## 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.

Reset

**RELIANCE STANDARD**
Life Insurance Company

# Proof of Loss Claim Statement
# VCI Wellness Benefit

## CLAIM SUBMISSION INSTRUCTIONS

**Employer/Administrator:** Please complete **PART A** in its entirety.

**Employee:** Please complete **PART B** in its entirety and submit the completed form along with **ONE OF THE FOLLOWING:**

a) A receipt or explanation of benefits showing the name of the test recipient, the screening test administered and the date of that test; **OR**
b) **PART C** must be completed by the health care service provider who performed the covered screening test.

**Fax the completed form to: (267) 256-3518 or (267) 256-3537**

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

To make the claim process as convenient as possible, we have requested only the information typically needed to make a claim determination. In a small number of cases, additional information may be required. Submission of the requested information does not waive our right to request additional information, or waive any of our rights or defenses, or admit liability.

## PART A: EMPLOYER/ADMINISTRATOR INFORMATION

| | | |
|---|---|---|
| Employer Name | Voluntary Critical Illness Policy Number | Employee Name |
| Date of Hire | Employee Occupation/Title/Position | Insurance Class (Refer to Policy Schedule of Benefits) |
| Date Critical Illness Coverage First Elected | Critical Illness Benefit Amount Elected | Date of Last Benefit Increase |
| Usual Number of Hours Employee Works(ed) Per Week | Date Employee Last Worked Usual Number of Hours | Reason Employee Did Not Return to Work (if applicable) |

Percentage of premium paid by employer:_____% Was Employee taxed on this amount? ☐ Yes ☐ No
Percentage of premium paid by employee:_____% ☐ Pre-tax dollars ☐ Post tax dollars
Percentages must total 100%. **If left blank, we will assume that 100% of premium is paid by employer and that employee was not taxed.**

## EMPLOYER/ADMINISTRATOR 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 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.**

| | | |
|---|---|---|
| Phone Number ( ) | Fax Number ( ) | Email Address |

| | | |
|---|---|---|
| Employer/Administrator Name (Please Print) | Employer/Administrator Signature | Date |

## PART B: EMPLOYEE/CLAIMANT INFORMATION

| | | |
|---|---|---|
| Employee Name and Address | Social Security Number | Date of Birth |

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's Name and Address | Social Security Number | Date of Birth | Relationship |

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

## 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 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.**

| | | |
|---|---|---|
| Phone Number ( ) | Social Security Number/Tax ID Number | Email Address |

| | | |
|---|---|---|
| Employee Name (Please Print) | Employee Signature | Date |

**IMPORTANT NOTE: This part (PART C) should be competed by the health care service provider who performed the covered screening test <u>ONLY IF YOU ARE NOT</u> submitting a receipt or explanation of benefits showing the name of the test recipient, the screening test administered and the date of that test.**

## PART C: HEALTH CARE SERVICE PROVIDER INFORMATION

| Test Recipient Name | Test Recipient Date of Birth (mm/dd/yyyy) |
|---|---|
| Test Recipient Address | Test Recipient Social Security Number |

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

**(Note: Attach test results, receipt, or other proof that test was performed as indicated)**

| | |
|---|---|
| ☐ Stress test on a bicycle or treadmill<br>Date Administered: (mm/dd/yyyy)_____ | ☐ Chest X-ray<br>Date Administered: (mm/dd/yyyy)_____ |
| ☐ Fasting blood glucose test<br>Date Administered: (mm/dd/yyyy)_____ | ☐ Colonoscopy<br>Date Administered: (mm/dd/yyyy)_____ |
| ☐ Blood test for triglycerides<br>Date Administered: (mm/dd/yyyy)_____ | ☐ Flexible sigmoidoscopy<br>Date Administered: (mm/dd/yyyy)_____ |
| ☐ Serum cholesterol test to determine level of HDL and LDL<br>Date Administered: (mm/dd/yyyy)_____ | ☐ Hemoccult stool analysis<br>Date Administered: (mm/dd/yyyy)_____ |
| ☐ Bone marrow testing<br>Date Administered: (mm/dd/yyyy)_____ | ☐ Mammography<br>Date Administered: (mm/dd/yyyy)_____ |
| ☐ Breast ultrasound<br>Date Administered: (mm/dd/yyyy)_____ | ☐ Pap smear<br>Date Administered: (mm/dd/yyyy)_____ |
| ☐ CA 15-3 (blood test for breast cancer)<br>Date Administered: (mm/dd/yyyy)_____ | ☐ PSA (blood test for prostate cancer)<br>Date Administered: (mm/dd/yyyy)_____ |
| ☐ CA 125 (blood test for ovarian cancer)<br>Date Administered: (mm/dd/yyyy)_____ | ☐ Serum Protein Electrophoresis (blood test for myeloma)<br>Date Administered: (mm/dd/yyyy)_____ |
| ☐ CEA<br>Date Administered: (mm/dd/yyyy)_____ | |

**Any person who knowingly and with intent to injure 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 pursue any and all appropriate legal remedies arising from such fraudulent insurance acts.**

Health Care Service Provider Name, Address, Zip Code (Please Print or Type)

| Phone Number<br>( ) | Fax Number<br>( ) | Email Address |
|---|---|---|

| Name of Authorized Representative (Please Print) | Signature of Authorized Representative Date |
|---|---|