RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

P.O. Box 7307
Philadelphia, PA 19101-7307

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 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 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, and may be revoked by me at any time upon written request to the address above. 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 C: VOLUNTARY ACCIDENT BENEFITS CLAIMED

Check all that apply. Note: Not all benefits are available under all policies. Consult your policy for additional information, including definitions.

EMERGENCY CARE BENEFITS

- ☐ Air Ambulance Transportation
- ☐ Ambulance Transportation
- ☐ Emergency Treatment
- ☐ Diagnostic Examination
- ☐ Initial Physician Office Visit

GENERAL TREATMENT BENEFITS

- ☐ Initial Hospital Admission
- ☐ Intensive Care Unit Hospital Admission
- ☐ Hospital Confinement _____ days
- ☐ Intensive Care Unit Confinement _____ days
- ☐ Rehabilitation Facility Confinement _____ days
- ☐ Follow-up Physician Office Visit
- ☐ Transportation
- ☐ Lodging _____ days

SPECIFIED COVERED INJURY AND TREATMENT BENEFITS

- ☐ Fracture, Surgical (specify) _____
- ☐ Fracture, non-Surgical (specify) _____
- ☐ Dislocation, Surgical (specify) _____
- ☐ Dislocation, non-Surgical (specify) _____
- ☐ Blood, Plasma and Platelets
- ☐ Burns: 2nd Degree _____ % of body
- ☐ Burns: 3rd Degree _____ % of body
- ☐ Burns: Skin Graft due to burns
- ☐ Coma
- ☐ Concussion
- ☐ Dental Injury (extraction)
- ☐ Dental Injury (crown)
- ☐ Eye Injury (removal of foreign object)
- ☐ Eye Injury (surgical repair)
- ☐ Laceration/no sutures
- ☐ Laceration/sutures (specify length in inches) _____

PARALYSIS BENEFITS

- ☐ Paraplegia or Hemiplegia
- ☐ Quadriplegia

SURGERY BENEFITS

- ☐ Exploratory Surgery (no repair)
- ☐ Knee Cartliage
- ☐ Abdominal or Thoracic Surgery
- ☐ Ruptured Disc
- ☐ Tendon, Ligament or Rotator Cuff (one)
- ☐ Tendon, Ligament or Rotator Cuff (two or more)

TRANSITIONAL BENEFITS

- ☐ Medical Appliance
- ☐ Prosthesis (one)
- ☐ Prosthesis (two or more)
- ☐ Physical Therapy _____ sessions

MEDICAL SERVICE PROVIDER INFORMATION

Please list all doctors, hospitals, or other medical service providers who provided services for injuries received from this accident. Use additional paper as necessary.

1. Name of doctor, hospital, pharmacy or other medical service provider	Phone Number ( )	Fax Number ( )
City, State, Zip Code		
2. Name of doctor, hospital, pharmacy or other medical service provider	Phone Number ( )	Fax Number ( )
City, State, Zip Code		
3. Name of doctor, hospital, pharmacy or other medical service provider	Phone Number ( )	Fax Number ( )
City, State, Zip Code		

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

IMPORTANT: ATTACH RECEIPTS, REPORTS OR OTHER PROOF TO SUPPORT BENFITS CLAIMED.