RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

Proof of Loss Claim Statement
VAI/VCI Benefit

CLAIM SUBMISSION INSTRUCTIONS

You must complete this form in its entirety and submit the completed form. The form will automatically be emailed to: VoluntaryClaims@RSLI.com

Additional information may be required. Submission of this claim form does not waive our right to request additional information, or waive any of our rights or defenses, or admit liability.

This claim is for ⓧ Voluntary Accident, Death, or Dismemberment Benefit (VAI) ◯ Voluntary Critical Illness Benefit (VCI)

Employer Name / Address	Voluntary Accident (VAI) Policy Number VAI827985	Voluntary Critical Illness (VCI) Policy Number N/A
	Employee Date of Hire	Date of Accident / Diagnosis:

Employee First Name	Employee Middle Name	Employee Last Name

Employee Social Security Number	Employee Date of Birth

Accident Happen at Work? Yes No Explain:	Current Status of Employee Still Working Retired Other:
Employee Phone Number	Employee Email Address

Employee Street Address Gender:

Employee City Employee State Employee Zip Code

IF CLAIM IS FOR A DEPENDENT, PROVIDE THE FOLLOWING:

Dependent's Name	Dependent Social Security Number	Dependent Date of Birth	Relationship to Insured

Other Names by which the Dependent may have been known (maiden name, hypothetical name, nickname, derivative form of name, alias)

Submitter's Information:

Name	Relationship to Insured	Phone Number	Email Address

Submitter's Signature: Date:

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 conjunctions 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.

Percentage of premium paid by employer: 0 % Was Employee taxed on this amount? Yes No
Percentage of premium paid by employee: 100 % Pre-tax dollars Post tax dollars
Percentages must total 100%. If left blank, we will assume that 100% of premium is paid by employer and that employee was not taxed

VOLUNTARY ACCIDENT BENEFITS CLAIMED

Check all that apply. Note: Not all benefits are available under all policies. Consult your policy for additional information, including definitions.

EMERGENCY CARE BENEFITS

- ☐ Air Ambulance Transportation
- ☐ Ambulance Transportation
- ☐ Emergency Treatment
- ☐ Diagnostic Examination
- ☐ Initial Physician Office Visit

GENERAL TREATMENT BENEFITS

- ☐ Initial Hospital Admission
- ☐ Intensive Care Unit Hospital Admission
- ☐ Hospital Confinement _____ days
- ☐ Intensive Care Unit Confinement _____ days
- ☐ Rehabilitation Facility Confinement _____ days
- ☐ Follow-up Physician Office Visit
- ☐ Transportation
- ☐ Lodging _____ days

SPECIFIED COVERED INJURY AND TREATMENT BENEFITS

- ☐ Fracture, Surgical (specify) _____
- ☐ Fracture, non-Surgical (specify) _____
- ☐ Dislocation, Surgical (specify) _____
- ☐ Dislocation, non-Surgical (specify) _____
- ☐ Blood, Plasma and Platelets
- ☐ Burns: 2nd Degree _____ % of body
- ☐ Burns: 3rd Degree _____ % of body
- ☐ Burns: Skin Graft due to burns
- ☐ Coma
- ☐ Concussion
- ☐ Dental Injury (extraction)
- ☐ Dental Injury (crown)
- ☐ Eye Injury (removal of foreign object)
- ☐ Eye Injury (surgical repair)
- ☐ Laceration/no sutures
- ☐ Laceration/sutures (specify length in inches) _____

PARALYSIS BENEFITS

- ☐ Paraplegia or Hemiplegia
- ☐ Quadriplegia

SURGERY BENEFITS

- ☐ Exploratory Surgery (no repair)
- ☐ Knee Cartliage
- ☐ Abdominal or Thoracic Surgery
- ☐ Ruptured Disc
- ☐ Tendon, Ligament or Rotator Cuff (one)
- ☐ Tendon, Ligament or Rotator Cuff (two or more)

TRANSITIONAL BENEFITS

- ☐ Medical Appliance
- ☐ Prosthesis (one)
- ☐ Prosthesis (two or more)
- ☐ Physical Therapy _____ sessions

MEDICAL SERVICE PROVIDER INFORMATION

Please list all doctors, hospitals, or other medical service providers who provided services for injuries received from this accident. Use additional paper as necessary.

1. Name of doctor, hospital, pharmacy or other medical service provider	Phone Number ( )	Fax Number ( )
City, State, Zip Code		
2. Name of doctor, hospital, pharmacy or other medical service provider	Phone Number ( )	Fax Number ( )
City, State, Zip Code		
3. Name of doctor, hospital, pharmacy or other medical service provider	Phone Number ( )	Fax Number ( )
City, State, Zip Code		

EMPLOYEE SIGNATURE

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Phone Number ( )	Social Security Number/Tax ID Number	Email Address
Employee Name (Please Print)	Employee Signature	Date

IMPORTANT: ATTACH RECEIPTS, REPORTS OR OTHER PROOF TO SUPPORT BENFITS CLAIMED.

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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 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 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

P.O. Box 8330
Philadelphia, PA 19101-8330
(800) 351-7500 Fax: (267) 256-4262

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:

_____

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If you would like to receive your payments via Direct Deposit, please complete the following. Otherwise, you will receive your reimbursements in the form of a check

Would you like apply for direct deposit? **Yes** **No**

I authorize RSL to send my payment(s) 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.

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

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Insured's Signature	Date
Telephone Number	
E-Mail Address	