RESET FORM

ACCELERATED BENEFIT CLAIM

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY (outside NY)
Members of the Voya® family of companies
(the "Company")
Voya Life Claims: PO Box 1548, Minneapolis, MN 55440; Phone: 888-238-4840
Voya Life Claims Overnight Mailing Address: 20 Washington Avenue South, Minneapolis, MN 55401

Sections 1-4 must be completed and **signed** by the employer. Sections 5-8 must be completed and **signed** by the insured. Sections 9 and 10 must be completed and **signed** if there is an irrevocable beneficiary, assignee, or spouse in a community property state. The separate Attending Physician's Statement of Terminal Condition or Continuous Confinement must be completed by the Insured's attending physician. Return the completed forms and a copy of the Insured's enrollment documentation, to one of the above addresses. Missing or incomplete information may delay claim processing.

SECTION 1. GROUP INFORMATION

Group Name _____

Group Policy Number _____ Account Number _____

SECTION 2. EMPLOYEE / INSURED INFORMATION

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

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Other Names the Insured May Have Been Known By _____

Address _____ City _____ State _____ ZIP _____

Marital Status: ☐ Married ☐ Domestic Partner/Civil Union ☐ Never Married ☐ Divorced ☐ Widowed

Date Last Actively at Work _____ **Employment Start Date** _____

Job Title _____

Salary $ _____ per: ☐ hour ☐ week ☐ month ☐ year Last Salary Change Date _____

Employment Status: ☐ Full Time ☐ Part Time Average Hours Per Week _____ Labor Status: ☐ Union ☐ Non Union

Employee Status: ☐ Active ☐ Retired ☐ Disability Waiver of Premium ☐ FMLA *(include FMLA documentation)*

Reason for Stopping Work _____

Have premiums been paid to the current date? ☐ Yes ☐ No If "No," to what date have premiums been paid? _____

SECTION 3. COVERAGE INFORMATION

Basic Life $_____ Effective Date _____

Supplemental Life $_____ Effective Date _____

Optional Life $_____ Effective Date _____

Other $_____ Effective Date _____

If claim is for accelerated benefits on a dependent, complete the following information concerning dependent *(list amount above.)*

Relationship to the Insured: ☐ Spouse ☐ Domestic Partner/Civil Union ☐ Child Date This Dependent Insured _____

Dependent Full Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Address _____ City _____ State _____ ZIP _____

Marital Status: ☐ Married ☐ Domestic Partner/Civil Union ☐ Never Married ☐ Divorced ☐ Widowed

Insured Name _____ Group Policy Number _____

SECTION 4. EMPLOYER CERTIFICATION *(The undersigned certifies that the above statements as to the insured are correct as reported on its records. See page 4 for Fraud Warnings.)*

Employer Name _____ Title _____

Employer Address _____ City _____ State _____ ZIP _____

Authorized Signature _____ Date _____

Email _____ Phone (_____)_____

SECTION 5. INSURED STATEMENT *(Please read and sign below. Please review the policy, certificate or rider to verify if continuous confinement is a qualifying event for receipt of a benefit, or if monthly payments are available to you. For group coverage, a copy of the certificate and any riders can be obtained from the Employer/Plan Sponsor. See page 4 for Fraud Warnings.)*

Date Employee Last Worked Preceding Claim *(month, day, year)* _____

Describe Condition or Illness _____

What is the qualifying event for this claim? ☐ Terminal Illness ☐ Continuous Confinement in an Institution

If qualifying event is continuous confinement in an institution, how would you like to receive your benefit? ☐ Lump Sum ☐ Monthly Payments

Requested whole percentage for monthly accelerated benefit *(See rider for percentages available. The percentage chosen must be a minimum of $500 monthly.)* _____

For Connecticut Policies *(Select one.)*: ☐ 25% or ☐ Other Percentage indicated in policy

SECTION 6. ATTENDING PHYSICIAN(S) *(List your primary care physicians.)*

Physician Name _____ Date _____

Physician Address _____ City _____ State _____ ZIP _____

Phone (_____)_____ Fax (_____)_____

Cause _____

Physician Name _____ Date _____

Physician Address _____ City _____ State _____ ZIP _____

Phone (_____)_____ Fax (_____)_____

Cause _____

Physician Name _____ Date _____

Physician Address _____ City _____ State _____ ZIP _____

Phone (_____)_____ Fax (_____)_____

Cause _____

SECTION 7. US TAXPAYER CERTIFICATIONS

Under penalties of perjury, I certify that:
1. The Taxpayer Identification Number that appears on this form is correct,
2. I am not subject to backup withholding due to failure to report interest and dividend income [1], and
3. I am a U.S. person

[1] *If you are subject to back-up withholding, you must strike through statement number 2.*

NON-RESIDENT ALIEN STATUS

If you are a Non-Resident Alien, please check the box and provide your country of residence below.

☐ Under penalties of perjury, I certify that I am a Non-Resident Alien and my country of residence is: _____.

The amount paid to you will be subject to 30% withholding, unless you submit an IRS Form W-8, and are entitled to claim a reduced rate of withholding under the applicable US tax treaty.

Insured Name _____ Group Policy Number _____

SECTION 8. ACKNOWLEDGEMENT AND AUTHORIZATION

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) or employer to give ReliaStar Life Insurance Company or ReliaStar Life Insurance Company of New York ("the Company") or its agents, employees and authorized representatives acting on its behalf, 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, my spouse, or any of my children who are insured. I give my permission to the Company, and its reinsurers, to make a brief report of personal health information to MIB about these same persons.

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 the Company 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.

NOTE: Receipt of accelerated benefits may be taxable. Assistance should be sought from a personal tax advisor. Receipt of these accelerated benefits may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

Receipt of these accelerated benefits may adversely affect the recipient's eligibility for future increases in life insurance coverage. Please refer to your certificate booklet for more information.

If accelerated benefits are paid, continued premium payments must be made, unless waived under the provisions of the policy, to keep life insurance coverage in force.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Insured Signature _____ Date _____

Phone (_____)_____ Email _____

SECTION 9. RELEASE

Release By Irrevocable Beneficiary or Assignee, or By Spouse in a Community Property State

If there is an irrevocable beneficiary or assignee, that person must sign this section and have it notarized. If you are married and live in a community property state, your spouse must sign this section and have it notarized.

The undersigned acknowledges and consents to this accelerated benefit claim; that if approved, payment of the accelerated benefit shall be made to the insured or his/her legal representative; and in consideration of such payment the undersigned agrees that the liability of the Company under the policy shall be discharged by the amount of the accelerated benefit paid.

Irrevocable Beneficiary or Assignee Signature _____ Date _____

Spouse Signature *(in Community Property State)* _____ Date _____

SECTION 10. NOTARY SECTION *(required with the above release by irrevocable beneficiary or assignee or spouse)*

State of _____

County of _____ ss.

On this _____ day of _____, 20 _____ before me personally appeared _____ to me known to be the same person who executed the above instrument and acknowledged that he/she executed the same as his/her free act and deed.

My commission expires _____ Notary Public _____

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 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.