

PART B: CRITICAL ILLNESS BENEFIT CLAIMED

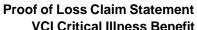
Please check ALL conditions listed below that apply. Not all benefits that are listed below are available under all policies. Consult your policy for additional information, including definitions.

- Addison's Disease 0
- 0 Alzheimer's Disease
- Blindness (Loss of Sight) 0
- Brain Related: Severe Brain Damage; Benign Brain Tumor; 0
- Cancer Related: Carcinomain Situ; Life Threatening Cancer; Skin Cancer
- Coma 0
- Hearing Loss
- Heart Related: Coronary Artery Bypass; Coronary Artery Disease; Heart Attack; Heart Valve Disease; Ruptured Cerebral, Carotid or Aortic Aneurysm; Stroke
- Kidney (Renal) Failure 0
- Malaria 0
- Motor Neuron Diseases 0
- Multiple Sclerosis 0
- **Paralysis** 0
- Parkinson's Disease 0
- Occupation Related (Occupational HIV; Occupational Hepatitis)
- Organ Failure or Organ Transplant (Major Organ) 0
- Respiratory Distress Syndrome (Acute) 0
- Speech (Loss of Speech) 0
- Tuberculosis

Applicable to Insured Dependent Children Only:

- Cerebral Palsy

 Cleft Lip or P Cystic Fibros Diabetes (Ty Down Syndro Muscular Dys 	is pe 1) ome					
o Spina Bifida						
		OCCURRENCE INF	ORMATION: CHECK ONE			
o First Occurrence	o Recurrence in Same Category Approximate Date of Prior Occurrence:			o Subsequent Occurrence in Different Category Approximate Date of Prior Occurrence:		
of claim or submits a nformation commits prosecution under sta	ny information in conjun a fraudulent insurance a	ctions with a claim co act, which is a crime. T	ntaining fraudulent, false These actions will result i	Life Insurance Company, files a statement e, misleading, incomplete or deceptive n the denial of the claim, and are subject to ooperate fully with any prosecution and wi		
hone Number)		Social Security Numb	er/Tax ID Number	Email Address		
Employee Name (Please Print)		•	Employee Signature	Date		
			1			





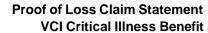
					VCI Critical Illness Benefit
	PART	C: HEALTH CA	RE PROVIDER STATEM	/ENT	
Please complete each applicable s the column below entitled Date of the completion of this Statement.	section of this form	n and provide all me	edical records in your possession	on for this Pati	ent from the earliest date you list in e for the expense associated with
Patient Name:			Patient Social Security Num	ber:	Patient Date of Birth (mm/dd/yyyy):
Patient Address					I
Please provide the requested infor	rmation for each co	ondition for which yo	ou are treating the above patien	t:	
Diagnosis	ICD-9 or IC	CD-10 Code	Date of First Diagnosis (m	m/dd/yyyy)	Date of First Treatment (mm/dd/yyyy)
			×		
Has the Patient ever had the same	e or similar conditi	on/s? (If yes, provid	de dates and details) o Yes	o No	
Has another Heath Care Provider Provider) o Yes o No	ever treated the P	atient for the same	or similar condition/s? (If yes,	provide name	& address of each Health Care
Has the Patient ever been hospital	lized for a condition	n listed above? (If y	es, provide each hospital name	e and dates of a	admission) o Yes o No
Was the Patient referred to you by	another Health C	are Provider? (If ye	s, provide name & address of t	he Health Car	e Provider) o Yes o No
Did the Patient have a cosmetic or dates and details) o Yes o N		a surgery not medi	cally necessary) that contribute	d to a conditio	n listed above? (If yes, provide
Did the Patient's use of alcohol or	drugs contribute to	a condition listed a	above? (If yes, please explain)	o Yes o	No
Current Patient medications (list al	ll)				
Any person who knowingly and information in conjunction with a insurance act, which is a crime.	a claim containing These actions wil	g fraudulent, false, Il result in the deni	misleading, incomplete or de al of the claim, and are subject	eceptive inforr ct to prosecut	nation commits a fraudulent ion under state and/or federal
Physician's Name, Address, ZIP (F			ali appropriate legal remedies	arising from	such traudulent insurance acts.
Telephone Number	le,	av Number		Specialty	
Telephone Number ()		Fax Number ()		Specialty	

Degree

Date

Physician's Tax ID No.

Physician's Signature





AUTHORIZATION FOR USE IN OBTAINING INFORMATION

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 Aut	NAME OF INSURED:	
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 Aut	INSURED'S DATE OF BIRTH:	
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	Date	Insured's Signature
(If the Insured is unable to sign, an authorized person may sign.)	(If the Insured is unable to sign, an author	orized person may sign.)
Date Authorized Person's Signature	Date	Authorized Person's Signature
Description of Authorized Person's authority to sign on behalf of Insured:	Description of Authorized Person's authorit	y to sign on behalf of Insured:



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.

DR-1323 (7/18) 5