Reset

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LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Proof of Loss Claim Statement
VAI Accident Benefit

CLAIM SUBMISSION INSTRUCTIONS

Employee: Please complete the Authorization for Use in Obtaining Information and **PARTS B and C** in their entirety. **Be sure to include attach receipts, reports or other proof to support the benefit(s) claimed.**

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

Email the completed form to: LifeClaimsScan@RSLI.com

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

Please forward the completed claim to Reliance Standard Life Only.

All sections of the form should be completed. If you have any questions or concerns in regards to completion of the form, please contact Customer Care at 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 Accident Policy Number	

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)

INFORMATION ABOUT THE ACCIDENT

When did accident happen ? (month, day, year) Time ☐ am ☐ pm

Where did accident happen ? ☐ home ☐ work ☐ elsewhere (specify):

What was Insured doing at the time of accident?

How did accident happen (describe fully)?

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PO Box 8330
Philadelphia, PA 19101-8330
Phone (800) 351-7500
Fax (267) 256-3519

AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF INSURED: _____
INSURED'S DATE OF BIRTH: _____
POLICYHOLDER: _____

To all physicians and other health care professionals, hospitals, other health care institutions, insurers, medical, hospital and prepaid health plans, pharmacies, pharmacy benefit managers, employers, group policyholders, contract holders, governmental agencies (including but not limited to the Internal Revenue Service and the Social Security Administration), private and/or public benefit plan administrators, and/or attorney representatives, including but not limited to covered entities and business associates under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the accompanying regulations:

You are authorized to provide Reliance Standard Life Insurance Company and/or its authorized administrators, including but not limited to Matrix Absence Management, with my complete medical records including, including but not limited to all information concerning medical care, advice, and/or treatment provided to me, the above named Insured, and/or any employment, salary, tax and/or benefit-related information concerning me, the above named Insured. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. I also understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be subject to protection under HIPAA and the accompanying regulations. A statement of Reliance Standard Life Insurance Company's privacy policy is available at www.rsli.com or upon request.

Reliance Standard Life Insurance Company will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on the provision of this Authorization, except that this Authorization may be required to allow a covered entity to disclose protected health information where such disclosure is necessary to evaluate my claim for benefits.

I understand that any such information will be used for the purpose of evaluating my claim for benefits. Upon request, I understand that I am entitled to receive a copy of this Authorization. This Authorization is valid from the date signed for the duration of the claim, and may be revoked by me at any time upon written request to the address above. A reproduction of this Authorization shall be considered as valid as the original.

Date: _____ Insured's Signature: _____
(If the Insured is unable to sign, an authorized person may sign.)

Date: _____ Authorized Person's Signature: _____
Description of Authorized Person's authority to sign on behalf of Insured: _____

PART C: VOLUNTARY ACCIDENT BENEFITS CLAIMED

Check all that apply. Note: Not all benefits are available under all policies. Consult your policy for additional information, including definitions.

EMERGENCY CARE BENEFITS

- ☐ Air Ambulance Transportation
- ☐ Ambulance Transportation
- ☐ Emergency Treatment
- ☐ Diagnostic Examination
- ☐ Initial Physician Office Visit

GENERAL TREATMENT BENEFITS

- ☐ Initial Hospital Admission
- ☐ Intensive Care Unit Hospital Admission
- ☐ Hospital Confinement _____ days
- ☐ Intensive Care Unit Confinement _____ days
- ☐ Rehabilitation Facility Confinement _____ days
- ☐ Follow-up Physician Office Visit
- ☐ Transportation
- ☐ Lodging _____ days

SPECIFIED COVERED INJURY AND TREATMENT BENEFITS

- ☐ Fracture, Surgical (specify) _____
- ☐ Fracture, non-Surgical (specify) _____
- ☐ Dislocation, Surgical (specify) _____
- ☐ Dislocation, non-Surgical (specify) _____
- ☐ Blood, Plasma and Platelets
- ☐ Burns: 2nd Degree _____ % of body
- ☐ Burns: 3rd Degree _____ % of body
- ☐ Burns: Skin Graft due to burns
- ☐ Coma
- ☐ Concussion
- ☐ Dental Injury (extraction)
- ☐ Dental Injury (crown)
- ☐ Eye Injury (removal of foreign object)
- ☐ Eye Injury (surgical repair)
- ☐ Laceration/no sutures
- ☐ Laceration/sutures (specify length in inches) _____

PARALYSIS BENEFITS

- ☐ Paraplegia or Hemiplegia
- ☐ Quadriplegia

SURGERY BENEFITS

- ☐ Exploratory Surgery (no repair)
- ☐ Knee Cartliage
- ☐ Abdominal or Thoracic Surgery
- ☐ Ruptured Disc
- ☐ Tendon, Ligament or Rotator Cuff (one)
- ☐ Tendon, Ligament or Rotator Cuff (two or more)

TRANSITIONAL BENEFITS

- ☐ Medical Appliance
- ☐ Prosthesis (one)
- ☐ Prosthesis (two or more)
- ☐ Physical Therapy _____ sessions

MEDICAL SERVICE PROVIDER INFORMATION

Please list all doctors, hospitals, or other medical service providers who provided services for injuries received from this accident. Use additional paper as necessary.

1. Name of doctor, hospital, pharmacy or other medical service provider	Phone Number ( )	Fax Number ( )
City, State, Zip Code		
2. Name of doctor, hospital, pharmacy or other medical service provider	Phone Number ( )	Fax Number ( )
City, State, Zip Code		
3. Name of doctor, hospital, pharmacy or other medical service provider	Phone Number ( )	Fax Number ( )
City, State, Zip Code		

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: ATTACH RECEIPTS, REPORTS OR OTHER PROOF TO SUPPORT BENFITS CLAIMED.

IMPORTANT INFORMATION REGARDING APPLICATION FOR BENEFITS

ALABAMA, ARKANSAS and LOUISIANA — 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.

CALIFORNIA – For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO — It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA — Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY — Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

MAINE — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND — Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY — Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO — 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 civil fines and criminal penalties.

NEW YORK (health insurance only) — 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.

OHIO — Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA – WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

PUERTO RICO – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

RHODE ISLAND — 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.

TENNESSEE, **WASHINGTON** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

VIRGINIA — Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

WASHINGTON, DC — WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.