

**EMPLOYER/ADMINISTRATOR INSTRUCTIONS**

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

**Return this form and the required Proof of Loss to:**

**First Reliance Standard Life Insurance Company**  
**Attn: Group Life Claims**  
**P.O. Box 8330**  
**Philadelphia, Pa 19101-8330**  
**Phone (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 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 further information.

All benefit payments of \$5,000 or more will be deposited into a 1st RSL Asset Account. 1st RSL will establish an interest-bearing account for the claimant 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 (see next page). 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.

**"Any person who knowingly and with intent 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.**

**PART A: EMPLOYER/ADMINISTRATOR INFORMATION**

Employer Name And Address				Policy Number (List all 1st RSL Policy Numbers under which 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	If No, Termination Date of Coverage	Date Of Birth	Date Employed	Employee Occupation/Job Title/Position	
Effective Date of Coverage on Employee	Insurance Class (Refer To Policy Schedule Of Benefits)	Salary On Last Benefit Change Date \$ <input type="checkbox"/> Hrly <input type="checkbox"/> Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Annly		Date Premium Paid To On Employee's Behalf	
Life Benefit In Force \$	Are Accidental Death Benefits Being Claimed? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> Retired <input type="checkbox"/> Premium Waiver for Disability <input type="checkbox"/> Approved Leave of Absence (Explain) <input type="checkbox"/> Other <input type="checkbox"/> _____ (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: <input type="checkbox"/> Full-time <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Exempt <input type="checkbox"/> Commissioned (Check All That Apply) <input type="checkbox"/> Part-time <input type="checkbox"/> Non-Union <input type="checkbox"/> Salaried <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Other (Explain)					

**If Claim Is For Dependent, In Addition To the Above Employee Information Provide the Following:**

Dependent's Name and Address	Social Security Number	Relationship	Amount of Benefit \$
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**EMPLOYER/ADMINISTRATOR SIGNATURE**

Date Signed 20	Place (City, State)	Phone Number
Employer/Administrator		By (Their Authorized Representative)

**PART B: IMPORTANT TAX INFORMATION**

<p><b>To Be Completed By Claimant</b></p> <p>Under penalties of perjury, I certify (1) that the Social Security Number shown on this form is my correct Social Security Number or Taxpayer 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.)</p> <p>By signing this form the claimant has read and agrees with the terms of the statement as well as any accompanying information.</p>	<p>Social Security Number/Tax ID Number</p> <p>_____</p> <p>Signature of the Claimant:</p> <p>_____</p> <p>If applicable, this signature specimen will be used on the 1st RSL Asset Account.</p> <p>Date Signed (month, day, year): _____</p>
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**PART C: CLAIMANT/BENEFICIARY INFORMATION**

In order to assure prompt processing, please be sure you provide the important tax information on the first page of this form. **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 form along with the certified death certificate and other required items should be returned to the Employer/Administrator for submission to 1st RSL. If you are interested in an optional Method of Settlement rather than a lump sum payment, please contact 1st RSL at the address shown on this form for the plans that are available.

**Important:** Upon approval of this claim, if the benefit amount is \$5,000 or more, at no cost to you we will deposit the benefit into an interest bearing account 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, submit the beneficiary's certificate of death. If the beneficiary is the Estate, we require the certified Letters of Administration or Letters of Testamentary, and the Estate Tax ID Number. If a 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" as well as below on his/her capacity on behalf of the minor beneficiary.

**If death was accidental, we require the police report, autopsy report and any newspaper clippings of the incident, 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

Signature of Beneficiary	Business Phone No. (     )	Home Phone No. (     )	Date
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**AUTHORIZATION**

First Reliance Standard Life Insurance Company (Referred to as 1st 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 1st 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 1st RSL with financial or employment-related information. I understand that any such information will be used by 1st RSL for the purpose of evaluating this claim for insurance benefits and that I or any authorized representative will 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 Next of Kin (No., Street, City, State)	Business Phone No. (     )
	Home Phone No. (     )

**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(s) of all physicians who treated Deceased
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<b>Cause of Death</b>	
Principle 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	if "Yes", please state date on which such illness or injury prevented the decease from working 20
Was Death Due To: <input type="checkbox"/> Accident? <input type="checkbox"/> Suicide? <input type="checkbox"/> Homicide?	if caused by accident was it associated with his/her occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name Of Physician (Please Type Or Print)	Address Of Physician

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Date 20	Phone Number	Physician's Signature	Degree
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**IMPORTANT INFORMATION REGARDING APPLICATION FOR GROUP LONG TERM  
DISABILITY AND GROUP LIFE-WAIVER OF PREMIUM BENEFITS**

**PLEASE READ THESE INSTRUCTIONS BEFORE COMPLETING THE ATTACHED FORMS**

This is a multi-purpose form that requires completion in full by all parties concerned. This information *must be provided two months prior to the end of the elimination period* in order to allow sufficient processing time. Each responsible party should complete their section as soon as possible. The entire claim form should be sent immediately upon completion to Reliance Standard Life Insurance Company, P.O. Box 8330, Philadelphia, PA 19101-8330. If you have any questions, please call our Customer Service Department at 1-800-351-7500.

**THE EMPLOYER IS RESPONSIBLE FOR COMPLETING THE FOLLOWING SECTIONS:**

Section 1      Employer's Statement, both sides  
Section 2      Occupation Analysis, both sides

**THE EMPLOYEE IS RESPONSIBLE FOR COMPLETING THE FOLLOWING SECTIONS:**

Section 3      Employee's Statement, both sides  
Section 4      Employment and Education Information, both sides  
Section 5      Sign and date the Authorization for Use in Obtaining Information

**THE ATTENDING PHYSICIAN IS RESPONSIBLE FOR COMPLETING THE FOLLOWING:**

Section 6      Physician's Statement

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**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 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 prison.

**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 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.