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

Proof of Loss Claim Statement
VAI Accident/Death/Dismemberment Benefit

CLAIM SUBMISSION INSTRUCTIONS

The **Employee** must complete:
(1) The Authorization for Use in Obtaining Information; and,
(2) PART B in its entirety; and,
(3) PARTC in its entirety, if submitting a claim for any benefits listed in this section; and,.
(3) PART D in its entirety, if submitting a claim for death benefits; and,
(4) Please attach receipts and include reports or other proof to support the benefit(s) claimed. If submitting a claim for death benefits, please include a certified copy of the insured's death certificate.

If submitting a claim for a Dismemberment Benefit, a **Health Care Provider**:
(1) Must complete PART E in its entirety: and,
(2) Provide all medical records in the Health Care Provider's possession for the Employee from the Employee's date of accident through the date that the Health Care Provider signs this form. The Employee is responsible for the expense associated with the completion of this Statement.

Email the completed form to: VoluntaryClaims@RSLI.com
OR fax the completed form to: (267) 256-3518 or (267) 256-3537
OR mail the completed form to: Reliance Standard Life Insurance Company
Attn: Voluntary Accident Claims
P.O. Box 7307
Philadelphia, PA 19101-7307
Phone 1-800-351-7500

Please Note: **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.

PART A: EMPLOYER/ADMINISTRATOR INFORMATION

Employer Name and Address	Voluntary Accident Policy Number
Unified School District #489 dba USD #489 323 W. 12th Street Hays, KS 67601	VAI 827754

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PART B: EMPLOYEE/CLAIMANT INFORMATION

Employee Name	Employee Social Security Number	Employee Date of Birth

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

Employee Address

IF CLAIM IS FOR A DEPENDENT, PROVIDE THE FOLLOWING:

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

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

Dependent's Address

INFORMATION ABOUT THE ACCIDENT

When did accident happen ? (month, day, year) Time ☐ am ☐ pm

Where did accident happen ? ☐ home ☐ work ☐ elsewhere (specify):

Did the accident result in the insured's death? ☐ yes ☐ no

What was Insured doing at the time of accident?

How did accident happen (describe fully)?

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PART C: ACCIDENT BENEFITS

If submitting a claim for an Accident Benefit, check all that apply.

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

- ☐ Ambulance: Air Ambulance Transportation
- ☐ Ambulance: Ground Ambulance Transportation
- ☐ Blood, Plasma and Platelets
- ☐ Burns: 2nd Degree Burns, Covering less than 10% of the body
- ☐ Burns: 2nd Degree Burns, Covering 10% but less than 25% of the body
- ☐ Burns: 2nd Degree Burns, Covering 25% but less than 35% of the body
- ☐ Burns: 2nd Degree Burns, Covering 35% or greater of the body
- ☐ Burns: 3rd Degree Burns, Covering less than 10% of the body
- ☐ Burns: 3rd Degree Burns, Covering 10% but less than 25% of the body
- ☐ Burns: 3rd Degree Burns, Covering 25% but less than 35% of the body
- ☐ Burns: 3rd Degree Burns, Covering 35% or greater of the body
- ☐ Skin Grafts due to Burns
- ☐ Chiropractic Services
- ☐ Coma
- ☐ Concussion
- ☐ Dental Injury: Extraction
- ☐ Dental Injury: Crown
- ☐ Diagnostic Examination
- ☐ Dislocation: Ankle
- ☐ Dislocation: Collarbone
- ☐ Dislocation: Elbow
- ☐ Dislocation: Finger
- ☐ Dislocation: Foot
- ☐ Dislocation: Hand
- ☐ Dislocation: Hip
- ☐ Dislocation: Knee
- ☐ Dislocation: Lower Jaw
- ☐ Dislocation: Shoulder
- ☐ Dislocation: Toe
- ☐ Dislocation: Wrist
- ☐ Dislocation: Partial
- ☐ Dislocation: Multiple
- ☐ Dislocation: Epidural Anesthesia Injection
- ☐ Eye Injury: Removal of Foreign Object
- ☐ Eye Injury: Surgical Repair
- ☐ Fractures: Ankle
- ☐ Fractures: Arm
- ☐ Fractures: Bones of Face
- ☐ Fractures: Coccyx
- ☐ Fractures: Collarbone
- ☐ Fractures: Elbow
- ☐ Fractures: Finger
- ☐ Fractures: Foot
- ☐ Fractures: Hand
- ☐ Fractures: Hip
- ☐ Fractures: Kneecap
- ☐ Fractures: Leg
- ☐ Fractures: Jaw
- ☐ Fractures: Nose
- ☐ Fractures: Pelvis
- ☐ Fractures: Rib
- ☐ Fractures: Shoulder Blade
- ☐ Fractures: Skull (Except bones of face or nose – depressed)
- ☐ Fractures: Skull (Simple)
- ☐ Fractures: Sternum
- ☐ Fractures: Toe
- ☐ Fractures: Vertebrae
- ☐ Fractures: Vertebral Column
- ☐ Fractures: Wrist
- ☐ Fractures: Chip Fractures
- ☐ Fractures: Multiple Fractures
- ☐ Hospitalization: Initial Hospital Admission
- ☐ Hospitalization: Initial Intensive Care Unit (ICU) Hospital Admission
- ☐ Hospitalization: Hospital Confinement
- ☐ Hospitalization: Intensive Care Unit (ICU) Confinement
- ☐ Lacerations: No Sutures Required
- ☐ Lacerations: Sutures Required; Less than 2” long
- ☐ Lacerations: Sutures Required; 2” but less than 6” long
- ☐ Lacerations: Sutures Required; 6” long or greater
- ☐ Lodging
- ☐ Medical Appliance
- ☐ Organized Youth Sports
- ☐ Paralysis: Paraplegia or Hemiplegia
- ☐ Paralysis: Quadriplegia
- ☐ Physical Therapy
- ☐ Physician Visit: Initial Physician Office Visit
- ☐ Physician Visit: Follow-up Physician Office Visit
- ☐ Prosthesis: One
- ☐ Prosthesis: Two or more
- ☐ Rehabilitation Facility Confinement
- ☐ Surgery: Abdominal or Thoracic Surgery (Surgically Repaired)
- ☐ Surgery: Exploratory Surgery (No Repair)
- ☐ Surgery: Knee Cartilage (Surgically Repaired)
- ☐ Surgery: Ruptured Disc (Surgically Repaired)
- ☐ Surgery: Tendon, Ligament, or Rotator Cuff (Surgically Repaired): - One Repair
- ☐ Surgery: Tendon, Ligament, or Rotator Cuff (Surgically Repaired): - Two or more Repairs
- ☐ Transportation
- ☐ X-Ray

