reliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Attn: Group Life Claims
P.O. Box 7307, Philadelphia, PA 19101-7307
Fax 267-256-3518 Telephone 1-800-351-7500
LifeClaimsScan@rsli.com

# Employer/Plan Administrator Instructions

1. Provide each beneficiary, the Beneficiary Instructions and the Beneficiary Section (Part B) of this Proof of Loss Statement to complete.
2. Complete, Sign and Date, the Employer/Administrator Section (Part A) within this Proof of Loss Statement.
3. Include the following information with your submission of the Employer/Administrator Section:
   a. A copy or screenshot of the Insured's initial enrollment or election form. This document should reflect both the benefit amount and the date the Insured elected the benefit;
   b. If applicable, a copy or screenshot of any subsequent changes to the Insured's initial enrollment or election;
   c. The most recent beneficiary designation form completed by the Insured;
   d. If the claim for benefits is for the Insured, payroll records for the three (3) pay periods immediately prior to the Insured's last date physically at work – this information should include the number of hours worked by the Insured, the pay received by the Insured, the type of compensation received by the Insured (e.g. overtime, bonus, commissions etc…), and deductions for RSLI Life Insurance premium if the Insured contributed to the insurance costs.
   e. If the claim for benefits is for an Insured's dependent, payroll records for the three (3) pay periods immediately prior to the Dependent's death – this information should include the number of hours worked by the Insured and deductions for RSLI Life Insurance premium if the Insured contributed to the insurance costs.
   f. If the RSLI Life Insurance benefit amount is based on the Insured's earnings, please provide the Insured's earnings as defined in the applicable plan.
4. Detach this page and submit all of the information above to Reliance Standard Life Insurance (RSLI):

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**LifeClaimsScan@rsli.com**

**For your information:**

- Each beneficiary must complete his/her own Beneficiary Section of the Proof of Loss Statement.
- If the beneficiary is a minor and a legal guardian has not been appointed to handle the minor's estate, a responsible adult should complete the Beneficiary's statement on behalf of the minor.
- If the beneficiary is a minor, the Proof of Loss Statement should be completed by the legal guardian appointed to handle the minor's estate. A copy of the court order appointing the legal guardian will need to be provided to RSLI.
- The Proof of Loss Statement should be completed with the minor beneficiary's information. The legal guardian or responsible adult should print, sign, date and provide his/her mailing address.
- The U.S. Postal Service will not forward Reliance Standard benefit payments. Please provide the complete current mailing address including any unit or apartment number for both the Employee and Dependent if applicable.
- For Accidental death benefits, the beneficiary may need to submit additional information. This may include a copy of police reports associated with the death, an autopsy report.
- Reliance Standard is unable to return original documents submitted to support a claim for benefits.

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# Group Life Claim Application Proof of Loss Statement

## Part A: EMPLOYER/ADMINISTRATOR Information

The Employer/Administrator must complete PART A in its entirety.
*For Dependent claims the Employee information must be provided to establish eligibility.*

LIFE CLAIM FOR ☐ Employee ☐ Dependent

| Employer Name and Address | | | Policy Number(s) | |
|---|---|---|---|---|
| Division Name and Address | | | Employee Social Security Number | |
| Employee Name and Address | | | Employee Date of Birth | Employee Date of Death |
| Provide all Names by which the Employee may have been known by: | | | | |
| Date of Hire: | Insurance class (per the Policy Schedule of Benefits page) | Occupation/Job Title | # of hours scheduled to work per week | Date last physically worked |

Status of Employee on Date of Death: ☐ Active: ☐ Full-time ☐ Part-time ☐ Non-Union ☐ Union
☐ Non–Active due to:
☐ Retired ☐ Approved Leave of Absence ☐ Disability/Worker's Compensation ☐ Premium Waiver for Disability
☐ Other (Explain)

| Date Coverage Elected by Employee: | Date of Last Salary change: | Basic Earnings $_____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annual | Date Premium Paid thru on Employee's Behalf: |
|---|---|---|---|

