

IMPORTANT INFORMATION REGARDING APPLICATION FOR BENEFITS

This form is to be attached to the proof of Loss Claim Statement when a claim is submitted to Reliance Standard Life. 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 for insurance 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 state prison.

State of Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

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 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.

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.

CLAIM SUBMISSION INSTRUCTIONS

Employer/Administrator: Please complete **PART A** in its entirety.

Employee: Please complete the Authorization for Use in Obtaining Information and **PARTS B and C** in their entirety. **Be sure to include attach receipts, reports or other proof to support the benefit(s) claimed.**

Fax the completed form to: (267) 256-3518 or (267) 256-3537

OR mail the completed form to: Reliance Standard Life Insurance Company
Attn: Voluntary Accident Claims
P.O. Box 7307
Philadelphia, PA 19101-7307
Phone 1-800-351-7500

To make the claim process as convenient as possible, we have requested only the information typically needed to make a claim determination. In a small number of cases, additional information may be required. Submission of the requested 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 Loyola University Chicago	Voluntary Accident Policy Number VAI827524	Employee Name
Date of Hire	Employee Occupation/Title/Position	Insurance Class (Refer to Policy Schedule of Benefits) Class 1 or Class 2
Plan Elected (Refer to Policy Schedule of Benefits) <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	Type of Coverage Elected <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Family	Date Voluntary Accident Coverage First Elected
Usual Number of Hours Employee Works(ed) Per Week	Date Employee Last Worked Usual Number of Hours	Reason Employee Did Not Return to Work (if applicable)
Did Accident Happen at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:		
Percentage of premium paid by employer: _____ % Was Employee taxed on this amount? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Percentage of premium paid by employee: _____ % <input type="checkbox"/> Pre-tax dollars <input type="checkbox"/> Post tax dollars		
Percentages must total 100%. If left blank, we will assume that 100% of premium is paid by employer and that employee was not taxed.		

EMPLOYER/ADMINISTRATOR SIGNATURE

Any person who knowingly and with intent to injure, defraud or deceive Reliance Standard Life Insurance Company, files a statement of claim or submits any information in conjunctions 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 cooperate fully with any prosecution and will seek any and all appropriate legal remedies.

Phone Number (312) 915-6175	Fax Number (312) 915-7612	Email Address
Employer/Administrator Name (Please Print)	Employer/Administrator Signature	Date

PART B: EMPLOYEE/CLAIMANT INFORMATION

Employee Name and Address	Social Security Number	Date of Birth
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Other Names by which the Employee may have been known (maiden name, hypothetical name, nickname, derivative form of first/middle name, alias)

IF CLAIM IS FOR A DEPENDENT, PROVIDE THE FOLLOWING:

Dependent's Name and Address	Social Security Number	Date of Birth	Relationship
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Other Names by which the Dependent may have been known (maiden name, hypothetical name, nickname, derivative form of first/middle name, alias)

INFORMATION ABOUT THE ACCIDENT

When did accident happen ? (month, day, year)	Time <input type="checkbox"/> am <input type="checkbox"/> pm	Where did accident happen ? <input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> elsewhere (specify):
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What was Insured doing at the time of accident?

How did accident happen (describe fully)?

Be Sure the Authorization For Use in Obtaining Information and Part C are Completed

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 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
(If the Insured is unable to sign, an authorized person may sign.)

Insured's Signature

Date

Authorized Person's Signature

Description of Authorized Person's authority to sign on behalf of Insured:

PART C: VOLUNTARY ACCIDENT BENEFITS CLAIMED

Check all that apply. Note: Not all benefits are available under all policies. Consult your policy for additional information, including definitions.

EMERGENCY CARE BENEFITS	SPECIFIED COVERED INJURY AND TREATMENT BENEFITS	PARALYSIS BENEFITS
<input type="checkbox"/> Air Ambulance Transportation <input type="checkbox"/> Ambulance Transportation <input type="checkbox"/> Emergency Treatment <input type="checkbox"/> Diagnostic Examination <input type="checkbox"/> Initial Physician Office Visit	<input type="checkbox"/> Fracture, Surgical (specify) _____ <input type="checkbox"/> Fracture, non-Surgical (specify) _____ <input type="checkbox"/> Dislocation, Surgical (specify) _____ <input type="checkbox"/> Dislocation, non-Surgical (specify) _____ <input type="checkbox"/> Blood, Plasma and Platelets <input type="checkbox"/> Burns: 2nd Degree _____ % of body <input type="checkbox"/> Burns: 3rd Degree _____ % of body <input type="checkbox"/> Burns: Skin Graft due to burns <input type="checkbox"/> Coma <input type="checkbox"/> Concussion <input type="checkbox"/> Dental Injury (extraction) <input type="checkbox"/> Dental Injury (crown) <input type="checkbox"/> Eye Injury (removal of foreign object) <input type="checkbox"/> Eye Injury (surgical repair) <input type="checkbox"/> Laceration/no sutures <input type="checkbox"/> Laceration/sutures (specify length in inches) _____	<input type="checkbox"/> Paraplegia or Hemiplegia <input type="checkbox"/> Quadriplegia <p align="center">SURGERY BENEFITS</p> <input type="checkbox"/> Exploratory Surgery (no repair) <input type="checkbox"/> Knee Cartilage <input type="checkbox"/> Abdominal or Thoracic Surgery <input type="checkbox"/> Ruptured Disc <input type="checkbox"/> Tendon, Ligament or Rotator Cuff (one) <input type="checkbox"/> Tendon, Ligament or Rotator Cuff (two or more) <p align="center">TRANSITIONAL BENEFITS</p> <input type="checkbox"/> Medical Appliance <input type="checkbox"/> Prosthesis (one) <input type="checkbox"/> Prosthesis (two or more) <input type="checkbox"/> Physical Therapy _____ sessions
GENERAL TREATMENT BENEFITS		
<input type="checkbox"/> Initial Hospital Admission <input type="checkbox"/> Intensive Care Unit Hospital Admission <input type="checkbox"/> Hospital Confinement _____ days <input type="checkbox"/> Intensive Care Unit Confinement _____ days <input type="checkbox"/> Rehabilitation Facility Confinement _____ days <input type="checkbox"/> Follow-up Physician Office Visit <input type="checkbox"/> Transportation <input type="checkbox"/> Lodging _____ days		

MEDICAL SERVICE PROVIDER INFORMATION

Please list all doctors, hospitals, or other medical service providers who provided services for injuries received from this accident. Use additional paper as necessary.

1. Name of doctor, hospital, pharmacy or other medical service provider	Phone Number ()	Fax Number ()
City, State, Zip Code		

2. Name of doctor, hospital, pharmacy or other medical service provider	Phone Number ()	Fax Number ()
City, State, Zip Code		

3. Name of doctor, hospital, pharmacy or other medical service provider	Phone Number ()	Fax Number ()
City, State, Zip Code		

EMPLOYEE SIGNATURE

Any person who knowingly and with intent to injure, defraud or deceive Reliance Standard Life Insurance Company, files a statement of claim or submits any information in conjunctions 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 cooperate fully with any prosecution and will seek any and all appropriate legal remedies.

Phone Number ()	Social Security Number/Tax ID Number	Email Address
Employee Name (Please Print)	Employee Signature	Date

IMPORTANT: ATTACH RECEIPTS, REPORTS OR OTHER PROOF TO SUPPORT BENEFITS CLAIMED.