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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

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.

Phone Number ( )	Employee Social Security Number	Employee Email Address

Employee Name (Please Print)	Employee Signature	Date

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PART D: DEATH BENEFITS

In order to assure prompt processing, please be sure you provide:
(1) Important tax information below.
(2) The Authorization for Use in Obtaining Information signed by the next of kin or authorized representative of the deceased.
(3) A completed and signed claim form along with the Certified Death Certificate. police report, autopsy report, an/or newspaper clippings.
(4) If the beneficiary is the Deceased's estate, certified Letters of Administration or Letters of Testamentary, and Estate Tax ID Number.
(5) If beneficiary is a minor, certified Letters of Guardianship for the minor's estate and the minor's social security number.
(6) If any designated beneficiary is deceased, submit the deceased beneficiary's certificate of death.

If you are interested in an optional Method of Settlement rather than a lump sum payment, please contact RSI for the plans that are available.

Beneficiary's Name	Relationship To Employee	Beneficiary's Date of Birth	Beneficiary's Address (Street, City, State)

ADDITIONAL INFORMATION ABOUT THE ACCIDENT

Please list all Health Care Providers who treated the insured for the injuries resulting from the accident

Health Care Provider Name and Address	Health Care Provider Name and Address	Health Care Provider Name and Address

Was an Autopsy or Inquest Was Held? ☐ yes ☐ no (If Yes, please attach a summary of Autopsy or copy of inquest verdict.

List all witnesses to the accident below:

Witness Name and Address	Witness Name and Address	Witness Name and Address

List all companies and amounts of other accidental death or life insurance held by deceased.

Name of Company	Amount $	Name of Company	Amount $
Name of Company	Amount $	Name of Company	Amount $

Your Name	Relationship to Deceased
Are you the Beneficiary named in the policy? ☐ Yes ☐ No	If no, in what capacity do you claim the insurance?

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Beneficiary Signature	Business Phone	Home Phone	Date

IMPORTANT TAX INFORMATION

To Be Completed By Beneficiary
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 subject to backup withholding.)

By signing this form the beneficiary has read and agrees with the terms of the statement as well as any accompanying information

Social Security Number/Tax ID Number

___ ___ ___ ___ ___ ___ ___ ___ ___

Signature of the Beneficiary:

_____

Date Signed (month, day, year): _____

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PART E: HEALTH CARE PROVIDER STATEMENT

Please complete each applicable section of this form and provide all medical records in your possession for this Patient from the Patient's date of accident through the date that you sign this form. The Patient is responsible for the expense associated with the completion of this Statement.

Patient Name	Patient Address (Street, City, State, Zip Code)
Nature of Injury (describe complications, if any)	
Date of Accident	When did the 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? If Yes, how many?	Loss of Thumb(s) Including surgical reattachment? ☐ Left Thumb ☐ Right Thumb	Loss of Toe(s) Including surgical reattachment? How many?

Loss of Speech? Please describe.

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 as part of 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-inflicted injury? ☐ 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.	Uncorrected O.S.	Corrected O.D.	Corrected 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

Has another Heath Care Provider ever treated the Patient for the same or similar condition/s? (If yes, provide name & address of each Health Care Provider)
☐ Yes ☐ No

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Health Care Provider Specialty	Tax Identification Number	
Health Care Provider Name (please print or type)	Address (No., Street, City, State, Zip Code)	
Health Care Provider Signature Date	Phone Number ( )	Fax Number ( )

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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:

_____

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.