RESET FORM

CRITICAL ILLNESS / SPECIFIED DISEASE CLAIM - EMPLOYEE / MEMBER

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya® family of companies
(the "Company")
Submit at voya.com/claims *(select Upload Documents)*
Phone: 877-236-7564
Voya Claims: PO Box 320, Minneapolis, MN 55440; **Overnight Address:** 20 Washington Ave. South, Minneapolis, MN 55401

CLAIM CHECKLIST

- ☐ SIGN and DATE this completed form, then submit using one of the above methods.
- ☐ Attach copies of all test results or operative reports.
- ☐ The **Attending Physician's Statement of Critical Illness / Specified Disease** form must be completed and signed by the Attending Physician and submitted with this form.
- ☐ Provide a written, signed, and dated authorization form in order for us to discuss this claim with anyone other than the coverage owner.

SECTION 1. GROUP INFORMATION *(This information can be obtained from the Employer / Administrator.)*

Group / Association Name _____

Group / Association Policy Number _____

Claim Number *(if available)* _____ Member ID Number *(for Association only)* _____

SECTION 2. EMPLOYEE / INSURED / MEMBER INFORMATION

Select, if applicable.: ☐ International / Foreign Address

Employee / Member Name *(First)* _____ *(Middle Initial)* ____ *(Last)* _____

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Address _____

Address _____

City _____ Province / State _____ ZIP _____

Country _____ Email _____

Phone (_____)_____ International Phone _____

If claim is NOT for the Employee / Member, complete the following information:

Relationship to the Employee / Member: ☐ Spouse ☐ Domestic Partner / Civil Union ☐ Child / Stepchild

Insured Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

SECTION 3. CRITICAL ILLNESS / SPECIFIED DISEASE INFORMATION

Which Critical Illness / Specified Disease are you claiming for? Select from the list below. **The conditions listed below may not be covered in your certificate.** *(See Certificate of Insurance and riders for eligible conditions and definitions. Certificate provided by your Employer / Administrator.)*:

- ☐ Abdominal Aortic Aneurysm
- ☐ Addison's Disease
- ☐ Advanced Dementia including Alzheimer's Disease
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Benign Brain Tumor
- ☐ Bone Marrow Transplant
- ☐ Cancer
  - ☐ Carcinoma in Situ
  - ☐ Invasive Cancer
  - ☐ Skin Cancer
- ☐ Coma
- ☐ Coronary Angioplasty
- ☐ Coronary Artery Bypass
- ☐ End Stage Renal (Kidney) Failure
- ☐ Heart Attack (Myocardial Infarction this does not include cardiac arrest)
- ☐ Huntington's Disease (Huntington's Chorea)
- ☐ Implantable Cardioverter Defibrillator (ICD) Placement
- ☐ Infectious Disease
- ☐ Loss of Hearing/Deafness
- ☐ Loss of Sight/Blindness
- ☐ Loss of Speech
- ☐ Major Organ Transplant/Failure
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Occupational Hepatitis B or C
- ☐ Occupational HIV
- ☐ Open Heart Surgery for Valve Replacement or Repair
- ☐ Pacemaker Placement
- ☐ Parkinson's Disease
- ☐ Permanent Paralysis
- ☐ Ruptured or Dissecting Aneurysm
- ☐ Severe Burns
- ☐ Stem Cell Transplant
- ☐ Stroke
- ☐ Systemic Lupus Erythematosus (SLE)
- ☐ Systemic Sclerosis (Scleroderma)
- ☐ Thoracic Aortic Aneurysm
- ☐ Transcatheter Heart Valve Replacement or Repair
- ☐ Transient Ischemic Attacks (TIA)
- ☐ Type 1 Diabetes [1]

[1] *It is not necessary to select Type 1 Diabetes in both sections.*

Group / Association Policy Number _____

Employee / Member Name *(First)* _____ *(Middle Initial)* ____ *(Last)* _____

SECTION 3. CRITICAL ILLNESS / SPECIFIED DISEASE INFORMATION *(Continued)*

Additional Child Diseases:

