RELIANCE STANDARD
Life Insurance Company

Proof Of Loss Claim Statement
Group Life/Accidental Death Insurance

EMPLOYER/ADMINISTRATOR INSTRUCTIONS

The Employer/Administrator must complete PART A of this form in its entirety. The beneficiary must complete PARTS B and C and sign this claim form where signatures are required.

Return this form and the required Proof of Loss to:

Reliance Standard Life Insurance Company
Attn: Group Life Claims
P.O. Box 8330
Philadelphia, PA 19101-8330
Phone 1-800-351-7500

In addition to the claim form, the following items are required for a completed Proof of Loss:

(1) Certified Death Certificate (with a raised or colored seal) providing the final cause of death.
(2) Original enrollment forms and any subsequent beneficiary and benefit changes.
(3) Copies of payroll records for a two (2) month period prior to the date last worked to confirm premium payment, if the employee was required to pay all or part of the premium for this insurance.
(4) Additional documents are required if the beneficiary is a minor or an Estate--See next page for information.

All benefit payments of $5,000 or more will be deposited into an RSL Asset Account®. RSL will establish an interest-bearing account for each beneficiary and provide him/her with personalized checks and access to the account.

A separate form must be completed and signed by each beneficiary. At times, we may require completion of the Physician's Statement PART D. Also, on a small number of claims, 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	Policy Number (List all RSL Policy Numbers under which a claim is being made)
Division Name And Address	Bill Group Number (If Applicable)
Employee Name And Address	Employee Social Security Number

Was Insurance In Force On Date Of Loss? ☐ YES ☐ NO	If No, Termination Date of Coverage	Date Of Birth	Date Employed	Employee Occupation/Job Title/Position

Effective Date of Coverage for Employee	Insurance Class (Refer To Policy Schedule Of Benefits)	Salary On Last Benefit Change Date $ ☐ Hrly ☐ Wkly ☐ Mthly ☐ Annly	Date Premium Paid To On Employee's Behalf

Life Benefit In Force $	Are Accidental Death Benefits Being Claimed? ☐ YES ☐ NO If Yes, Amount Claimed $	Date Of Last Salary Increase	Date Of Last Benefit Increase (Refer To Policy Schedule Of Benefits)	Date of Death

Status Of Employee On Date Of Death
Active ☐ Retired ☐ Premium Waiver For Disability ☐ Approved Leave Of Absence (Explain) ☐ Other ☐ ____________ (specify)

Number Of Hours Employee Scheduled To Work Per Week	Date Employee Last Worked Scheduled Hours Per Week	Reason Employee Did Not Return To Work

Employee Was: **(Check All That Apply)**	☐ Full-time ☐ Part-time	☐ Union ☐ Non-Union	☐ Hourly ☐ Salaried	☐ Exempt ☐ Non-Exempt	☐ Commissioned ☐ Other (Explain)

If Claim Is For Dependent, In Addition To The Above Employee Information Please Provide The Following:

Dependent's Name And Address	Social Security Number	Relationship	Amount Of Benefit $

EMPLOYER/ADMINISTRATOR SIGNATURE

"A person who knowingly and with intent to injure, defraud, or deceive an insurance company and who files a statement of claim containing false, incomplete or misleading information commits a fraudulent insurance act, which is a crime."

Dated 20	At (City, State, Zip)

Employer/Administrator	By (Authorized Representative)	Employer Phone Number

PART B: 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 Taxpayor 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:

If applicable, this signature specimen will be used on the RSLAsset Account®.

Date Signed (Mo., Day, Year): ____________

Be certain Part C is completed.

PART C: CLAIMANT/BENEFICIARY INFORMATION

In order to assure prompt processing, please be sure you complete PART B. **If you, as beneficiary, are not related to the deceased, be certain the Authorization section below is signed by the deceased's next-of-kin or authorized representative.** The completed and signed claim form along with the certified death certificate and other required items should be returned to the employer/Administrator for submission to RSL. If you are interested in an optional Method of Settlement rather than a lump sum payment, please contact RSL at the address and telephone number shown on this form for the options that are available.

IMPORTANT: Upon approval of the claim, if the benefit amount is $5,000 or more, at no cost to you we will deposit the benefit into an RSL Asset Account®, an interest-bearing checking account established in your name and provide you with personalized checks to access the account.

Name Of Beneficiary	Relationship To Employee	Beneficiary's Date Of Birth	Address Of Beneficiary (No., Street, City, State, Zip)

Note: If any designated beneficiary is deceased, we require the beneficiary's certificate of death. If the beneficiary is the Estate, we require certified Letters of Administration or Testamentary, and the Estate Tax ID Number. If beneficiary is a minor, we require certified Letters of Guardianship for the minor's estate and the minor's social security number. The Guardian should sign PART B "Important Tax and Signature Information," and also sign below in his/her capacity on behalf of the minor beneficiary.

If death was accidental, we require the police report, autopsy report and newspaper clippings, if any.

List Other Coverages And Amounts Of Insurance In Force At The Time Of The Insured's Death.

Companies	Policy Number	Effective Date	Amount Of Insurance

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Signature Of Beneficiary	Business Phone No.	Home Phone No.	Date
	( )	( )	

AUTHORIZATION

Reliance Standard Life Insurance Company (Referred To As RSL)

Upon presentation of the original or a photocopy of this signed Authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide RSL or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, information concerning advice, care, treatment provided to or claims made by the deceased named herein, including information relating to mental illness, use of drugs or alcohol, or treatment for HIV, or HIV Related conditions. I authorize the employer, group policyholder or benefit plan administrator to provide RSL with financial or employment-related information. I understand that any such information will be used by RSL for the purpose of evaluating this claim for insurance benefits and that I or any authorized representative may receive a copy of this authorization upon request.

This authorization is valid from the date signed for the duration of the claim.

Signature of Beneficiary, Authorized Representative, or Next of Kin		Date Signed (Mo., Day, Year)
Address of Individual above (No., Street, City, State, Zip)	Business Phone Number ( )	Home Phone Number ( )

Completion of PART D below may help to expedite the processing and review of this claim.

PART D: ATTENDING PHYSICIAN'S STATEMENT

Name of Deceased	Name(s)/Address(es) of all physicians who treated Deceased

Cause of Death

Principal Cause		Date of Onset 20
Contributing Cause		Date of Onset 20
I Attended Deceased	From 20	To 20

Was deceased unable to work due to illness or injury prior to date of death? ☐ Yes ☐ No	If **"Yes"**, please state date on which such illness or injury prevented the deceased from working 20
Was Death Due To: ☐ Accident? ☐ Suicide? ☐ Homicide?	If caused by accident was it associated with his/her occupation? ☐ Yes ☐ No
Name Of Physician (Please Type Or Print)	Address Of Physician

"A person who knowingly and with intent to injure, defraud, or deceive an insurance company and who files a statement of claim containing false, incomplete or misleading information commits a fraudulent insurance act, which is a crime."

Date	Phone Number	Physician's Signature
20		**Degree**