RELIANCE STANDARD
Life Insurance Company

Proof of Loss Claim Statement
Medical Treatment Benefit

CLAIM SUBMISSION INSTRUCTIONS

Employer/Administrator: Please complete **PART A** in its entirety.

a) **Employee: Please complete PART B in its entirety and submit the completed form along with an itemized bill listing patient name, date of service and diagnosis code.**

Fax the completed form to: (512) 275-9355

OR mail the completed form to: Bay Bridge Administrators L.L.C.
PO Box 161690
Austin TX 78716
800-845-7519

To make the claim process as convenient as possible, we have requested only the information typically needed to make a claim determination. In a small number of cases, additional information may be required. Submission of the requested 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	Policy Number	Employee Name
Employee Occupation/Title/Position	Date Employee Missed Complete Day of Regularly Scheduled Workday due to sickness or injury:	

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 Representative Name & Title (Please Print)	Employer Representative Signature	Date

PART B: EMPLOYEE/CLAIMANT INFORMATION

Employee Name and Address	Social Security Number	Date of Birth

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

Date(s) of Medical Services that you are claiming that required you to receive treatment by a Doctor: **(Note: treatment is not for routine dental care)**

Was treatment the result of sickness or injury that required treatment by a Doctor other than in a Hospital Emergency Room? ☐

Was treatment the result of sickness or injury that required treatment by a Doctor in a Hospital Emergency Room? ☐

EMPLOYEE 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 ( )	Social Security Number/Tax ID Number	Email Address
Employee Name (Please Print)	Employee Signature	Date

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 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 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.