RESET FORM

HOSPITAL CONFINEMENT INDEMNITY CLAIM - EMPLOYER

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
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: 250 Marquette Ave., Suite 900, Minneapolis, MN 55401

NOTE: If the Employer has submitted enrollment data electronically, this form does not need to be completed.

CLAIM CHECKLIST

☐ SIGN and DATE this completed form, then submit using one of the above methods.

☐ Provide a **Hospital Confinement Indemnity Claim - Employee** form to the Employee / Insured. The Employee / Insured is responsible for completion and submission of the **Hospital Confinement Indemnity Claim - Employee** form. We may reach out to the Employee / Insured for additional proof of loss documentation.

☐ Attach the enrollment documentation.

SECTION 1. GROUP INFORMATION *(All sections completed by Employer.)*

Group Name _____

Group Policy Number _____ Account Number _____

Claim Number *(if available)* _____

SECTION 2. EMPLOYEE / INSURED INFORMATION

Select, if applicable.: ☐ International / Foreign Address

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

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Other names the Employee may have been known by _____

Address _____

Address _____

City _____ Province / State _____ ZIP _____

Country _____

Phone (_____)_____ International Phone _____

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

Date Last Actively at Work *(also include for dependent claims)* _____ **Employment Start Date** _____

Job Title _____

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

If this claim is for hospital confinement indemnity benefits on a dependent, complete the following information concerning dependent *(list amount below)*.:

Relationship to Employee / Insured: ☐ Spouse ☐ Domestic Partner / Civil Union ☐ Child / Stepchild Effective Date This Dependent Was Insured _____

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

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Is the address the same as Employee? ☐ Yes ☐ No *(If "no," provide address below.)*

Address _____ City _____ State _____ ZIP _____

SECTION 3. COVERAGE INFORMATION

Hospital Confinement Indemnity Coverage: Effective Date _____ **Premium Paid to:** Date _____

Coverage Level: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family

Employee: Basic Coverage $_____ Supplemental/Voluntary Coverage $_____

Spouse: Basic Coverage $_____ Supplemental/Voluntary Coverage $_____

Child: Basic Coverage $_____ Supplemental/Voluntary Coverage $_____

Order #167546 (e) 07/09/2024

Group Policy Number _____

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

SECTION 4. EMPLOYER CERTIFICATION

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

New York Fraud Warning: 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.

Employer Name *(First)* _____

Title _____

Employer Address Line 1 _____

Employer Address Line 2 _____

City _____ State _____ ZIP _____

Primary Phone (_____)_____ Mobile Phone (_____)_____ Email _____

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.

Authorized 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 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.

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

New York: 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.

Group Policy Number _____

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

FRAUD WARNINGS *(Continued)*

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.