HOSPITAL INDEMNITY CLAIM FORM

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

PART A – CLAIM FORM INSTRUCTIONS (*PLEASE PRINT*)

1. **READ** both sides of this form and **COMPLETELY FILL OUT PARTS B-D** (Part E is optional.)
2. **SIGN AND DATE PART F**.
3. Remember to provide your Social Security Number.
4. **ATTACH A COPY OF UB-04 FORM FROM YOUR HOSPITAL. THIS FORM IS THE STANDARD BILLING FORM UTILIZED BY HEALTH CARE FACILITIES. IF YOU CANNOT OBTAIN A COPY OF THIS FORM, YOU MUST PROVIDE THE FOLLOWING INFORMATION ON A SEPARATE SHEET OF PAPER:**
   - Doctor's Name and Address
   - Doctor's Tax Identification Number
   - Patient Name
   - Diagnosis Code ICD-9
   - Date of Service
   - Charges/Cost of each treatment
   - Procedure Codes CPT
   - Place of Service Code
5. **Sign PART E** if you want benefits paid to your medical provider
6. Please mail this claim form and any attachments to:

RSL Specialty Products Administration
505 South Lenola Road, Suite 231
Moorestown, NJ 08057
1-866-375-0775

7. **MAKE A COPY OF THIS FORM** for your records.

PART B – EMPLOYEE INFORMATION

EMPLOYEE NAME (LAST, first, middle) ☐ **Male** ☐ **Female**

DATE of BIRTH MM DD YY _____/_____/_____

SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

PHONE NUMBER (☐☐☐) ☐☐☐-☐☐☐☐

EMPLOYER NAME

EMPLOYER GROUP NUMBER

DOES THE EMPLOYEE HAVE OTHER HEALTH BENEFIT COVERAGE? ☐ **YES** ☐ **NO**

IF **YES**, PLEASE PROVIDE THE INSURANCE PLAN NAME OR PROGRAM NAME AND THE POLICY OR GROUP NUMBER. _____

PART C – PATIENT INFORMATION

PATIENT NAME (LAST, first, middle) ☐ **Male** ☐ **Female**

PATIENT DATE of BIRTH MM DD YY _____/_____/_____

PATIENT SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

RELATIONSHIP TO EMPLOYEE (i.e. SELF, SPOUSE)

IF PATIENT IS YOUR CHILD AND OVER 25, IS HE OR SHE HANDICAPPED? ☐ **YES** ☐ **NO**

PART D – CLAIM INFORMATION

IS THE CLAIM FOR AN: ☐ **ACCIDENT OR** ☐ **ILLNESS?**

IS TREATMENT THE RESULT OF OCCUPATIONAL ILLNESS OR INJURY? ☐ **YES** ☐ **NO**

WHEN DID THE ACCIDENT OR ILLNESS OCCUR? MM DD YY _____/_____/_____

PLEASE EXPLAIN WHAT YOU WERE TREATED FOR AND, IF TREATMENT WAS THE RESULT OF AN ACCIDENT, PROVIDE DETAILS OF WHEN, WHERE AND HOW THE ACCIDENT HAPPENED. (If you need additional space, attach a sheet of paper to this form.)

PART E – ASSIGNMENT OF BENEFITS

TO BE COMPLETED BY THE EMPLOYEE. DO NOT SIGN THIS SECTION IF FEES HAVE ALREADY BEEN PAID TO YOUR PROVIDER.
I APPROVE THE PAYMENT OF BENEFITS TO THE DOCTOR OR OTHER MEDICAL PROVIDER SHOWN ON THE ITEMIZED BILL (Tax Identification Number included). I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY THIS AUTHORIZATION.

SIGNATURE OF EMPLOYEE

DATE MM DD YY _____/_____/_____

PART F – AUTHORIZATION

INSTRUCTIONS: THIS AUTHORIZATION MUST BE COMPLETED AND SIGNED BY THE PATIENT. IF THE PATIENT IS A MINOR OR IS UNABLE TO SIGN, THIS AUTHORIZATION MUST BE COMPLETED AND SIGNED BY THE LEGAL GUARDIAN OR NEXT-OF-KIN.

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, Social Security Administration, Blue Cross-Blue Shield, self-insured and pre-paid health plans):

You are authorized to permit Reliance Standard Life Insurance Company, its Third Party Administrators, 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 information relating to mental illness, drug or alcohol treatment, HIV (AIDS Virus), and disease of

_____

Print Name of Patient

I understand the information obtained will only be used by Reliance Standard Life Insurance Company to determine eligibility for insurance and benefits claimed under the policy. I consent to redisclosure 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 consent.

I understand this authorization may be revoked by written notice to Reliance Standard Life Insurance Company but this revocation 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.

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 your claim, and are subject to prosecution under state and/or federal law. Reliance Standard Life Insurance Company will pursue any and all appropriate legal remedies arising from such fraudulent insurance acts.

SIGNED	**DATE** **MM DD YY** _____/_____/_____	**RELATIONSHIP TO THE PATIENT IF SIGNED BY OTHER THAN THE PATIENT**

IF SIGNED BY OTHER THAN THE PATIENT, PLEASE PRINT NAME & ADDRESS AND INCLUDE GUARDIANSHIP PAPERS OR OTHER EVIDENCE OF LEGAL REPRESENTATION

SEND TO: RSL Specialty Products Administration ▪ 505 South Lenola Road, Suite 231 ▪ Moorestown, NJ 08057

NOTE: Incomplete forms and the absence of itemized bills may delay the processing of your claim.

FRAUD NOTICE

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.

The laws of some states require us to furnish you with the following notice:

California and Texas: Any person who knowingly presents 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.

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 insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of loss or benefit is a crime punishable by fines or imprisonment, or both.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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

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.

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.