reliancestandard
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Hospital Indemnity Benefit
Proof of Loss Claim Statement

HOW TO FILE THIS CLAIM

Please follow the instructions listed below to avoid unnecessary delays in processing.

Employer/Policyholder

- Complete, Sign and Date Part I.

Employee

- Complete, Sign and Date Part II.
- Enter Employee Name on the Authorization for Use in Obtaining Information and the Health Care Provider statement.
- The **patient who received treatment** should complete The Authorization for Use in Obtaining Information on page 5.
- Attach all original itemized bills providing complete information on:
  - Health Care Provider(s) Name and Address
  - Patient Name
  - Diagnosis Code (ICD-9/ICD-10)
  - Date(s) of Service
  - Treatment Charge(s)
  - Procedure Code(s) (CPT)
  - Place of Service Code(s)

Health Care Provider

- Complete, Sign, and Date Part III.

Please submit all completed claim forms to Reliance Standard Life Insurance Company (RSLI) and any attachments to support the claim for benefits by any of the following methods:

Email	VHIIntake@rsli.com
Fax	267-256-3518
Mail	Reliance Standard Life P.O. Box 7307 Philadelphia, PA 19101-7307

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PART I – TO BE COMPLETED BY EMPLOYER/POLICYHOLDER

Employer Name and Address	Hospital Indemnity 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, nickname, derivative form of first/middle name, alias*):

Date of Hire	Employment Termination Date (*if applicable*)	Employee Occupation/Title/Position
Effective Date of Coverage for Employee	Date Hospital Indemnity Coverage First Elected	Elected Plan (*If applicable*)
Employee Premium Paid Through Date	Usual Number of Hours Employee Works(ed) Per Week	Date Employee Last Worked Usual Number of Hours

Status of Employee
☐ Still Working ☐ Retired ☐ Other (*Explain*)_____
☐ Approved Leave of Absence (*Explain*)_____

Coverage Termination Date (*if applicable*)

Reason Employee Did Not Return To Work (*if applicable*)

Employee Was (**Check All That Apply**):

☐ Full-Time ☐ Union ☐ Hourly ☐ Exempt ☐ Commissioned
☐ Part-Time ☐ Non-Union ☐ Salaried ☐ Non-Exempt ☐ 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 equal 100%. If left blank, we will assume employer pays 100% of premium and that the employee was not taxed.

DEPENDENT INFORMATION (*if applicable*)

Dependent's Name and Address	Social Security Number	Date of Birth	Relationship to Employee

Other names by which the Dependent may have been known (*maiden name, nickname, derivative form of first/middle name, alias*):

EMPLOYER/ADMINISTRATOR SIGNATURE

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.

Employer/Policyholder Name			Fax Number
Employer/Policyholder Signature	Date	Telephone Number	Email Address

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PART II – TO BE COMPLETED BY EMPLOYEE

EMPLOYEE INFORMATION

Employee Name (*Last, First, Middle*)	Date Of Birth	Social Security Number

Street Address	City	State	Zip

Employer/Policyholder Name	Employer/Policyholder Phone Number	Policy Number

DEPENDENT INFORMATION (*if applicable*)

Dependent Name (*Last, First, Middle*)	Dependent Date Of Birth	Dependent Social Security Number

Dependent Street Address	City	State	Zip

Relationship To Employee (*Self, Spouse, Child*)	If the dependent is your child and over 25, is he or she disabled? ☐ Yes ☐ No

TREATMENT INFORMATION

Is the claim for an:	Is treatment the result of occupational illness or injury?	When did the accident, illness or wellness visit occur?
☐ Accident ☐ Illness ☐ Wellness Visit	☐ Yes ☐ No	

Please explain the nature and reason(s) for the treatment. If any treatment was the result of an accident, provide details of when, where and how the accident happened. (*If you need additional space, attach a sheet of paper to this form.*)

HOSPITAL INFORMATION

Hospital Name	Date(s) of Treatment

Street Address	City	State	Zip Code

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Employee Name (*Last, First, Middle*)

DIRECT DEPOSIT AUTHORIZATION

I authorize Reliance Standard Life Insurance Company (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, I request that all approved benefits are provided via Direct Deposit ☐ No, I request that all approved benefits are provided via physical check	Type of Account: ☐ Checking ☐ Savings
Bank Name	Bank Transit/Routing Number (*9 Digits*)
Bank Address	Personal Account Number (*Or attach a voided check imprinted with your name*)

EMPLOYEE SIGNATURE

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Employee Signature	Date	Telephone Number	Email Address

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AUTHORIZATION FOR USE IN OBTAINING INFORMATION

Employee Name (*Last, First, Middle*)

NAME OF PATIENT: _____
PATIENT'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: _____ Patient'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: _____

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PART III – TO BE COMPLETED BY HEALTH CARE PROVIDER

Please complete each applicable section of this form and provide all medical records in your possession for this Patient from the earliest date you list in the column below entitled Date of First Diagnosis through the date that you sign this form. The Patient is responsible for the expense associated with the completion of this Statement.

Employee Name (*Last, First, Middle*)	Patient Name (*Last, First, Middle*)

Patient Address	Patient Date of Birth	Patient Social Security Number

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

Diagnosis	ICD-10 Code	Date of First Diagnosis	Date of First Treatment

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

Has the Patient ever been hospitalized for a condition noted above? (*If yes, provide each hospital name and dates of admission*)
☐ Yes ☐ No

Has another Heath Care Provider ever treated the Patient for the same or similar condition(s)? (*If yes, provide name & address of each Health Care Provider*)
☐ Yes ☐ No

Did the Patient have a cosmetic or elective surgery that contributed to a condition listed above? (*If yes, provide dates and details*)
☐ Yes ☐ No

Did the Patient's use of alcohol or drugs contribute to a condition listed above? (*If yes, please explain*)
☐ Yes ☐ No

Current Patient Medications (*list all*)

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HEALTH CARE PROVIDER SIGNATURE

Health Care Provider Name and Address	Health Care Provider Tax ID Number

Telephone Number	Fax Number	Specialty

Health Care Provider Signature	Date	Degree

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.

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.