

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

New York Disability Benefit Law

Short Term Disability Benefits

Initial Statement of Claim

HOW TO FILE A CLAIM

Please follow the instructions listed below to avoid unnecessary delays in processing your claim. This form must be fully completed for each disability claim. If the claim form is not fully completed, the processing of the claim may be delayed.

- Employee**
- 1) Complete and sign Part I answering all questions; and
 - 2) Complete and sign the AUTHORIZATION FOR USE IN OBTAINING INFORMATION form; and
 - 3) Have your medical provider complete and sign the MEDICAL PROVIDER STATEMENT (Part III).

- Employer**
- 1) Complete and sign Part II answering all questions.

When all sections of this form have been completed submit the claim to: **Reliance Standard Life Insurance Company**
P.O. Box 7749
Philadelphia, PA 19101-7749
(800) 351-7500 or
You May Fax to: (267) 256-3519

PART I FOR EMPLOYEE TO COMPLETE						
Employee's Name Last	First	Middle Initial	Employee's Birth Date	Employee's Social Security No.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	

Employee's Address (Street, City, State, Zip)	Employee's Occupation
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Is this claim based on an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did injury occur at work? I~"Yes," for whom were you working? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Last day worked	Did you work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date you were first unable to work because of this disability
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Date of Accident	Time <input type="checkbox"/> AM <input type="checkbox"/> PM	How and where did accident happen?
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Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYERS			DATES OF EMPLOYMENT		AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM	THROUGH	
			Mo. Day Yr.	Mo. Day Yr.	

Are you now receiving or eligible to receive as a result of this disability: Social Security Worker's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	State Disability No Fault Disability Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes" give name and address of insurer, amount of income, date benefits began and ended.
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I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began. Yes No

If "Yes", fill in the following: I have been paid by _____ From _____ Date To _____ Date

Name and Address of Medical Provider	Date you returned to work	Are you now receiving Unemployment Compensation benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Employee's Signature	Telephone Number ()	Date
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IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005	SI TIENE DUDAS REPLICACIONADAS CON LA RECLAMACION DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA DE NUEVA YORK O ESCRIBA A: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005
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I authorize FRSL to send my disability payments to the Bank designated below for electronic deposit in my Account. I understand that I may terminate this arrangement at any time by writing to the FRSL address above.

Yes Set-up Direct Deposit

Bank/Financial Institution Information

Name of Bank (Print)		
Address of Bank		
City	State	Zip

Choose Type of Account

Checking Savings

Bank Transit/Routing Number (9 Digits)
Personal Account Number
Or Attach a Voided Check imprinted with your name.

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FIRST RELIANCE STANDARD

LIFE INSURANCE COMPANY

A MEMBER OF THE TOKIO MARINE GROUP

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.

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

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:

PART II**FOR EMPLOYER TO COMPLETE**

Employee's Name		Social Security No.		STD Policy No. DBL Policy No.	
Job Title	Insurance Class	Hire Date	Date Enrollment Card Signed	Effective Date of Insurance	
Date Laid Off (If Applicable)	Date Retired (If Applicable)	Weekly Earnings	Date Last Worked	Date Returned to Work	
Is Employee receiving sick leave benefits from present employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Began	Dated Ended	Reason For Stopping Work	
Is Disability Due To Employment? <input type="checkbox"/> Yes If yes, explain <input type="checkbox"/> No			Brief Description of Duties		

Date Employee wages ceased.	
Date Employee returned to work.	
Has Employment terminated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, date of termination.	
Was Employee laid off or was layoff contemplated prior to disability?	
If so, give day of layoff.	
Are wages going continued during disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, does your Employer request reimbursement.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was Employee on the job when disability occurred?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has claim been filed for Workmen's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, WC carrier name and address	
Is Employee member of a union that provides payment of weekly cash benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give name and address of union.	

Is this claimant a N.Y. employee? Yes No Full Time Part Time
 Normal work week (check boxes to show usual days worked)

	S	M	T	W	TH	F	S
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gross Earnings 8 weeks prior to disability							
Week Ending	No. Days					Gross Amount	
	Mo.	Day	Yr.	Worked			
1							
2							
3							
4							
5							
6							
7							
8							

Contribution % paid by Employee – pre or post tax. _____
 Contribution % paid by Employer _____

Employer Name & Address			Employer's Telephone Number		
Authorized Signature	Date	Title	Fax Number and Email Address		

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED **WHILE EMPLOYED OR BECOMES SICK OR DISABLED WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT**. OTHERWISE USE GREEN FORM DB-300.

PART III MEDICAL PROVIDER'S STATEMENT (PLEASE ANSWER ALL QUESTIONS AND SIGN)

Patients Name _____

Diagnosis and Concurrent Conditions _____

Surgical or Obstetrical Procedure _____

Current Medications _____

Frequency of Treatment Weekly Other
 Monthly

Is condition due to injury or sickness arising from patient's employment? Yes No
 Has patient ever had same or similar symptoms? Yes No
 If Yes, when _____

Date symptoms first appeared or accident happened _____
 Date patient first consulted you for this condition _____
 Is patient still under your care for this condition? Yes No

If condition is due to pregnancy, give LMP and expected date of delivery. LMP _____
 Expected Date of delivery _____
 If patient hospitalized, give name of hospital _____
 Admission Date _____
 Discharge Date _____

Is patient able to perform his/her job? Yes No
 Date patient was continuously unable to work From _____ To _____

Estimate date patient should be able to return to work. _____ Patient will be partially disabled From: _____ To: _____

MENTAL CONDITION

Is the patient competent to endorse checks and direct the use of the proceeds thereof? Yes No

COMPLETE THIS SECTION ONLY IF DISABILITY IS DUE TO CARDIAC CONDITION

CARDIAC

Functional Capacity (American Heart Ass'n) Class 1 (no limitation) Class 2 (slight limitation)
 Class 3 (marked limitation) Class 4 (complete limitation)
 Blood Pressure and Dates _____

COMPLETE THIS SECTION ONLY IF DISABILITY IS DUE TO VISUAL IMPAIRMENT

VISUAL IMPAIRMENT

What was vision at last observation?	Snellen Notation				
	With Glasses	O.D.	O.S.	Month	Day
Without Glasses	O.D.	O.S.	Month	Day	20

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I affirm that I am a Chiropractor Physician Psychologist Dentist Podiatrist Nurse-Midwife
 Licensed in the State of _____ License Number _____

Medical Provider's Name, Address, ZIP (Please Print or Type) _____

Telephone Number () _____ Fax Number () _____ Specialty _____

Medical Provider's Signature _____ Date _____ Degree _____ Medical Provider's Tax ID No. _____

IMPORTANT: PLEASE ATTACH ALL MEDICAL RECORDS FROM THREE (3) MONTHS PRIOR TO DATE OF DISABILITY TO PRESENT.

HIPAA NOTICE – In order to adjudicate a worker's compensation claims, WCL-13-1(4)(a) and 2 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatments with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.