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

Proof of Loss Claim Statement
Accidental Death Benefit

ADMINISTRATOR INSTRUCTIONS

The Employer/Administrator must complete PART A in its entirety. The Beneficiary must complete The Authorization for Use in Obtaining Information and PARTS B and 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 claim form, the following items are required:

1. Certified Death Certificate.
2. Original enrollment forms and any subsequent changes, including all beneficiary designations.
3. Payroll records showing premium deduction if the employee was required to pay any portion of the premiums for this insurance.
4. Any police report, autopsy report, and/or newspaper clippings.

A separate form must be completed and signed by each Beneficiary. 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 IASIS Healthcare, LLC 117 Seaboard Lane, Building E, Franklin TN 37067	Policy Number VAR672937
Division Name and Address	Employee Social Security Number
Employee Name and Address	Date Employment Commenced

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

Was Insurance in Effect on Date of Loss? O Yes O No	If No, Termination Date of Coverage	Date of Birth	Date of Death	Employee Occupation/Title/Position

Effective Date of Coverage for Employee	Insurance Class (Refer to Policy Schedule of Policy)	Salary on Last Benefit Change Date $ O Hrly O Wkly O Mthly O Annly	Date Premium Paid To On Employee's Behalf
Accidental Death Benefit in Force	Date of Accident	Date of Last Salary Increase	Date of Last Benefit Increase

Status of Employee on Date

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

Usual Number of Hours Employee Worked Per Week	Date Employee Last Worked Usual Number of Hours	Reason Employee Did Not Return to Work

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

If Claim is For Dependent, Provide the Following:

Dependent's Name and Address	Social Security Number	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

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

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

<u>To Be Completed By Beneficiary</u>
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 you 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. police report, autopsy report, and newspaper clippings should be returned to the Employer/Administrator. If you are interested in an optional Method of Settlement rather than a lump sum payment, please contact RSL at the address on this form for the plans that are available.

Name of Beneficiary	Relationship To Employee	Beneficiary's Date of Birth	Address of Beneficiary (No., Street, City, State)

Note: If any designated beneficiary is deceased, submit that beneficiary's certificate of death. If beneficiary is the Deceased's estate, furnish certified Letters of Administration or Letters of Testamentary, and Estate Tax ID Number. If beneficiary is a minor, furnish certified Letters of Guardianship for the minor's estate and the minor's social security number.

When did accident happen? (month, day, year) Time o am o pm

Where did accident happen? (if city or town, show street number)

How did accident happen? (describe fully)

What was Deceased doing at time of accident?

Date of Death (Mo., Day, Year) Attach copy of Death Certificate

Describe injuries received

List all physicians and surgeons who attended deceased for these injuries.

Name and Address	Name and Address	Name and Address

Advise if Autopsy or Inquest Was Held (Note: Attach summary of Autopsy or copy of inquest verdict.)

List all witnesses to accident.

Name and Address	Name and Address	Name and Address

List all physicians and surgeons who attended deceased during the last five years. (state ailments involved)

Name and Address	Ailment
Name and Address	Ailment
Name and Address	Ailment

List all companies and amounts of other accidental death or life insurance carried by deceased.

Name of Company	Amount $	Name of Company	Amount $
Name of Company	Amount $	Name of Company	Amount $

Your Name

Relationship to Deceased

Are you the Beneficiary named in the policy? o Yes o No

If no, in what capacity do you claim the insurance?

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.

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