FIRST RELIANCE STANDARD
Life Insurance Company

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 PARTS B and C (see next page) and sign this claim form where signatures are required

Return this form and the required Proof of Loss to:

First Reliance Standard Life Insurance Company
Attn: Group Life Claims
P.O. Box 8330
Philadelphia, Pa 19101-8330
Phone (800) 351-7500

In addition to the claim form, the following items are required for a completed Proof of Loss:
(1) Certified Death Certificate (with a raised or colored seal) providing the final cause of death
(2) Original enrollment forms and any subsequent beneficiary and benefit changes.
(3) Copies of payroll records for a two (2) month period prior to date last worked to confirm premium payment if the employee was required to pay all or part of the premium for this insurance
(4) Additional documents are required if the beneficiary is a minor or an Estate--see next page for further information

All benefit payments of $5,000 or more will be depostited into a 1st RSL Asset Account 1st RSL will establish an interest-bearing account for the claimant and provide him/her with personalized checks and access to the account

A separate form must be completed and signed by each beneficiary. At times we may require completion of the physician s statement PART D (see next page). Also, on a small number of claims, 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

"Any person who knowingly and with intent 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 fraudulant 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.

PART A: EMPLOYER/ADMINISTRATOR INFORMATION

Employer Name And Address				Policy Number (List all 1st RSL Policy Numbers under which claim is being made)
Division Name And Address				Bill Group Number (If Applicable)
Employee Name And Address				Employee Social Security Number
Was Insurance In Force On Date Of Loss? ☐ YES ☐ NO	If No Termination Date of Coverage	Date Of Birth	Date Employed	Employee Occupation/Job Title/Position
Effective Date of Coverage on Employee	Insurance Class (Refer To Policy Schedule Of Benefits)	Salary On Last Benefit Change Date $ ☐ Hrly ☐ Wkly ☐ Mthly ☐ Annly		Date Premium Paid To On Employee s Behalf
Life Benefit In Force $	Are Accidental Death Benefits Being Claimed? ☐ YES ☐ NO If Yes Amount Claimed $	Date Of Last Salary Increase	Date Of Last Benefit Increase (Refer to Policy Schedule Of Benefits)	Date of Death

Status of Employee on Date of Death
Active ☐ Retired ☐ Premium Waiver for Disability ☐ Approved Leave of Absence (Explain) ☐ Other ☐ _____ (specify)

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

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

If Claim Is For Dependent, In Addition To the Above Employee Information Provide the Following:

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

EMPLOYER/ADMINISTRATOR SIGNATURE

Date Signed 20	Place (City State)	Phone Number
Employer/Administrator	By (Their Authorized Representative)	

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 Taxpayor 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

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Signature of the Claimant:

_____

If applicable this signature specimen will be used on the 1st RSL Asset Account

Date Signed (month day, year): _____

PART C: CLAIMANT/BENEFICIARY INFORMATION

In order to assure prompt processing, please be sure you provide the important tax information on the first page of this form. **If you, as beneficiary, are not related to the deceased, be certain the Authorization section below is signed by the deceased's next-of-kin or authorized representative.** The completed and signed form along with the certified death certificate and other required items should be returned to the Employer/Administrator for submission to 1st RSL. If you are interested in an optional Method of Settlement rather than a lump sum payment please contact 1st RSL at the address shown on this form for the plans that are available

Important: Upon approval of this claim, if the benefit amount is $5,000 or more at no cost to you we will deposit the benefit into an interest bearing account in your name and provide you with personalized checks to access the account.

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

Note: If any designated beneficiary is deceased, submit the beneficiary's certificate of death. If the beneficiary is the Estate, we require the certified Letters of Administration or Letters of Testamentary, and the Estate Tax ID Number. If a beneficiary is a minor, we require certified Letters of Guardianship for the minor's estate and the minor's social security number. The Guardian should sign Part B "Important Tax and Signature Information" as well as below on his/her capacity on behalf of the minor beneficiary

If death was accidental, we require the police report, autopsy report and any newspaper clippings of the incident, if any.

List Other Coverages And Amounts Of Insurance In Force At The Time Of The Insured's Death.

Companies	Policy Number	Effective Date	Amount Of Insurance

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

AUTHORIZATION

First Reliance Standard Life Insurance Company (Referred to as 1st RSL)

Upon presentation of the original or a photocopy of this signed Authorization, I authorize any medical professional, hospital, or other medical-care institution insurance support organization, pharmacy governmental agency insurance company, group policyholder, employer or benefit plan administrator to provide 1st RSL or an agent, attorney consumer reporting agency or independent administrator, acting on its behalf, information concerning advice care, treatment provided to or claims made by the deceased named herein, including information relating to mental illness, use of drugs or alcohol or treatment for HIV, or HIV Related conditions. I authorize the employer, group policyholder or benefit plan administrator to provide 1st RSL with financial or employment-related information. I understand that any such information will be used by 1st RSL for the purpose of evaluating this claim for insurance benefits and that I or any authorized representative will receive a copy of this authorization upon request.

This authorization is valid from the date signed for the duration of the claim.

Signature of Beneficiary Authorized Representative or Next of Kin		Date Signed (Mo Day Year)
Address of Next of Kin (No Street, City, State)	Business Phone No. ( )	Home Phone No ( )

Completion of PART D below may help to expedite the processing and review of this claim.

PART D: ATTENDING PHYSICIAN'S STATEMENT

Name of Deceased	Name(s) Address(s) of all physicians who treated Deceased

Cause of Death

Principle Cause		Date of Onset 20
Contributing Cause		Date of Onset 20
I Attended Deceased	From 20	To 20
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 decease from working 20
Was Death Due To: ☐ Accident? ☐ Suicide? ☐ Homicide?		If caused by accident was it associated with his/her occupation? ☐ Yes ☐ No
Name Of Physician (Please Type Or Print)		Address Of Physician

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Date 20	Phone Number	Physician's Signature Degree