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LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Reset

Short-Term Disability Benefits
Initial Statement of Claim

HOW TO FILE A CLAIM

Please follow the instructions listed below to avoid unnecessary delays in processing your claim. This form must be fully completed for each disability claim. If the claim form is not fully completed, the processing of the claim may be delayed.

Employer: 1) Complete and sign Part I answering all questions;
2) Attach job description; and
3) Attach proof of earnings as defined by applicable policy (example: payroll records, W-2, K1, 1099, etc.)

Insured: 1) Complete and sign Part II answering all questions; and
2) Complete and sign the AUTHORIZATION FOR USE IN OBTAINING INFORMATION form, and
3) Have the attending physician complete and sign the ATTENDING PHYSICIAN STATEMENT. **IMPORTANT: PLEASE ATTACH ALL MEDICAL RECORDS FROM THREE (3) MONTHS PRIOR TO DATE OF DISABILITY TO PRESENT.**

Please fax completed claim forms and attachments to 267-256-3519, email to claimsintake@rsli.com or mail to Reliance Standard Life, P.O. Box 7749, Philadelphia, PA 19101-7749

PART I FOR EMPLOYER TO COMPLETE

Name of Insured (Last, First, Middle Initial)	Date of Birth	Social Security No.	Policy No.

Job Title	Insurance Class	Hire Date	Date Enrollment Card Signed	Effective Date of Insurance

Date Laid Off (If Applicable)	Date Retired (If Applicable)	Weekly Earnings ☐ Weekly ☐ Bi-weekly	Date Last Worked	Numbers of Hours Worked 2 Weeks Preceding the Last Day Worked	Date Returned to Work

Work schedule at time of disability ___ day/week ___ hrs./day

How is Claimant Paid? ☐ Hourly ☐ Salaried ☐ Salary & Bonus ☐ Salary & Commission ☐ Commission Only ☐ Other:

Did the employee receive sick pay after ceasing work? ☐ Yes ☐ No	Date Began	Dated Ended	Reason For Stopping Work

Was sick pay exhausted? ☐ Yes ☐ No Date exhausted?	If they did not exhaust their sick pay, provide number of remaining sick days or hours

Did the employee receive salary continuation? ☐ Yes ☐ No Date Began Date Ended	Work State

Is disability work related? ☐ No ☐ Yes If "Yes," Explain	Brief Description of Duties

Percentage of premium paid by: Claimant _____% Employer _____% If claimant pays any portion of the premium, please indicate whether the claimant's portion of the premium is paid with: ☐ Pre-tax dollars ☐ Post-tax dollars

Is there any reason why FICA taxes should not be withheld from claimant's benefits? ☐ Yes ☐ No If yes, please explain:

Employer Name & Address	Employer's Telephone Number Ext.

Authorized Signature Date	Fax Number	Email Address

PART II FOR INSURED TO COMPLETE

Home Address (Street, City, State, Zip)	Gender ☐ Male ☐ Female	Dominant Hand ☐ Right ☐ Left Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Mailing Address if different than Home Address (Street, City, State Zip)	Do you wish to receive communications by Email or Mail ☐ Email ☐ Mail	Email Address

Is this Claim Based on an accident? ☐ Yes ☐ No	Did injury occur at work? If "Yes," for whom were you working? ☐ Yes ☐ No	Date you were first unable to work because of this disability

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Date of Accident (if any)	Time ☐ AM ☐ PM	How and where did accident happen?

Name and Address of Attending Physician	Date you returned to work

Are you now receiving Unemployment Compensation benefits? ☐ Yes ☐ No

Are you now receiving or eligible to receive as a result of this disability:
Social Security ☐ Yes ☐ No
Worker's Compensation ☐ Yes ☐ No

State Disability ☐ Yes ☐ No
No Fault Disability ☐ Yes ☐ No
Other _____ ☐ Yes ☐ No

If "Yes" give name and address of insurer, amount of income, date benefits began and ended.

