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.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Reset

Proof of Loss Claim Statement
Group Life/Accidental Death Insurance

EMPLOYER/ADMINISTRATOR INSTRUCTIONS

The Employer/Administrator must complete PART A in its entirety. The Beneficiary must complete The Authorization for Use in Obtaining Information and PART B and PART C.

Return this form to:

Reliance Standard Life Insurance Company
Attn: Group Life Claims
P.O. Box 7307
Philadelphia, PA 19101-7307
Phone 1-800-351-7500

In addition to the Proof of Loss Claim Statement, the following items are required:

1. **Certified Death Certificate (with raised or colored seal) providing the final cause and manner of death.**
2. **Original enrollment forms and any subsequent changes, including all beneficiary designations.**
3. **Payroll records for at least two (2) pay periods prior to the date last worked confirming premium deduction (if the employee was required to pay any portion of the premiums for this insurance).**
4. **If the benefit is based on Earnings, please provide us with the appropriate Earnings Records (as defined in the Group Policy).**
5. **Additional documents are required if the beneficiary is a Minor or an Estate-See next page for additional information.**
6. **If Accidental Death Benefits are being claimed, provide any police report, autopsy report and/or relevant newspaper clippings (Note: In some instances, RSL may need to request these documents directly from the source before a determination can be made on the claim).**

A separate form must be completed and signed by each Beneficiary. In certain instances, we may require completion of the Attending Physician's Statement (Part D). Also, on a small number of cases, 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.

PART A: EMPLOYER/ADMINISTRATOR INFORMATION

Employer Name and Address	All RSL Policy Numbers Under Which Claim Is Being Made
IASIS Healthcare, LLC 117 Seaboard Lane, Building E, Franklin TN 37067	GL668964
Division Name and Address	Employee Occupation/Title/Position
Employee Name and Address	Employee Social Security Number

Other Names By Which The Employee May Have Been Known (Maiden Name, Hypothetical Name, Nickname, Derivative Form Of First/Middle Name, Alias)

Date Employed (Date of Hire)	Effective Date of Coverage for Employee	Insurance Class (Refer to Policy **Schedule of Benefits** Page)	Employee's Date of Birth	Employee's Date of Death

Was Insurance in Effect on Date of Loss?	If No, Termination Date of Coverage	Salary on Last Benefit Change Date Per Policy	Date of Last Salary Change
☐ Yes ☐ No		$ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually	☐ Increase OR ☐ Decrease

Life Benefit Amount Claimed	Are Accidental Death Benefits Being Claimed?	Date of Last Benefit Increase	Date To Which Premium Was Paid On Employee's Behalf
$	☐ Yes ☐ No Amount Claimed $		

Status of Employee on Date of Death:

☐ Active ☐ Retired ☐ Approved Premium Waiver for Disability ☐ Approved Leave of Absence (Explain) ☐ Other (Explain)

Number of Hours Employee **Scheduled** to Work Per Week in the Place Where the Job is Normally Performed	Number of Hours Employee **Actually** Worked Per Week in the Place Where the Job Is Normally Performed	Date Employee Last Worked	Reason Employee Stopped Working

Employee Was: ☐ Full-time ☐ Union ☐ Hourly ☐ Exempt ☐ Commissioned
(Check All That Apply) ☐ Part-time ☐ Non-Union ☐ Salaried ☐ Non-Exempt ☐ Other (Explain)

If Claim is For Dependent, Provide the Following as it Pertains to the Dependent and the Dependent's Relationship to Employee:

Dependent's Name	Social Security Number	Relationship to Employee	Date of Death	Dependent Life Benefit
				$

Dependent's Address	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 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 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

Be Sure the Authorization For Use in Obtaining Information and Parts B and C are Completed Per Instructions

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

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

LIFE CLAIM AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF DECEDENT: _____
DECEDENT'S DATE OF BIRTH: _____
DATE OF DEATH: _____
BENEFICIARY: _____
NEXT OF KIN OR LEGAL REPRESENTATIVE OF
DECEDENT'S ESTATE: _____
RELATIONSHIP: _____
(*If Executor, Administrator etc., Provide Appropriate Court Order)*

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 with information concerning medical care, advice, and/or treatment provided to the above named Decedent, and/or any employment, salary and/or benefit-related information concerning the above named Decedent. 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 below. A reproduction of this Authorization shall be considered as valid as the original.

_____ _____
Date Beneficiary's Signature

If the Beneficiary is not the Decedent's next of kin or legal representative, the next-of-kin or authorized legal representative of the Decedent's Estate must sign below:

_____ _____
Date Authorized Person's Signature

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

PART B: IMPORTANT TAX INFORMATION

To Be Completed By Beneficiary

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.)

By signing this form the beneficiary has read and agrees with the terms of the statement as well as any accompanying information.

Social Security Number/Tax ID Number

___ ___ ___ ___ ___ ___ ___ ___ ___

Signature of the Beneficiary:

_____

Date Signed (month, day, year): _____

PART C: BENEFICIARY INFORMATION

In order to assure prompt processing, please be sure to provide the **IMPORTANT TAX INFORMATION** above. Be certain the Authorization for Use in Obtaining Information is signed by the next of kin or authorized representative of the deceased. The completed and signed claim form along with the Certified Death Certificate and other required items should be returned to the Employer/Administrator for submission. If you are interested in an optional Method of Settlement rather than a lump sum payment, please contact us at the address or telephone number on this form for the plans that are available.

Name of Beneficiary (Please Print)	Relationship of Beneficiary To Employee	Beneficiary's Date of Birth	Address of Beneficiary (No., Street, City, State) (Please provide your email address, if available)
Email address:			

Note: If any designated beneficiary is deceased, submit that beneficiary's certificate of death. If beneficiary is the deceased's Estate, provide certified Letters of Administration or Letters Testamentary along with the Estate's Tax ID Number. If beneficiary is a minor, provide certified Letters of Guardianship for the minor's Estate and the minor's social security number. The Guardian should sign Part B (IMPORTANT TAX INFORMATION) above, and should also sign where indicated below in his/her capacity on behalf of the Estate of the Minor.

List Other Insurance Coverage In Force At the Time of the Insured's Death

Companies	Policy Number	Effective Date	Amount of Insurance

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

PART D: ATTENDING PHYSICIAN'S STATEMENT

Completion of PART D may help to expedite the processing and review of this claim. May not be necessary if Employee was on Approved Waiver.

Name of Deceased	Names(s)/Address(es) of all Physicians Who Treated Deceased

Cause of Death

Principal Cause			Date of Onset
Contributing Cause			Date of Onset
I Attended Deceased	From (Date) To (Date)	If Decedent Was Hospitalized, Provide the Name of Hospital and Admission and Discharge Dates Name of Hospital: Admit (Date) Discharge (Date)	

Was deceased unable to work due to illness or injury prior to date of death? ☐ Yes ☐ No	If **"Yes"** please state date on which such illness or injury prevented the deceased from working: _____
Was Death Due To: ☐ Accident? ☐ Suicide? ☐ Homicide?	If caused by accident, was it associated with his/her occupation? ☐ Yes ☐ No
Name of Physician (Please Print)	Address of Physician

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Date	Phone Number ( )	Fax Number ( )	Physician's Signature	Degree