ACCIDENTAL DISMEMBERMENT 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, Toll-Free: 888-238-4840
Voya Life Claims Overnight mailing address: 20 Washington Ave. So, Minneapolis, MN 55401

The Group, Employee, Claim Information and Certification sections must be completed by the employer. The Insured Statement must be completed by the Insured. The separate Attending Physician's Statement of Dismemberment must be completed by the Insured's attending physician. The completed forms, along with a copy of the Insured's enrollment form and copies of any accident reports must be sent to the above address.

CHECKLIST

☐ Is the Employer certification complete and signed?
☐ Is the Insured Statement complete and signed?
☐ Is the enrollment documentation attached?

GROUP INFORMATION

Group Name ______________________________

Group Number ______________________ Account Number ______________________

EMPLOYEE INFORMATION

Insured Name ______________________________

Birth Date ______________________ SSN ______________________

Other names the Insured may have been known by *(maiden name, hyphenated, nickname, derivative of first or middle name, or alias):*

____

Address ______________________________

City ______________________ State ________ ZIP ________

Marital Status: ☐ Married ☐ Domestic Partner/Civil Union ☐ Never Married ☐ Divorced ☐ Widow(er) Gender: ☐ Male ☐ Female

Job Title ________________ Employment Start Date ________________ Date Last Worked ________________

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

Employment Status: ☐ Full Time ☐ Part Time If part-time, average hours per week ________________ ☐ Union ☐ Non Union

CLAIM INFORMATION

Basic Dismemberment $ ________________ Dependent Dismemberment $ ________________

Optional Dismemberment $ ________________ Other ________________ $ ________________

Supplemental Dismemberment $ ________________

If claim is for insurance on a dependent, give the following information concerning dependent *(list claim amount above)*

Name *(Please print.)* ______________________ Date This Dependent Insured ________________

Birth Date ______________________ SSN ______________________

Address ______________________________

City ______________________ State ________ ZIP ________

Relationship to Insured: ☐ Spouse ☐ Domestic Partner/Civil Union ☐ Child

Marital Status: ☐ Married ☐ Domestic Partner/Civil Union ☐ Never Married ☐ Divorced Gender: ☐ Male ☐ Female

Insured Name ______________________ SSN ________________ Group Number ____________________

EMPLOYER CERTIFICATION

The undersigned certifies that the above statements as to the insured are correct as reported on its records.

Employer Name ____

Employer Address ____

City ______________________________ State ________ ZIP ____________

Authorized Signature ______________________________________ Date ____________

Title ____________________ Phone (______)____________ E-mail ____________________

INSURED STATEMENT *(Use separate sheet to provide additional information if needed.)*

Accident Date ____________ Describe accident ____

____

____

Attending Physician Name *(Please print.)* ______________________________ Date ____________

Address ____

City ______________________________ State ________ ZIP ____________

Cause ____

Attending Physician Name *(Please print.)* ______________________________ Date ____________

Address ____

City ______________________________ State ________ ZIP ____________

Cause ____

Attending Physician Name *(Please print.)* ______________________________ Date ____________

Address ____

City ______________________________ State ________ ZIP ____________

Cause ____

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., 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.

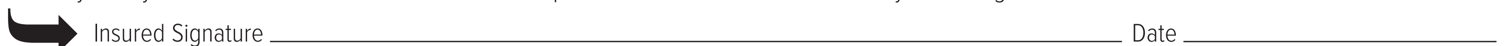
I give my permission to the Company to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected 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.

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



Insured Signature ______________________________________ Date ____________

Home Phone (______)______________________ E-mail ____________________

Insured Name ____________ SSN ____________ Group Number ____________

FRAUD WARNINGS

Alaska, Alabama, 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.