We are required to withhold federal income tax from any benefit payments upon your request. If benefits are taxable by your state, we will also withhold state income tax upon your request. We must also send a report to your employer at the end of each calendar year showing your name, social security number, any benefits paid and any taxes withheld. If you would like us to withhold any taxes, please indicate the dollar amount to be withheld each week:

Federal Tax to be Withheld _____ ($20.00 Minimum per week, whole dollars only)
State Tax to be Withheld _____ ($ 2.00 Minimum per week, whole dollars only)

I authorize RSL to send my disability payments 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 address above.

☐ Yes Set-up Direct Deposit

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
Or Attach a Voided Check imprinted with your name.

Any person who knowingly and with intent to injure 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 pursue any and all appropriate legal remedies arising from such fraudulent insurance acts.

Insured's Signature	Date	Telephone Number ( )	E-Mail Address

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AUTHORIZATION FOR RELEASE OF INFORMATION

STEP 1: COMPLETE ALL INFORMATION REQUESTED BELOW

Employee's First Name:	Employee's Last Name:	Claim Number:
Employee's Street Address:		
Employee's City, State, Zip Code:		
Employee's Phone Number:	Employee's Date of Birth:	Last 4 Digits of SSN:
Employer Name:	Last Day Worked:	First Day Away from Work:

STEP 2: PLEASE READ THE FOLLOWING AUTHORIZATION FOR RELEASE OF INFORMATION

- **Authorization.** I authorize 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 to disclose to Reliance Standard Life Insurance Company ("RSLI") and/or its authorized administrators, including but not limited to Matrix Absence Management and any other authorized representative(s), and/or attorney representatives, any and all information about my health records, medical care treatment, employment, or my short-term disability, long-term disability, worker's compensation, leave of absence, accommodation, or other absence management program claim(s). In addition, I authorize RSLI to disclose to my employer, its affiliates, or other authorized representatives stated above, any and all information about my health records, medical care treatment, employment, and absence management claim(s) information.

- ***This authorization to obtain and disclose information about me, includes my permission to obtain and disclose the following:*** All of my medical and health information and records concerning my medical condition(s), disability, diagnosis, physical/mental health treatment, alcohol and substance abuse treatment, HIV related treatment, prescriptions, medical advice,

facts, reports, diagnostic tests, x-rays, statements of charges, diagnoses, treatments rendered or recommended, prognoses, medications (prescription and over-the-counter), opinions of disability, charts, notes, correspondence, photographs, videos, digital images, films, and any other information relating to my medical condition, care, treatment, and/or or evaluations, as well as any employment, payroll, tax, benefit, wages, or earnings information within their knowledge.

- **Purpose.** I understand this information will be used to determine my eligibility for the benefits or compensation to which I may be entitled under any benefit plan, policy, or practice of my employer or pursuant to any municipal, state, or federal leave or benefits law, or for other employment benefits, terms, conditions, obligations, rights, plans, or policies.

- **Voluntary authorization; no effect on treatment or other rights.** I am signing this Authorization voluntarily. I understand that treatment, payment, or my eligibility for benefits or other claims will not be affected if I do not sign this Authorization, although I understand that determination of my claim may be delayed and/or my claim may be denied if I do not fulfill my obligation to provide sufficient medical information to support my claim.

- **Revocation.** I understand that I may revoke this authorization at any time upon written notice to the address below. If revoked, the information described above may no longer be used or disclosed for the purposes described in this written authorization; however, any use or disclosure already made with permission cannot be undone.

- **Release of certain information.** I understand that if my claim relates to a psychiatric/mental illness, drug or alcohol treatment, or treatment for the Human Immunodeficiency Virus (HIV), that records regarding these conditions are protected records and it is my right not to allow access to these records. Understanding this, I wish to have these records released so that RSLI will have a full understanding of my medical condition and claims. If I do not wish to release such records, I may cross out and initial this paragraph.

