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 Florida
Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

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 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.

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.

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

Proof of Loss Claim Statement
VAI Accident Benefit

CLAIM SUBMISSION INSTRUCTIONS

Employer/Administrator: Please complete **PART A** in its entirety.

Employee: Please complete the Authorization for Use in Obtaining Information and **PARTS B and C** in their entirety. **Be sure to include attach receipts, reports or other proof to support the benefit(s) claimed.**

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

To make the claim process as convenient as possible, we have requested only the information typically needed to make a claim determination. In a small number of cases, additional information may be required. Submission of the requested 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 City of Grandview	Voluntary Accident Policy Number VAI827683	Employee Name
Date of Hire	Employee Occupation/Title/Position	Insurance Class (Refer to Policy Schedule of Benefits)
Plan Elected (Refer to Policy Schedule of Benefits) ☐ A ☐ B ☐ C	Type of Coverage Elected ☐ Employee Only ☐ Employee & Child(ren) ☐ Employee & Spouse ☐ Family	Date Voluntary Accident Coverage First Elected
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)

Did Accident Happen at Work? ☐ Yes ☐ No 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 that 100% of premium is paid by employer and that employee was not taxed.**

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

PART B: EMPLOYEE/CLAIMANT INFORMATION

Employee Name and Address	Social Security Number	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)

IF CLAIM IS FOR A DEPENDENT, PROVIDE THE FOLLOWING:

Dependent's Name and Address	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)

INFORMATION ABOUT THE ACCIDENT

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

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

What was Insured doing at the time of accident?

How did accident happen (describe fully)?

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

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

P.O. Box 7307
Philadelphia, PA 19101-7307

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.

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 C: VOLUNTARY ACCIDENT BENEFITS CLAIMED

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

EMERGENCY CARE BENEFITS	SPECIFIED COVERED INJURY AND TREATMENT BENEFITS	PARALYSIS BENEFITS
☐ Air Ambulance Transportation ☐ Ambulance Transportation ☐ Emergency Treatment ☐ Diagnostic Examination ☐ Initial Physician Office Visit	☐ Fracture, Surgical (specify) _____ ☐ Fracture, non-Surgical (specify) _____ ☐ Dislocation, Surgical (specify) _____ ☐ Dislocation, non-Surgical (specify) _____ ☐ Blood, Plasma and Platelets ☐ Burns: 2nd Degree _____ % of body ☐ Burns: 3rd Degree _____ % of body ☐ Burns: Skin Graft due to burns ☐ Coma ☐ Concussion ☐ Dental Injury (extraction) ☐ Dental Injury (crown) ☐ Eye Injury (removal of foreign object) ☐ Eye Injury (surgical repair) ☐ Laceration/no sutures ☐ Laceration/sutures (specify length in inches) _____	☐ Paraplegia or Hemiplegia ☐ Quadriplegia
GENERAL TREATMENT BENEFITS		**SURGERY BENEFITS**
☐ Initial Hospital Admission ☐ Intensive Care Unit Hospital Admission ☐ Hospital Confinement _____ days ☐ Intensive Care Unit Confinement _____ days ☐ Rehabilitation Facility Confinement _____ days ☐ Follow-up Physician Office Visit ☐ Transportation ☐ Lodging _____ days		☐ Exploratory Surgery (no repair) ☐ Knee Cartliage ☐ Abdominal or Thoracic Surgery ☐ Ruptured Disc ☐ Tendon, Ligament or Rotator Cuff (one) ☐ Tendon, Ligament or Rotator Cuff (two or more)
		TRANSITIONAL BENEFITS
		☐ Medical Appliance ☐ Prosthesis (one) ☐ Prosthesis (two or more) ☐ Physical Therapy _____ sessions

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 ( )	Social Security Number/Tax ID Number	Email Address
Employee Name (Please Print)	Employee Signature	Date

IMPORTANT: ATTACH RECEIPTS, REPORTS OR OTHER PROOF TO SUPPORT BENFITS CLAIMED.