

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 First 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.

FIRST RELIANCE STANDARD

LIFE INSURANCE COMPANY

A MEMBER OF THE TOKIO MARINE GROUP

Proof of Loss Claim Statement Group Life Accelerated Benefit

EMPLOYER/ADMINISTRATOR INSTRUCTIONS

The Employer/Administrator must complete PART A in its entirety. The Claimant should complete, sign and date PART B, the Authorization for Use in Obtaining Information form and PART C in their entirety. Part D must be completed by the attending physician without expense to FRSLIC.

Return this form to:
First 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. Copies of enrollment forms and any subsequent changes;
 2. Proof of earnings (as defined by the applicable policy) and, if the employee is required to pay all or part of the premiums for this insurance, copies of payroll records for a two (2) month period prior to date last worked to confirm premium payments.
- Additional medical information may be required from the physician and an independent medical examination may be requested by FRSLIC. A notarized consent must be received from any Irrevocable Beneficiary and any Assignee. FRSLIC must comply with all state regulations. This may delay processing of the claim.

PART A: EMPLOYER/ADMINISTRATOR INFORMATION

Employer Name and Address				List all Applicable FRSLIC Policy Numbers Under Which a Claim is Being Made	
Division Name and Address				Employee Social Security Number	
Employee Name and Address				Bill Group Number (if applicable)	
Is Employee's Insurance Currently In Force? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Coverage Terminated	Date of Birth	Date Employed	Employee Occupation/Title/Position	
Effective Date of Coverage for Employee	Insurance Class (Refer to Policy Schedule of Benefits)	Salary on Last Benefit Change Date \$ <input type="checkbox"/> Hrly <input type="checkbox"/> Wkly <input type="checkbox"/> Mthly <input type="checkbox"/> Anny	Date Premium Paid To On Employee's Behalf		
Life Insurance In Force \$	Accelerated Benefit Amount Requested (based on the limits stated in the policy) \$	Date of Last Benefit Increase (Refer to Policy Schedule of Benefits)			
Current Status of Employee <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Premium Waiver for Disability <input type="checkbox"/> Approved Leave of Absence (Explain) <input type="checkbox"/> Other (specify) _____					
Number of Hours Employee Scheduled to Work Per Week	Is Employee Still Working? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Employee Last Worked	Reason Employee Did Not Return to Work		
Employee Is (Was): (Check All That Apply)	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Union <input type="checkbox"/> Non-Union	<input type="checkbox"/> Hourly <input type="checkbox"/> Salaried	<input type="checkbox"/> Exempt <input type="checkbox"/> Non-Exempt	<input type="checkbox"/> Commissioned <input type="checkbox"/> Other (Explain)
If Claim is For Dependent, Provide the Following:					
Dependent's Name and Address		Social Security Number	Relationship	Amount of Benefit \$	

AUTHORIZED EMPLOYER/ADMINISTRATOR SIGNATURE

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Phone Number ()	Fax Number ()	E-mail Address
Name (Please Print)	Employer/Administrator Signature	Date

PART B: IMPORTANT TAX INFORMATION

To Be Completed By Claimant 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 claimant 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 Claimant: _____ Date Signed (month, day, year): _____
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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 First 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 First Reliance Standard Life Insurance Company's privacy policy is available at www.rsli.com or upon request.

First 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 but not longer than 24 months, 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
(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: CLAIMANT INFORMATION

In order to assure prompt processing, please be certain the Authorization for Use in Obtaining Information is signed and dated. The completed and signed claim form including PART D below should be returned to the Employer/Administrator. **The payment of the Accelerated Benefit will reduce the Death Benefit under your Life Insurance.**

Important tax information: Accelerated Benefits may be considered taxable income and assistance should be sought from a personal tax advisor. Receipt of these benefits may affect your eligibility for other government programs such as Medicaid and Supplemental Security Income (SSI).

Name of Claimant	Relationship To Employee	Date of Birth	E-mail Address

"I hereby request First Reliance Standard Life to accelerate the portion of my term life insurance coverage specified on this claim statement. This request is being made voluntarily and without coercion on the part of any third party. I understand that receipt of an accelerated benefit may affect my eligibility for a state or federal program such as Medicaid, and that these benefits may be taxable. I also understand that the death benefit will be reduced if I receive an accelerated benefit."

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Signature of Claimant	Date	Home Phone Number ()	Business Phone Number ()
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Address of Claimant (No., Street, City, State, Zip)

PART D: ATTENDING PHYSICIAN'S STATEMENT

Instructions to Physician: Please complete each section of this form and provide all reports and treatment records pertaining to this patient. The Claimant is responsible for the completion of this statement without expense to the Company.

Patient's Name	Date of Birth
Principle Diagnosis INCLUDING ICD-9 or ICD-10 CODE	Date of Onset
Contributing Cause INCLUDING ICD-9 or ICD-10 CODE	Date of Onset

Objective findings (attach results of x-rays, lab tests, EKGs, MRIs, and scans). Provide most recent lab values and diagnostic test results.

Describe Treatment programs, including surgery or medications (attach copies of treatment records)

I attended patient:	From (date of first visit)	To (date of treatment)	Frequency of visits (treatment)
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Is patient now totally and continuously disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please state date on which total and continuous disability began:
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Please provide the name(s) and address(es) of any other physician currently treating this patient:

In your opinion, does the patient possess the mental capacity to understand his/her financial affairs and to direct the use of his/her funds?
 Yes No

Based upon this patient's medical condition and your current clinical findings, does this patient have a Life Expectancy of:

Less than 12 months <input type="checkbox"/>	More than 12 months, but less than 24 months <input type="checkbox"/>	Greater than 24 months <input type="checkbox"/>	Cannot be determined <input type="checkbox"/>
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What is this patient's prognosis?

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Physician's Specialty	Tax Identification Number		
Physician's Name (please print or type)	Address (No., Street, City, State, Zip Code)		
Physician's Signature	Date	Phone Number ()	Fax Number ()

REMINDER: PLEASE PROVIDE ALL REPORTS AND TREATMENT RECORDS PERTAINING TO THIS PATIENT.