    - **Effect of disclosure or re-disclosure on HIPAA-protected information.** I understand that disclosure of the above-requested information may include disclosure of protected health information as defined by the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and applicable accompanying regulations. I further understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure to others by RSLI, my employer, or any of their authorized representatives and is no longer protected by the Privacy Rule of HIPAA. For more information, please see RSLI's privacy policy at: https://www.reliancestandard.com/home/privacy/

- ****IMPORTANT NOTICE:**** The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. **"Genetic information,"** as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

STEP 3: <u>INITIAL ALL</u> PAGES AT THE BOTTOM, <u>SIGN</u> PAGE 3, AND <u>RETURN ALL</u> PAGES

I have read this authorization and understand it. Unless revoked, this authorization expires in one year or after the duration of my claim for benefits, whichever is earlier. A copy of this authorization is valid as an original.

_____ _____

Signature of Employee Date

STEP 4: IF EMPLOYEE/CLAIMANT IS UNABLE TO SIGN, A DESIGNATED REPRESENTATIVE MAY SIGN. PLEASE COMPLETE THE DESIGNATED REPRESENTATIVE INFORMATION

_____

Name of Designated Representative (PRINT)

_____ _____

Signature of Designated Representative Date

Description of authority to sign on behalf of above person:

_____

STEP 5: PLEASE RETURN <u>ALL PAGES</u> TO:

Reliance Standard Life Insurance Company
PO Box 8330
Philadelphia PA 19101-8330
FAX: 267-256-3519

IMPORTANT: PLEASE ATTACH ALL MEDICAL RECORDS FROM THREE (3) MONTHS PRIOR TO DATE OF DISABILITY TO PRESENT.

PART III ATTENDING PHYSICIAN'S STATEMENT (PLEASE ANSWER ALL QUESTIONS AND SIGN)

Patient's Name

Diagnosis and Concurrent Conditions (including ICD-9 or ICD-10 codes)

Surgical or Obstetrical Procedure

Current Medications

Frequency of Treatment ☐ Weekly ☐ Other ☐ Monthly

Is condition due to injury or sickness arising from patient's employment? ☐ Yes ☐ No	Has patient ever had same or similar symptoms? ☐ Yes ☐ No If Yes, when	
Date symptoms first appeared or accident happened	Date patient first consulted you for this condition	Is patient still under your care for this condition? ☐ Yes ☐ No
If condition is due to pregnancy, give LMP and expected date of delivery. LMP _____ Expected Date of delivery _____	If patient hospitalized, give name of hospital Admission Date _____ Discharge Date _____	
Is patient able to perform his/her job? ☐ Yes ☐ No	Date patient was continuously unable to work From _____ To _____	
Estimate date patient should be able to return to work.	Patient will be partially disabled From: To:	

Physical Impairment

☐ Class 1 – No limitation of functional capacity; capable of heavy work* …. .No restrictions (0-10%)
☐ Class 2 – Medium manual activity* ……(15-30%)
☐ Class 3 – Slight limitation of functional capacity; capable of light work* ……...(35-55%)
☐ Class 4 – Moderate limitation of function capacity; incapable of clerical or administrative (sedentary*) activity ……..(60-70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity ……(75-100%)
☐ Remarks

*As defined in the Federal Dictionary of Occupational Titles

Psychiatric Impairment -Complete only if applicable.

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations *(no limitations)*.
☐ Class 2 – Patient is able to function in most stress situations and engage in only limited interpersonal relations *(slight limitations)*.
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations *(moderate limitations)*.
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations *(marked limitations)*.
☐ Class 5 – Patient has significant loss of psychological, physiological, personal, and social adjustments *(severe limitations)*.
☐ Remarks

Please define stress as it applies to this patient.
What stress and problems in interpersonal relations has patient had on the job?
Do you believe a legal guardian or conservator should be appointed for this problem? ☐ Yes ☐ No
Is the patient competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

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Physician's Name, Address, ZIP (Please Print or Type)

Telephone Number ( )	Fax Number ( )	Specialty

Physician's Signature	Date	Degree	Physician's Tax ID No.

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.