RELIANCE STANDARD
Life Insurance Company

**Short-Term Disability Benefits**
**Initial Statement of Claim**

## HOW TO FILE A CLAIM

Please follow the instructions listed below to avoid unnecessary delays in processing your claim. This form must be fully completed for each disability claim. If the claim form is not fully completed, the processing of the claim may be delayed.

**Employer:** 1) Complete and sign Part I answering all questions;

2) Attach job description; and

3) Attach proof of earnings as defined by applicable policy (example: payroll records, W-2, K1, 1099, etc.)

**Insured:** 1) Complete and sign Part II answering all questions; and

2) Complete and sign the AUTHORIZATION FOR USE IN OBTAINING INFORMATION form, and

3) Have the attending physician complete and sign the ATTENDING PHYSICIAN STATEMENT.

Please fax completed claim forms and attachments (only) to 267-256-3519 or mail to Reliance Standard Life, P. O. Box 7749, Philadelphia, PA 19101-7749.

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Interactive Form
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# Short-Term Disability Benefits
# Initial Statement of Claim

Please fax completed claim forms and attachments (only) to 267-256-3519 or mail to Reliance Standard Life, P. O. Box 7749, Philadelphia, PA 19101-7749.

**PART I** **FOR EMPLOYER TO COMPLETE**

| Name of Insured (Last, First, Middle Initial) | Date of Birth | Social Security No. | Policy No. |
|---|---|---|---|
| | | | |

| Job Title | Insurance Class | Hire Date | Date Enrollment Card Signed | Effective Date of Insurance |
|---|---|---|---|---|
| | | | | |

| Date Laid Off (If Applicable) | Date Retired (If Applicable) | Weekly Earnings | Date Last Worked | Date Returned to Work |
|---|---|---|---|---|
| | | | | |

| Is Employee receiving sick leave benefits from present employer? ☐ Yes ☐ No | Date Began | Dated Ended | Reason For Stopping Work |
|---|---|---|---|
| | | | |

| Is disability work related? ☐ No ☐ Yes If "Yes," Explain | Brief Description of Duties |
|---|---|
| | |

| Percentage of premium paid by: Claimant % Employer % | If claimant pays any portion of the premium, please indicate whether the claiman'ts portion of the premium is paid with: ☐ Pre-tax dollars ☐ Post-tax dollars |
|---|---|
| | |

Is there any reason why FICA taxes should not be withheld from claimant's benefits? ☐ Yes ☐ No
If "Yes," please explain:

| Employer Name & Address | Employer's Telephone Number Ext. |
|---|---|
| | |

| Authorized Signature Date | Fax Number | Email Address |
|---|---|---|
| | | |

**PART II** **FOR INSURED TO COMPLETE**

| Home Address (Street, City, State, Zip) | Gender: ☐ Male ☐ Female | Dominant Hand: ☐ Right ☐ Left |
|---|---|---|
| | | |

| Is this Claim Based on an accident? ☐ Yes ☐ No | Did injury occur at work? I f "Yes," for whom were you working? ☐ Yes ☐ No | Date you were first unable to work because of this disability |
|---|---|---|
| | | |

| Date of Accident (if any) | Time ☐ AM ☐ PM | How and where did accident happen? |
|---|---|---|
| | | |

| Name and Address of Attending Physician | Date you returned to work |
|---|---|
| | |

Are you now receiving Unemployment Compensation benefits? ☐ Yes ☐ No

Are you now receiving or eligible to receive as a result of this disability:
Social Security ☐ Yes ☐ No
Worker's Compensation ☐ Yes ☐ No
State Disability ☐ Yes ☐ No
No Fault Disability ☐ Yes ☐ No
Other ☐ Yes ☐ No
If "Yes" give name and address of insurer, amount of income, date benefits began and ended.

**We are required to withhold federal income tax from any benefit payments upon your request. If benefits are taxable by your state, we will also withhold state income tax upon your request. We must also send a report to your employer at the end of each calendar year showing your name, social security number, any benefits paid and any taxes withheld. If you would like us to withhold any taxes, please indicate the dollar amount to be withheld each week:**

Federal Tax to be Withheld _____ ($20.00 Minimum per week, whole dollars only)
State Tax to be Withheld _____ ($ 2.00 Minimum per week, whole dollars only)

**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.**

| Insured's Signature Date | Telephone Number ( ) | E-Mail Address |
|---|---|---|
| | | |

RELIANCE STANDARD
Life Insurance Company

P.O. Box 7749
Philadelphia, PA 19101-7749

# AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF INSURED: _____
INSURED'S SSN: _____
POLICYHOLDER: _____

To all physicians and other health care professionals, hospitals, other health care institutions, insurers, medical, hospital and prepaid health plans, pharmacies, employers, group policyholders, contract holders, governmental agencies (including but not limited to 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 with information concerning medical care, advice, and/or treatment provided to me, the above named Insured, and/or any employment, salary 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 III** **ATTENDING PHYSICIAN'S STATEMENT (PLEASE ANSWER ALL QUESTIONS AND SIGN)**

Patients Name | Social Security Number

Diagnosis and Concurrent Conditions (including ICD-9 codes)

Surgical or Obstetrical Procedure

Current Medications

Frequency of Treatment ☐ Weekly ☐ Other ☐ Monthly

| | | |
|---|---|---|
| Is condition due to injury or sickness arising from patient's employment? ☐ Yes ☐ No | Has patient ever had same or similar symptoms? ☐ Yes ☐ No If Yes, when | |
| Date symptoms first appeared or accident happened | Date patient first consulted you for this condition | Is patient still under your care for this condition? ☐ Yes ☐ No |
| If condition is due to pregnancy, give LMP and expected date of delivery. LMP _____ Expected Date of delivery _____ | If patient hospitalized, give name of hospital Admission Date _____ Discharge Date _____ | |
| Is patient able to perform his/her job? ☐ Yes ☐ No | Date patient was continuously unable to work From _____ To _____ | |
| Estimate date patient should be able to return to work. | Patient will be partially disabled From: To: | |

**MENTAL CONDITION**

Is the patient competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

COMPLETE THIS SECTION ONLY IF DISABILITY IS DUE TO CARDIAC CONDITION

**CARDIAC**

Functional Capacity (American Heart Ass'n) ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

Blood Pressure and Dates

COMPLETE THIS SECTION ONLY IF DISABILITY IS DUE TO VISUAL IMPAIRMENT

**VISUAL IMPAIRMENT**

| | | Snellen Notation | | | |
|---|---|---|---|---|---|
| What was vision at last observation? | With Glasses | O.D. | O.S. | Month | Day 20 |
| | Without Glasses | O.D. | O.S. | Month | Day 20 |

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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 DISABILITY TO PRESENT.**