- ☐ Cerebral Palsy
- ☐ Congenital Birth Defects
- ☐ Cystic Fibrosis
- ☐ Down Syndrome
- ☐ Gaucher Disease, Type II or III
- ☐ Infantile Tay Sachs
- ☐ Niemann-Pick Disease
- ☐ Pompe Disease (Type II Glycogen Storage Disease)
- ☐ Sickle Cell Anemia
- ☐ Type 1 Diabetes [1]
- ☐ Type IV Glycogen Storage Disease
- ☐ Zellweger Syndrome

[1] *It is not necessary to select Type 1 Diabetes in both sections.*

Describe Condition:

On what date were you first seen for this condition? _____ Confirmed Diagnosis Date _____

Have you ever been treated for a same or similar condition in the past? ☐ Yes ☐ No *If "yes," when?* _____

Were you hospitalized for this condition? ☐ Yes ☐ No *(If "yes," provide names and addresses of hospitals below. [2])*

[2] *Use separate document to provide additional information if needed.*

Select, if applicable.: ☐ International / Foreign Address

Hospital / Physician Name _____

Hospital Admission Date _____ Hospital Discharge Date _____

Hospital / Physician Address _____

Hospital / Physician Address _____

City _____ Province / State _____ ZIP _____

Country _____ International Phone _____

Hospital / Physician Phone (_____) _____ Hospital / Physician Fax (_____) _____

Reason for Hospitalization _____

Did the condition result in Death? ☐ Yes [3] ☐ No If "yes," what was the date of death? _____

[3] *Attach a death certificate indicating manner and cause of death. Additional documentation may be required.*

Select, if applicable.: ☐ International / Foreign Address

Hospital / Physician Name _____

Hospital Admission Date _____ Hospital Discharge Date _____

Hospital / Physician Address _____

City _____ Province / State _____ ZIP _____

Country _____ International Phone _____

Hospital / Physician Phone (_____) _____ Hospital / Physician Fax (_____) _____

Reason for Hospitalization _____

Group / Association Policy Number _____

Employee / Member Name *(First)* _____ *(Middle Initial)* ____ *(Last)* _____

SECTION 4. PAYMENT METHOD SELECTION

Payment Method: ☐ Check ☐ Electronic Funds Transfer / EFT *(U.S. bank only)* ☐ ACH *(Foreign bank only)*
(For EFT or ACH, complete the following Bank Information. [4])

Bank Name _____ Bank Account Type: ☐ Checking ☐ Savings

Bank Routing Number *(9 digits)* _____ Bank Account Number _____

Bank Swift BIC code (*Foreign bank only)* _____

Notice regarding Electronic Funds Transfer: When you select electronic funds transfer as your payment method, we may receive and contribute customer account and payment account data to a third party consumer reporting agency to confirm the feasibility of a transaction to your account.

[4] For your protection, if your claim is approved and we are unable to validate your banking information, we will issue you a check to avoid any delay in payment.

SECTION 5. AUTHORIZATION AND ACKNOWLEDGMENT

For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, MIB, Inc. (MIB), Social Security Administration or employer to give the Company or its agents, employees and authorized representatives acting on its behalf (including ChoicePoint or any consumer reporting agency), ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or non-medical information regarding Social Security benefits or earnings information and other employment-related information, as they apply to me. I give my permission to the Company to get consumer or investigative consumer reports about me. I give my permission to the Company, or its reinsurers, to make a brief report of personal health information to MIB about me.

I give my permission to the Company to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between the Company and its affiliates and may be sent to MIB. This information may be made available to any Company affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I or my authorized representative have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This authorization will be valid for the duration of my claim for benefits. I acknowledge that I have been given the Company's Consumer Privacy Notice and Insurance Information Practices Notice.

I hereby certify that the statements on this form are complete and accurate to the best of my knowledge.

By typing your name in the box below, you are electronically signing this document. Your electronic signature will be legally binding and enforceable and the legal equivalent of your handwritten signature.

➥ Employee / Insured / Member Signature _____ Date _____

FRAUD WARNINGS

Alabama, Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, Maine, Minnesota, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files a 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 may subject such person to criminal and civil penalties, and denial of insurance benefits.

Arizona: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form. Any person who knowingly presents 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.

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.

District of Columbia: 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.

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 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.

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 Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information 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.

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 intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures
For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices
Collecting Information
Your application or claim form is our main source of information. But we may:
- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, Inc., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports
Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use
We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure
We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information
If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc.
We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901 (TTY 866 346-3642). We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.