

# RELIANCE STANDARD

LIFE INSURANCE COMPANY

A MEMBER OF THE TOKIO MARINE GROUP

## Short-Term Disability Benefits Initial Statement of 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, or email to [claimsintake@rsl.com](mailto:claimsintake@rsl.com).

### 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		#Hours Worked Last Day		Date Returned to Work			
Work schedule at time of disability ___ day/week ___ hrs./day						How is Claimant Paid? <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried <input type="checkbox"/> Salary & Bonus <input type="checkbox"/> Salary & Commission <input type="checkbox"/> Commission Only <input type="checkbox"/> Other:							
Is Employee receiving sick leave benefits from present employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Began		Dated Ended		Reason For Stopping Work							
Is disability work related? <input type="checkbox"/> No <input type="checkbox"/> Yes				Brief Description of Duties									
If "Yes," Explain													
Percentage of premium paid by: Claimant ___% Employer ___% If claimant pays any portion of the premium, please indicate whether the claimant's portion of the premium is paid with: <input type="checkbox"/> Pre-tax dollars <input type="checkbox"/> Post-tax dollars													
Is there any reason why FICA taxes should not be withheld from claimant's benefits? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female		Dominant Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left							
Is this Claim Based on an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did injury occur at work? If "Yes," for whom were you working? <input type="checkbox"/> Yes <input type="checkbox"/> No				Date you were first unable to work because of this disability							
Date of Accident (if any)		Time <input type="checkbox"/> AM <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No													
Are you now receiving or eligible to receive as a result of this disability:				State Disability <input type="checkbox"/> Yes <input type="checkbox"/> No		No Fault Disability <input type="checkbox"/> Yes <input type="checkbox"/> No		Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No				If "Yes" give name and address of insurer, amount of income, date benefits began and ended.	
Social Security <input type="checkbox"/> Yes <input type="checkbox"/> No				Worker's Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No									
<b>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:</b>													
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			
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**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](http://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:  
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