injury prevented the deceased from working:         Was Death Due To:       Accident?       If caused by accident, was it associated with his/her occupation?       Yes         Name of Physician (Please Print)       Address of Physician         Any person who knowingly and with Intent to injure, defraud or deceive Reliance Standard Life Insurance Company, files a statement of or submits any Information in conjunction with a claim containing fraudulent, false, misleading, incomplete or deceptive Information cor fraudulent insurance act, which is a crime. These actions will result in the denial of the claim, and are subject to prosecution under state foderal law. Reliance Standard Life Insurance Company will cooperate fully with any prosecution and will seek any and all appropriate k remedies.	Completion of P	ART D may help to expedi							if Employe	e was on Approved Walve		
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Cause       If Decedent Was Hospitalized, Provide the Name of Hospital and Admission and Discharge Data Name of Hospital: Deceased         To (Date)       If Decedent Was Hospitalized, Provide the Name of Hospital and Admission and Discharge Data Name of Hospital: Admit (Date)         Was deceased unable to work due to Illness or injury prior to date of death?       If "Yes" please state date on which such Illness or injury prevented the deceased from working:         Was Death Due To:       Accident?       If caused by accident, was it associated with his/her occupation?         Name of Physician (Please Print)       Address of Physician         Any person who knowingly and with Intent to Injure, defraud or deceive Reliance Standard Life Insurance Company, files a statement of or submits any Information in conjunction with a claim containing fraudulent, false, misleading, incomplete or deceptive Information cor fraudulent insurance act, which is a crime. These actions will result in the denial of the claim, and are subject to prosecution under state federal law. Reliance Standard Life Insurance Company will cooperate fully with any prosecution and will seek any and all appropriate law remedies.	Principal Cause					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Date of Ons	et			
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Was deceased unable to work due to illness or injury prior to date of death?       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         Was Death Due To:       Accident?       Suicide?       Homicide?       If caused by accident, was it associated with his/her occupation?       Yes       Address of Physician         Name of Physician (Please Print)       Address of Physician         Any person who knowingly and with Intent to injure, defraud or deceive Reliance Standard Life Insurance Company, files a statement of or submits any information in conjunction with a claim containing fraudulent, faise, misleading, incomplete or deceptive Information cor fraudulent insurance act, which is a crime. These actions will result in the denial of the claim, and are subject to prosecution under state federal law. Reliance Standard Life Insurance Company will cooperate fully with any prosecution and will seek any and all appropriate k remedies.		Admit (Date) Discharge (Date)							and Discharge Dates			
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Date         Phone Number         Fax Number         Physician's Signature         Degree	or submits any i fraudulent insur federal law. Reli	information in conjunction ance act, which is a crime	with a c	claim containii actions will re	ng fraudule suit in the c	ont, faise denial of	, misleading the claim, a	, incomplete ( nd are subjec	or deceptiv	e Information commits a sution under state and/or		
	Date	Phone Number ()	Fax Nu (	umber )		Physicia	in's Signature			Degree		

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### A MEMBER OF THE TOKIO MARINE GROUP

# LIFE CLAIM AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF DECEDENT:
DECEDENT'S DATE OF BIRTH:
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, 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 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 <u>www.rsli.com</u> 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:

#### 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.