reliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Reset

Proof of Loss Claim Statement
VCI Critical Illness Benefit

EMPLOYER/ADMINISTRATOR INSTRUCTIONS

The Employer/Administrator must complete PART A in its entirety. The claimant must complete The Authorization for Use in Obtaining Information and Part B. Part C must be completed by the attending physician.

Return this form to:

Reliance Standard Life Insurance Company
Attn: Critical Illness 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 **only if** the employee was required to pay any portion of the premiums for this insurance:
1. Original enrollment forms and any subsequent changes along with any benefit confirmation statements; and
2. Payroll records showing the applicable premium deduction.

In 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 and Address	Critical Illness Policy Number
Division Name and Address (if different)	Employee Social Security Number
Employee Name and Address	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)

Date Employment Commenced	Was Insurance in Effect on Date of Diagnosis? ☐ Yes ☐ No	If No, Termination Date of Coverage
Effective Date of Coverage for Employee	Employee Occupation/Title/Position	Insurance Class (Refer to Policy Schedule of Benefits)
Date Premium Paid To On Employee's Behalf	Critical Illness Benefit Amount Elected	Date of Last Benefit Increase
Status of Employee ☐ Still Working ☐ Retired ☐ Other (Explain) _____ ☐ Approved Leave of Absence (Explain) _____		Date Critical Illness Coverage First Elected Under Reliance Standard Policy_____ Under prior carrier's policy_____
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)

Employee Was: **(Check All That Apply)**
☐ Full-time ☐ Part-time ☐ Union ☐ Non-Union ☐ Hourly ☐ Salaried ☐ Exempt ☐ Non-Exempt ☐ Commissioned ☐ Other (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 100% of premium is paid by employer and that employee was not taxed.

If Claim is For Dependent, Provide the Following:

Dependent's Name and Address	Social Security Number	Date of Birth	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)

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 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 ( )	Fax Number ( )	Email Address

Employer/Administrator Name (Please Print)	Employer/Administrator Signature	Date

Be Sure the Authorization For Use in Obtaining Information and Parts B and C are Completed

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LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

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: CRITICAL ILLNESS BENEFIT CLAIMED

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

CATEGORY 1 (check all that apply)	CATEGORY 2 (check all that apply)	CATEGORY 3 (check all that apply)
☐ Carcinoma in Situ	☐ Coronary Artery Bypass	☐ Blindness
☐ Life Threatening Cancer	☐ Heart Attack (Myocardial Infarction)	☐ Coma
	☐ Ruptured Cerebral, Carotid or Aortic Aneurysm	☐ Kidney (Renal) Failure
	☐ Stroke	☐ Major Organ Transplant
	`	☐ Paralysis
		☐ Severe Brain Damage

OCCURRENCE INFORMATION: CHECK ONE

☐ First Occurrence	☐ Recurrence in Same Category Approximate Date of Prior Occurrence:	☐ Subsequent Occurrence in Different Category Approximate Date of Prior Occurrence:

MEDICAL SERVICE PROVIDER INFORMATION

Please list all doctors, hospitals, pharmacies and other medical service providers you have utilized in the past five (5) years. 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		
4. Name of doctor, hospital, pharmacy or other medical service provider	Phone Number ( )	Fax Number ( )
City, State, Zip Code		
5. Name of doctor, hospital, pharmacy or other medical service provider	Phone Number ( )	Fax Number ( )
City, State, Zip Code		

MEDICATION INFORMATION

Please list all prescription medications you have taken in the past five (5) years. Use additional paper as necessary.

Medication	Date Prescrived (mm/dd/yyyy)	Date Last Taken (mm/dd/yyyy)
1.		
2.		
3.		
4.		
5.		

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Phone Number ( )	Social Security Number/Tax ID Number	Email Address

Claimant Name (Please Print)	Claimant Signature	Date

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

Patient's Name:	Patient's Social Security Number:
Patient's Address	
Gender: ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy):

Please provide the requested information for each condition for which you are treating the above patient:

Diagnosis	ICD-9 or ICD-10 Code	Date of First Diagnosis(mm/dd/yyyy)	Date of First Treatment (mm/dd/yyyy)
		`	

Has the patient ever had the same or a similar condition? (If yes, provide dates and details) ☐ Yes ☐ No

Has another physician ever treated the patient for the same or a similar condition? (If yes, provide name & address of the physician) ☐ Yes ☐ No

Has the patient ever been hospitalized for a condition listed above? (If yes, provided hospital name and dates of admission) ☐ Yes ☐ No

Have you treated the patient previously? (If yes, provide dates, conditions and details) ☐ Yes ☐ No

Was the patient referred to you by another physician? (If yes, provide name & address of the physician) ☐ Yes ☐ No

Did cosmetic or elective surgery (not medically necessary) contribute to any listed condition? (If yes, provide dates and details) ☐ Yes ☐ No

Did alcohol or drugs contribute to any listed condition? (If yes, please explain) ☐ Yes ☐ No

Current Medications (list all)

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

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.