RELIANCE STANDARD
Life Insurance Company

Weekly 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.

Employee: 1) Complete and sign Part I 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.

Employer: 1) Complete and sign Part II 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.)

When all sections of this form have been completed, submit the claim to: **Reliance Standard Life Insurance Company**
P.O. Box 7749
Philadelphia, PA 19101-7749

PART I — FOR EMPLOYEE TO COMPLETE

Employee's Name Last First Middle Initial	Employee's Birth Date	Employee's Social Security No.	Sex ☐ Male ☐ Female

Employee's Address (Street, City, State, Zip)	Job Title

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

Date of Accident	Time ☐ AM ☐ PM	How and where did accident happen

Name and Address of Attending Physician	Date you returned to work

Dominant Hand: ☐ Right ☐ Left	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.

Employee's Signature	Telephone Number ( )	Date

PART II — FOR EMPLOYER TO COMPLETE

Employee's Name	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 Due To Employment? ☐ Yes If yes, explain ☐ No	Brief Description of Duties

Employer Name & Address	Employer's Telephone Number Ext.

Authorized Signature Date	Fax Number	Email Address