RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

Proof of Loss Claim Statement
VAI/VCI Wellness Benefit

CLAIM SUBMISSION INSTRUCTIONS

The **Employee** must complete this form in its entirety and submit the completed form. The form will automatically be emailed to: VoluntaryClaims@RSLI.com. In order to submit an online application, your Policy Number(s) is required. Please contact your Employer if you do not know your Policy Number(s).

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.

This claim is for ⓧVoluntary Accident Wellness (VAI) ◯Voluntary Critical Illness Wellness (VCI) ◯VAI & VCI

Employer Name	Voluntary Accident (VAI) Policy Number VAI827985	Voluntary Critical Illness (VCI) Policy Number
	Employee Date of Hire	# of Hours Employee Works Weekly

Employee First Name	Employee Middle Name	Employee Last Name
Employee Social Security Number	Employee Date of Birth	Employee Phone Number

Employee Street Address

Employee City Employee State Employee Zip Code

Employee Gender Employee Email

IF CLAIM IS FOR A DEPENDENT, PROVIDE THE FOLLOWING:

Dependent's Name	Dependent Social Security Number	Dependent Date of Birth	Relationship

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

Employee Signature: Date:

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.

Test Recipient Name	Test Recipient Date of Birth (mm/dd/yyyy)

HEALTH SCREENING TEST ADMINISTERED

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

Health Screen Test
Date Test Administered

Health Care Provider Name, Address, Zip Code
Phone Number
Submitter's Email Address

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

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If you would like to receive your payments via Direct Deposit, please complete the following. Otherwise, you will receive your reimbursements in the form of a check

Would you like apply for direct deposit? **Yes** **No**

I authorize RSL to send my payment(s) to the Bank designated below for electronic deposit in my Account. I understand that I may terminate this arrangement at any time by writing to the RSL.

Bank/Financial Institution Information

Name of Bank (Print)
Address of Bank
City, State Zip

Choose Type of Account

Checking Savings

Bank Transit/Routing Number (9 Digits)
Personal Account Number

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