

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.

Part I The employee should fully complete and sign this section answering all questions

Part II The employer should fully complete and sign this section answering all questions

Part III Have the attending physician complete the "Attending Physician's Statement."

When all sections of this form have been completed submit the claim to: **Reliance Standard Life Insurance Company
c/o Matrix Absence Management, Inc.
Seven Skyline Drive, Suite 275
Hawthorne, NY 10532
1-877-315-9838**

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	
Is this Claim Based on an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did injury occur at work? If "Yes," whom were you working for? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date you were first unable to work because of this disability	
Date of Accident	Time <input type="checkbox"/> AM <input type="checkbox"/> PM	How and where did accident happen		
Name and Address of Attending Physician		Date you returned to work	Are you now receiving Unemployment Compensation benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you now receiving or eligible to receive as a result of this disability: Social Security Worker's Compensation	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.	

Any person who knowingly and with intent to injure 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 pursue any and all appropriate legal remedies arising from such fraudulent insurance acts.

The above statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital, physician or any other organization, institution, company, governmental agency, or person who has examined or attended me or who has any records or knowledge of me or my health to furnish to Reliance Standard Life Insurance Company, its subsidiaries, or its representatives any and all information with respect to any illness or injury medical history, consultation, prescriptions, treatments or benefits, and copies of all hospital records, medical records, or any other documentation. A photostatic copy of this authorization will be considered as effective and valid as the original.

Employee's Signature	Telephone Number ()	Date
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Federal law requires us to withhold income tax from your check if you request to do so. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate in the block the dollar amount to be held per week.

\$ 20.00 minimum - whole dollars only \$ _____

Employee's Signature	Date
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PART II FOR EMPLOYER TO COMPLETE

Employee's Name		Date of Birth	Social Security No.	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			
Employer Name & Address			Employer's Telephone Number	
Authorized Signature	Date	Title	Fax Number and Email Address	

BASE WEEKS AND BASE YEAR GROSS WAGES

A BASE WEEK is a calendar week in which the claimant had New Jersey earnings of \$144.00 or more during the Base Year. The BASE YEAR is the 52 calendar weeks preceding the week in which the disability occurred.

(a) Total number of **BASE WEEKS** _____

(b) Total Gross Wages in Base Year (Include all wages earned by the claimant.) _____

REGULAR WEEKLY WAGE \$ _____

WEEKLY WAGES – Indicate the dates and claimant's GROSS earnings in NJ employment during the listed calendar weeks.

Description of Calendar Week	Calendar Week Ending Date	Gross Wages
Week Disability Began		\$
Week Before Disability		\$
2 nd Week Before Disability		\$
3 rd Week Before Disability		\$
4 th Week Before Disability		\$
5 th Week Before Disability		\$
6 th Week Before Disability		\$
7 th Week Before Disability		\$
8 th Week Before Disability		\$
9 th Week Before Disability		\$
10 th Week Before Disability		\$
TOTAL GROSS WAGES FOR ABOVE		\$

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

PART III ATTENDING PHYSICIAN'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			
		O.D.	O.S.	Month	Day
With Glasses					20
Without Glasses					20

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

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

Physician's Signature _____ Date _____ Degree _____ Physician's Tax ID No. _____

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