reliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Reset

Proof of Loss Claim Statement
VAI Dismemberment Benefits

EMPLOYER/ADMINISTRATOR INSTRUCTIONS

The Employer/Administrator must complete PART A in its entirety. The Employee should complete, sign and date the Authorization for Use in Obtaining Information form and PART B. PART C must be completed by the attending physician.

Return this form to: **Reliance Standard Life Insurance Company**
Attn: Group Life Claims
P.O. Box 7307
Philadelphia, PA 19101-7307
Phone 1-800-351-7500

In addition to the claim form, the following items are required:

1. A copy of the original enrollment forms and any subsequent changes;
2. Payroll records showing premium deduction, if the employee is required to pay all or part of the premiums for this insurance.
3. Information on other insurance carriers, including company name, address, phone number, policy number and type of coverage for each.

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.

PART A: EMPLOYER/ADMINISTRATOR INFORMATION

Employer Name	Voluntary Accident Policy Number	Employee Name
Employee Social Security Number	Date of Birth	Date of Hire
Date of Accident	Employee Occupation/Title/Position	Insurance Class (Refer to Policy Schedule of Benefits)

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

Plan Elected (Refer to Policy Schedule of Benefits) ☐ A ☐ B ☐ C	Type of Coverage Elected ☐ Employee Only ☐ Employee & Child(ren) ☐ Employee & Spouse ☐ Family	Date Voluntary Accident Coverage First Elected
Usual Number of Hours Employee Works(ed) Per Week	Date Employee Last Worked Usual Number of Hours	Reason Employee Did Not Return to Work (if applicable)

Did Accident Happen at Work? ☐ Yes ☐ No Explain:

Percentage of premium paid by employer:_____% Was Employee taxed on this amount? ☐ Yes ☐ No
Percentage of premium paid by employee:_____% ☐ 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.**

IF CLAIM IS FOR A DEPENDENT, PROVIDE THE FOLLOWING:

Dependent's Name and Address	Social Security Number	Relationship	Amount of Benefit

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

AUTHORIZED EMPLOYER/ADMINISTRATOR SIGNATURE

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 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 cooperate fully with any prosecution and will seek any and all appropriate legal remedies.

Phone Number ( )	Fax Number ( )	Email Address
Employer/Administrator Name (Please Print)	Employer /Administrator Signature	Date

Be Certain Authorization for Use in Obtaining Information form and Part C are Completed.

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PO Box 8330
Philadelphia, PA 19101-8330
Phone (800) 351-7500
Fax (267) 256-3519

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 my complete medical records including, including but not limited to all 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. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. 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: _____

PART B: CLAIMANT INFORMATION (USE EXTRA SHEETS IF NECESSARY)

Describe fully how the accident happened:	What was the date of the accident?

List all medical providers (e.g. physicians, surgeons etc.) providing care, consultation and/or treatment as a result of the above injuries:

Name	Address	Phone Number

List all witnesses to accident. USE EXTRA SHEETS IF NEEDED.

Name	Address	Phone Number

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Signature of Claimant Date	Home Phone No. ( )	Business Phone No. ( )

Address of Claimant (No., Street, City, State, Zip)	Email Address

PART C: ATTENDING PHYSICIAN'S STATEMENT

Instructions to Physician: Please complete each applicable section of this form and provide all reports and treatment records requested pertaining to this patient. The Claimant is responsible for the completion of this Statement without expense to the Company.

Name of Patient	Address (Street, City, State, Zip Code)

Nature of Injury (describe complications, if any)

Date of Accident	When did patient first consult you for this condition?

DID THE ACCIDENTAL INJURY RESULT IN:

Loss of Hand(s) Including surgical reattachment? ☐ Left ☐ Right	Loss of Foot (feet) Including surgical reattachment? ☐ Left ☐ Right	Loss of Arm(s) Including surgical reattachment? ☐ Left ☐ Right
Loss of Leg(s) Including surgical reattachment? ☐ Left ☐ Right	Loss of Sight? ☐ Left Eye ☐ Right Eye	Loss of Hearing? ☐ Left Ear ☐ Right Ear
Loss of Finger(s) Including surgical reattachment? How many?	Loss of Thumb(s) Including surgical reattachment? ☐ Left Thumb ☐ Right Thumb	Loss of Toe(s) Including surgical reattachment? How many?

In your opinion, was any disease, infection, or bodily or mental infirmity an underlying cause in the loss(es) indicated above?
☐ Yes ☐ No If "Yes", please explain.

Was an operation performed in conjunction with the treatment of the loss(es) indicated above?
☐ Yes ☐ No If "Yes, please describe briefly. (Attach surgery records)

In your opinion, did the loss(es) result from any self-inflicted injury or attempted self-destruction? ☐ Yes ☐ No

If the indicated loss(es) include loss of sight, please answer the following questions.

If the loss of sight is partial, but irrecoverable, please state amount of vision in each eye with Snellen notations, or Jaeger scale, if pertinent.

Uncorrected O.D. O.S.	Corrected O.D. O.S.	Date of Examination (attach copies of examination records)

Do you believe vision can be restored in whole or part by treatment or operation? ☐ Yes ☐ No

If an operation is contemplated, give approximate date.

Was patient confined to a hospital? ☐ Yes ☐ No If "Yes" give name and address of hospital

Treatment - PLEASE ATTACH COPIES OF ALL RELEVANT TREATMENT RECORDS FOR THIS PATIENT.

Date of First Visit	Dates of Subsequent Visits			

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Physician's Specialty	Tax Identification Number

Physician's Name (please print or type)	Address (No., Street, City, State, Zip Code)

Physician's Signature Date	Phone Number ( )	Fax Number ( )

REMINDER: PLEASE PROVIDE ALL REPORTS AND TREATMENT RECORDS PERTAINING TO THIS PATIENT.

IMPORTANT INFORMATION REGARDING APPLICATION FOR BENEFITS

ALABAMA, ARKANSAS and LOUISIANA — 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.

CALIFORNIA – For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO — It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA — Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY — Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

MAINE — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND — Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY — Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO — 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 civil fines and criminal penalties.

NEW YORK (health insurance only) — 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.

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.

OKLAHOMA – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

PUERTO RICO – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

RHODE ISLAND — 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.

TENNESSEE, **WASHINGTON** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VIRGINIA — Any person who, with the 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 may have violated the state law.

WASHINGTON, DC — WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.