

Supplemental Health Wellness Claim Form

You may submit this claim using one of the following methods:

Email VoluntaryClaims@RSLI.com

Mail Attn: Voluntary Claims
 P.O. Box 7307
 Philadelphia, PA 19101-7307

Please Note: Please complete each field below. Your claim may be delayed if the information requested is not provided.

PART A: EMPLOYEE INFORMATION

Employee Name (<i>First & Last</i>): _____		Social Security Number: ____-____-____	Date of Birth: ___/___/____
Employee Address: Street _____		City _____	State _____ Zip Code _____
Employee Date of Hire: ___/___/____	Employee's Phone Number: ____-____-____	Employee's Email Address _____	

PART B: POLICYHOLDER INFORMATION

Policyholder Name: _____	Group Policy Number(s) (<i>if attainable</i>): _____
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PART C: DEPENDENT INFORMATION (*Complete if claim is for a Spouse or Child*)

Spouse or Child Name (<i>First & Last</i>): _____	Social Security Number: ____-____-____	Date of Birth: ___/___/____
Relationship to Employee: _____		

PART D: CHILD ADDITIONAL INFORMATION: (*Complete if claim is for a Child*)

Is the Child a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Child is not a full-time student and is over 25 years old, is the Child totally disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide a copy of their Social Security Disability Award Letter</i>
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PART E: CLAIM INFORMATION

Select which policies you are filing a wellness claim for (select up to 3):

Accident Critical Illness Hospital Indemnity

Did you or your Dependent listed above have a preventative health screening, vision test, diagnostic procedure, immunization, dental visit, or other routine examination? Yes No *If yes, date completed* ___/___/____

Provider's Name: _____ Provider's Phone Number: _____

Provider's Address: _____

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.

Claimant's Signature:

Date Signed:

__/__/____

PART F: DIRECT DEPOSIT

Would you like to receive your claim payment via direct deposit? Yes No *If Yes, please provide your bank information in the section below.*

Bank Name:

Bank Address:

Choose one type of account: Checking Savings

Routing Number:

Account Number:

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Signing the below authorizes Reliance Standard Life Insurance Company to send my payment(s) to the bank designated above for electronic deposit into my Account. I understand that I may terminate this arrangement at any time by writing to RSLC directly.

Claimant's Signature:

Date Signed:

__/__/____