reliancematrix
A MEMBER OF THE TOKIO MARINE GROUP

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 *(First & Last)*: _____

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: _Neenah Joint School District_____

Group Policy Number(s) *(if attainable)*: _VAI451808, VCI451814, VHI451818_____

PART C: DEPENDENT INFORMATION *(Complete if claim is for a Spouse or Child)*

Spouse or Child Name *(First & Last)*: _____

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? ☐ Yes ☐ No

If Child is not a full-time student and is over 25 years old, is the Child totally disabled? ☐ Yes ☐ No
If yes, please provide a copy of their Social Security Disability Award Letter

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 d/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:**

_____ _____

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.

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:**

_____ ___/___/_____