Reset

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

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

Proof of Loss Claim Statement
VAI/VCI Wellness Benefit

CLAIM SUBMISSION INSTRUCTIONS

The **Employee** must complete BOTH PART A and PART B in their entirety.

Email the completed form to: VoluntaryClaims@RSLI.com

OR fax the completed form to: (267) 256-3518 or (267) 256-3537

OR mail the completed form to: Reliance Standard Life Insurance Company
Attn: Voluntary Wellness Claims
P.O. Box 7307
Philadelphia, PA 19101-7307
Phone 1-800-351-7500

Additional information may be required. Submission of this claim form does not waive our right to request additional information, or waive any of our rights or defenses, or admit liability.

PART A: EMPLOYEE INFORMATION

Employee Name	Employee Social Security Number	Employee Date of Birth
Employee Address	Employee Email Address	Employee Phone Number Day Night Cell
Employer/Policyholder Name and Address	Voluntary Accident (VAI) Policy Number	Voluntary Critical Illness (VCI) Policy Number

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

IF CLAIM IS FOR A DEPENDENT, PROVIDE THE FOLLOWING:

Dependent Name	Dependent Social Security Number	Dependent Date of Birth	Relationship to Insured

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

Dependent Address

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.

Employee Name (Please Print)	Employee Signature	Date

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PART B: HEALTH SCREENING TEST INFORMATION

Test Recipient Name	
Health Care Provider Name, Address, Zip Code (Please Print or Type)	Health Care Provider Phone Number

HEALTH SCREENING TEST(S) ADMINISTERED (CHECK ALL THAT APPLY)

Please Note: Not all benefits that are listed below are available under all policies. Consult the policy for additional information, including definitions.

☐ ALT/AST (liver function test) Date Administered: (mm/dd/yyyy) _____	☐ Flexible sigmoidoscopy Date Administered: (mm/dd/yyyy) _____
☐ Biopsy for cancer Date Administered: (mm/dd/yyyy) _____	☐ Genetic tests Date Administered: (mm/dd/yyyy) _____
☐ Blood test for triglycerides Date Administered: (mm/dd/yyyy) _____	☐ Hemoccult stool analysis Date Administered: (mm/dd/yyyy) _____
☐ Bone density testing (DEXA scan) Date Administered: (mm/dd/yyyy) _____	☐ Hepatitis screening Date Administered: (mm/dd/yyyy) _____
☐ Bone marrow testing Date Administered: (mm/dd/yyyy) _____	☐ Human Immunodeficiency Virus (HIV) screening Date Administered: (mm/dd/yyyy) _____
☐ CA 15-3 (blood test for breast cancer) Date Administered: (mm/dd/yyyy) _____	☐ Mammography Date Administered: (mm/dd/yyyy) _____
☐ CA 125 (blood test for ovarian cancer) Date Administered: (mm/dd/yyyy) _____	☐ Pap test Date Administered: (mm/dd/yyyy) _____
☐ CEA (blood test for colon cancer) Date Administered: (mm/dd/yyyy) _____	☐ PSA (blood test for prostate cancer) Date Administered: (mm/dd/yyyy) _____
☐ Chest X-ray Date Administered: (mm/dd/yyyy) _____	☐ Serum cholesterol test to determine level of HDL and LDL Date Administered: (mm/dd/yyyy) _____
☐ Colonoscopy Date Administered: (mm/dd/yyyy) _____	☐ Serum Protein Electrophoresis (blood test for myeloma) Date Administered: (mm/dd/yyyy) _____
☐ Echocardiogram Date Administered: (mm/dd/yyyy) _____	☐ Skin cancer screening Date Administered: (mm/dd/yyyy) _____
☐ Electrocardiogram Date Administered: (mm/dd/yyyy) _____	☐ Stress test Date Administered: (mm/dd/yyyy) _____
☐ Fasting blood glucose test Date Administered: (mm/dd/yyyy) _____	☐ Ultrasound screening (please see policy) Date Administered: (mm/dd/yyyy) _____

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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.

EF-1205