RESET FORM

AUTHORIZATION TO RELEASE INFORMATION

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Security Life of Denver Insurance Company, Denver, CO
Midwestern United Life Insurance Company, Fishers, IN
Voya Insurance and Annuity Company, Des Moines, IA
Members of the Voya® family of companies
(the "Company")
Voya Life Claims: PO Box 1548, Minneapolis, MN 55440
Voya Life Claims Overnight Mailing Address: 20 Washington Ave. South, Minneapolis, MN 55401
Phone: 888-238-4840; Fax: 855-653-5339; Submit at voya.com *(select Contact & Services > Claims > Upload a Claim)*

Insured / Patient Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____
Insured / Patient Birth Date _____ Group or Association Name [1] *(if applicable)* North American Division of Seventh-day Adventists
Group or Association Policy Number [1] 678074 **OR** Insurance Policy Number _____

[1] ***Group or Association Name*** *and* ***Group or Association Policy Number*** *apply ONLY if coverage was obtained through an Employer or Association.*

☐ This is an employer-sponsored plan. Please provide employment information as of the date of application.

Employee Name _____

Employer Name _____ Employer Phone (_____)_____

Employer Address _____ City _____ State _____ ZIP _____

Use the table below to list:

- the Insured's primary care physician, from _____ to _____
- all hospitals, clinics or institutions where the Insured was treated, from _____ to _____
- all pharmacies where the insured received prescriptions, from _____ to _____

Name	Complete Mailing Address	Phone Number	Fax Number

ATTACH ADDITIONAL DOCUMENTS IF MORE SPACE IS NEEDED.
IMPORTANT! SIGNATURE REQUIREMENT ON PAGE 2.

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

Group or Association Name [1] *(if applicable)* North American Division of Seventh-day Adventists

Group or Association Policy Number [1] 678074 **OR** Insurance Policy Number _____

[1] ***Group or Association Name*** *and* ***Group or Association Policy Number*** *apply ONLY if coverage was obtained through an Employer or Association.*

I authorize release of the following information:

☐ Abstract (The Abstract includes: History & Physical Exams, Operative Reports, Discharge Summaries, EKG/Cardiovascular, Substance Abuse, Mental Health, Emergency Medicine Reports, Office Notes, Consultations/Evaluations, Diagnostic Reports

☐ HIV/AIDS Testing & Treatment ☐ Laboratory Reports ☐ Employment Records ☐ Police and Accident Reports ☐ Medical Examiner/Coroner Reports

☐ Other _____

Collection of Information: In order to evaluate or administer claims for benefits, we must collect information about the insured. The type of information that we may collect includes, but is not limited to, the following examples: any medical information regarding the diagnosis, treatment and prognosis of any physical or mental condition; prescription drug records and related information; any non-medical information, including earnings and other employment-related information; accident, incident, or police reports; medical examiner and coroner reports. The sources that we may contact for information include, but are not limited to, the following: physicians, medical practitioners, hospitals, clinics, medically-related facilities, insurance or reinsuring companies, MIB, Inc., employer or group policy owners, contract holders, benefit plan administrators, and any other organizations.

Acknowledgement: I acknowledge these statements:

- I understand that I may revoke this Authorization at any time by sending a written request to Voya. Such revocation will not have any effect on any action taken by Voya and its' affiliates prior to the revocation.
- This authorization will expire one (1) year from the date of signature or when revoked or on the following date _____.
- I understand that this information may include information relating to: (a) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection, (b) Mental or behavioral health or psychiatric care, (c) Treatment of drug or alcohol abuse.
- I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.
- This information will be used/disclosed for insurance claim determination.
- I understand that a photocopy of this Authorization will be as valid as the original.

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.

Signature _____ Date _____

If signed by someone other than the insured, indicate relationship:

☐ Legal Guardian [2] ☐ Estate Representative [2] ☐ Health Care Power of Attorney [2] ☐ Self ☐ Parent ☐ Spouse ☐ Next of Kin ☐ Beneficiary

☐ Other _____

[2] *If signed by a Legal Representative attach appropriate documentation to verify authority.*