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)*: _____

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:**

_____ _____

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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:**

_____ ___/___/_____