Pay type: (check all that apply) ☐ Hourly ☐ Salaried ☐ Commission ☐ Weekly ☐ Monthly ☐ Bi weekly ☐ Semi-monthly
☐ Union ☐ Non-Union ☐ Exempt ☐ Non-Exempt

Life Benefit amount claimed:

Basic $_____ Supplemental /Voluntary $_____ Spouse $_____ Dependent $_____

Is this claim also for an Accidental Death? ☐ Yes ☐ No

Basic Accidental $ Voluntary Accidental $ Dependent/Family Accidental $

**If Claim is For Dependent, Provide the Following:**

| Dependent's Name and Address | Social Security Number | Relationship | Date of Birth | Date of Death |
|---|---|---|---|---|
| Provide all Names by which the Dependent may have been known by: | | | | |

**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 |

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# Beneficiary Instructions

Please accept our condolences on your recent loss. We realize this is a difficult time and are committed to assisting you through our claims process. Please read the instructions below and contact us with any questions you may have regarding the submission of a Life claim.

1. Complete, Sign and Date, the Beneficiary Section (Part B) within this Proof of Loss Statement.
2. Read, Sign and Date, the Authorization to Release Information form.
3. Obtain a copy of a certified death certificate. The cause and manner of death documented on the certificate is required. If the death certificate states PENDING as a cause of death, the amended death certificate will also be required. We will accept scanned copies of the death certificate as long as the state seal is visible and the document is legible. We reserve the right to request an original death certificate with the raised state seal.
4. Detach this page and submit all of the information above to Reliance Standard Life Insurance (RSLI):

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**LifeClaimsScan@rsli.com**

**For your information:**

- Each beneficiary must complete his/her own Beneficiary Section of the Proof of Loss Statement.
- If the beneficiary is a minor and a legal guardian has not been appointed to handle the minor's estate, a responsible adult should complete the Beneficiary's statement on behalf of the minor.
- If the beneficiary is a minor, the Proof of Loss Statement should be completed by the legal guardian appointed to handle the minor's estate. Please provide a copy of the court order appointing the legal guardian of the estate of the minor with this claim application.
- The Proof of Loss Statement should be completed with the minor beneficiary's information. The legal guardian or responsible adult should print, sign, date and provide his/her mailing address.
- The U.S. Postal Service will not forward Reliance Standard benefit payments. Please provide the complete current mailing address including any unit or apartment number.
- Reliance Standard is unable to return orginal documents submitted to support a claim for benefits.
- For Accidental death benefits, the beneficiary may need to submit additional information. This may include a copy of police reports associated with the death, an autopsy report or other information related to the insured's accident.

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## Part B: BENEFICIARY'S Information

Each Beneficiary must complete PART B in its entirety.

Print:

| | | |
|---|---|---|
| Employee's name:<br><br>First Last | Decedent's name:<br><br>First Last | |
| Full Name of person completing this form: | | |
| First | Middle Initial | Last |
| Phone Number | Secondary/Business Phone Number | |
| Email Address: | | Are you the beneficiary?<br>☐ Yes ☐ No |
| Your relationship to the decedent:<br>You are the ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Legal Guardian, ☐ Responsible adult of minor beneficiary<br>☐ Other( explain) | | |
| Date of Birth of Beneficiary: | Social Security Number of Beneficiary: | |
| Mailing address of the Beneficiary: | | |
| **If the Beneficiary is a Minor:** | | |
| First | Middle Initial | Last |
| **If the Beneficiary is a Trust, Estate, or Charity:** | | |
| Full name of Estate, Trust or Charity: | | |
| Estate, or Trust Tax Identification #<br><br>_____<br><br>Please forward a copy of the Certified Letters of Testamentary, or Court Order appointing the Executor/ Administrator of the Estate or Trustee and a complete copy of the Trust agreement. | | |
| **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.** | | |
| Signature of person completing this form | | Date signed |

**Be Sure the Authorization For Use in Obtaining Information and Part B are completed by the Beneficiar(ies)**

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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:_____

# 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.