RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

P.O. Box 7307, Philadelphia, PA 19101-7307

Proof of Loss Claim Statement
VCI Critical Illness Benefit

CLAIM SUBMISSION INSTRUCTIONS

The **Employer/Administrator** must (1) Complete PART A in its entirety; and (2) Provide a copy of the enrollment form and any subsequent changes; and (3) If the Employee is required to pay all or part of the premiums for this insurance, provide payroll records showing premium deductions.

The **Employee** must complete (1) Part B and (2) The Authorization for Use in Obtaining Information.

A **Health Care Provider** must (1) Complete PART C in its entirety and (2) Provide all medical records in the Health Care Provider's possession for the Employee from the earliest date that the Health Care Provider lists in the column in PART C entitled Date of First Diagnosis through the date that the Health Care Provider signs this form. The Employee is responsible for the expense associated with the completion of this Statement.

Email the completed form to: VoluntaryClaims@RSLI.com

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

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

Additional information may be required. Submission of this claim form 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 and Address	Critical Illness Policy Number
Teamsters Local 1932, 433 N. Sierra Way, San Bernadino, CA 92410	VCI801526
Employer Division Name and Address (if different from above)	Employee Social Security Number
Employee Name and Address	Employee Date of Birth

Other Names by which the Employee may have been known (maiden name, hypothetical name, nickname, derivative form of first/middle name, alias)

Employee Date of Hire	Usual Number of Hours Employee Works(ed) Per Week	Date Employee Last Worked Usual Number of Hours	Date Premium Paid To On Employee's Behalf

Current Status of Employee	Date Critical Illness Coverage First Elected
o Still Working o Retired o Approved Leave of Absence (Explain) _____ o Other (Explain) _____	Reliance Standard Policy: Prior Carrier Policy: Critical Illness Benefit Amount Elected
Date of Last Benefit Increase	If applicable, Termination Date of Coverage

Percentage of premium paid by employer: 0 % Was Employee taxed on this amount? o Yes o No

Percentage of premium paid by employee: 100 % o Pre-tax dollars o Post tax dollars

Percentages must total 100%. If left blank, we will assume 100% of premium is paid by employer and that employee was not taxed.

If Claim is For Dependent, Provide the Following:

Dependent's Name and Address	Dependent Social Security Number	Date of Birth	Relationship	Amount of Benefit

Other Names by which the Dependent may have been known (maiden name, hypothetical name, nickname, derivative form of first/middle name, alias)

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	Fax Number	Email Address
( )	( )	

Employer/Administrator Name (Please Print)	Employer/Administrator Signature	Date

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PART B: CRITICAL ILLNESS BENEFIT CLAIMED

Please check **ALL** conditions listed below that apply. Not all benefits that are listed below are available under all policies. Consult your policy for additional information, including definitions.

- o Addison's Disease
- o Alzheimer's Disease
- o Blindness (Loss of Sight)
- o Brain Related: Severe Brain Damage; Benign Brain Tumor;
- o Cancer Related: Carcinoma in Situ; Life Threatening Cancer; Skin Cancer
- o Coma
- o Hearing Loss
- o Heart Related: Coronary Artery Bypass; Coronary Artery Disease; Heart Attack; Heart Valve Disease; Ruptured Cerebral, Carotid or Aortic Aneurysm; Stroke
- o Kidney (Renal) Failure
- o Malaria
- o Motor Neuron Diseases
- o Multiple Sclerosis
- o Paralysis
- o Parkinson's Disease
- o Occupation Related (Occupational HIV; Occupational Hepatitis)
- o Organ Failure or Organ Transplant (Major Organ)
- o Respiratory Distress Syndrome (Acute)
- o Speech (Loss of Speech)
- o Tuberculosis

Applicable to Insured Dependent Children Only:

- o Cerebral Palsy
- o Cleft Lip or Palate
- o Cystic Fibrosis
- o Diabetes (Type 1)
- o Down Syndrome
- o Muscular Dystrophy
- o Spina Bifida

OCCURRENCE INFORMATION: CHECK ONE		
o First Occurrence	o Recurrence in Same Category Approximate Date of Prior Occurrence:	o Subsequent Occurrence in Different Category Approximate Date of Prior Occurrence:

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Phone Number ( )	Social Security Number/Tax ID Number	Email Address

Employee Name (Please Print)	Employee Signature	Date

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PART C: HEALTH CARE PROVIDER STATEMENT

Please complete each applicable section of this form and provide all medical records in your possession for this Patient from the earliest date you list in the column below entitled Date of First Diagnosis through the date that you sign this form. The Patient is responsible for the expense associated with the completion of this Statement.

Patient Name:	Patient Social Security Number:	Patient Date of Birth (mm/dd/yyyy):

Patient Address

Please provide the requested information for each condition for which you are treating the above patient:

Diagnosis	ICD-9 or ICD-10 Code	Date of First Diagnosis (mm/dd/yyyy)	Date of First Treatment (mm/dd/yyyy)
		`	

Has the Patient ever had the same or similar condition/s? (If yes, provide dates and details) o Yes o No

Has another Heath Care Provider ever treated the Patient for the same or similar condition/s? (If yes, provide name & address of each Health Care Provider) o Yes o No

Has the Patient ever been hospitalized for a condition listed above? (If yes, provide each hospital name and dates of admission) o Yes o No

Was the Patient referred to you by another Health Care Provider? (If yes, provide name & address of the Health Care Provider) o Yes o No

Did the Patient have a cosmetic or elective surgery (a surgery not medically necessary) that contributed to a condition listed above? (If yes, provide dates and details) o Yes o No

Did the Patient's use of alcohol or drugs contribute to a condition listed above? (If yes, please explain) o Yes o No

Current Patient medications (list all)

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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.

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AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF INSURED: _____

INSURED'S DATE OF BIRTH: _____

POLICYHOLDER: Teamsters Local 1932

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.

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: _____

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 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.

EF-1205