

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.

- Employer:** 1) Complete and sign Part I answering all questions;
2) Attach job description; and
3) Attach proof of earnings as defined by applicable policy (example: payroll records, W-2, K1, 1099, etc.)
- Insured:** 1) Complete and sign Part II answering all questions; and
2) Complete and sign the AUTHORIZATION FOR USE IN OBTAINING INFORMATION form, and
3) Have the attending physician complete and sign the ATTENDING PHYSICIAN STATEMENT.

Please mail completed claim forms and attachments (only) to Bay Bridge Administrators, LLC, P.O. Box 161690, Austin, TX 78716

PART I FOR EMPLOYER TO COMPLETE					
Name of Insured (Last, First, Middle Initial)		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 work related? <input type="checkbox"/> No <input type="checkbox"/> Yes		Brief Description of Duties			
If "Yes," Explain		Employer Name & Address		Employer's Telephone Number Ext.	
Authorized Signature		Date		Fax Number	
Email Address					

PART II FOR INSURED TO COMPLETE					
Home Address (Street, City, State, Zip)			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Dominant Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left
Is this Claim Based on an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did injury occur at work? If "Yes," for whom were you working? <input type="checkbox"/> Yes <input type="checkbox"/> No			Date you were first unable to work because of this disability
Date of Accident (if any)		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:		State Disability <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes" give name and address of insurer, amount of income, date benefits began and ended.	
Social Security <input type="checkbox"/> Yes <input type="checkbox"/> No		No Fault Disability <input type="checkbox"/> Yes <input type="checkbox"/> No			
Worker's Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No		Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No			

We are required to withhold federal income tax from any benefit payments upon your request. If benefits are taxable by your state, we will also withhold state income tax upon your request. We must also send a report to your employer at the end of each calendar year showing your name, social security number, any benefits paid and any taxes withheld. If you would like us to withhold any taxes, please indicate the dollar amount to be withheld each week:

Federal Tax to be Withheld _____ (\$20.00 Minimum per week, whole dollars only)
State Tax to be Withheld _____ (\$ 2.00 Minimum per week, whole dollars only)

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.

Insured's Signature		Date		Telephone Number ()	
				E-Mail Address	

AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF INSURED: _____

INSURED'S SSN: _____

POLICYHOLDER: _____

To all physicians and other health care professionals, hospitals, other health care institutions, insurers, medical, hospital and prepaid health plans, pharmacies, employers, group policyholders, contract holders, governmental agencies (including but not limited to 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 with information concerning medical care, advice, and/or treatment provided to me, the above named Insured, and/or any employment, salary 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 SignatureDescription of Authorized Person's authority to sign on behalf of Insured:

PART III ATTENDING PHYSICIAN'S STATEMENT (PLEASE ANSWER ALL QUESTIONS AND SIGN)

Patients Name _____ Social Security Number _____

Diagnosis and Concurrent Conditions (including ICD-9 codes) _____

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		O.D.	O.S.	Month	Day 20
Without Glasses		O.D.	O.S.	Month	Day 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.