RESET FORM

DISABILITY INCOME INSURANCE CLAIM - EMPLOYER

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, New York, NY
Members of the Voya® family of companies
(the "Company")
Submit at voya.com/claims *(select Upload Documents);*
Disability Reinsurance Management Services, Inc.
is the claims administrator on behalf of the Company.
P.O. Box 9757, Portland, ME 04101-9757
Phone: 888-305-0602; Fax: 888-305-0605

CLAIM CHECKLIST

- ☐ SIGN and DATE this completed form, then submit using one of the above methods.
- ☐ Provide the **Disability Income Insurance Claim - Employee** form to the Employee / Insured. The Employee / Insured is responsible for completion and submission of the **Disability Income Insurance Claim - Employee** form.
- ☐ Provide a separate **Attending Physician's Statement** to the Employee / Insured for the Attending Physician to complete and sign.
- ☐ Section 5 (Waiver of Premium) should be completed ONLY if Life Insurance with Waiver of Premium is included in the Employee's Benefits Package.
- ☐ Attach a copy of the following documents to this form: Employee's Workers' Compensation claim(s) and Approval/Denial Notification; Employee's prior year's W-2 form OR if no W-2 is available, list the basic monthly earnings for the past 12 months just prior to the employee's date of disability; Employee's current job description.

SECTION 1: GROUP INFORMATION

Group Name _____

Group Policy Number _____ Account Number _____

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 _____ Email _____

Phone (_____)_____ International Phone _____

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

Employment Start Date _____ Coverage Effective Date _____

Employee Class _____

Date Disability Began _____ Date Last Worked _____

How many hours per week did the Employee normally work? _____ What type of shift? _____

Was Employee late enrollee? . . . . . ☐ Yes ☐ No

Salary $_____ per: ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Prior Year W-2 Parsonage $_____ OR _____%

Commissions *(If "yes," attach list of commissions.)* . . . . . ☐ Yes ☐ No

Last Salary Change Date _____ Earnings Prior to Increase $_____

Is a layoff planned at Employee's location? . . . . . ☐ Yes ☐ No

Does the employee pay for any part of the premium? *(If "yes," attach a copy of signed Enrollment form.)* . . . . . ☐ Yes ☐ No

Occupation/Duties ***(Attach a copy of Employee's job description.)*** _____

Group Policy Number _____

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

SECTION 2: EMPLOYEE / INSURED INFORMATION *(Continued)*

The Employee is filing a claim for the following type of disability *(Select one.)*: ☐ Long Term Disability ☐ Short Term Disability

Is disability work-related? . . . ☐ Yes ☐ No

If "yes," has a Workers' Compensation claim been filed? . . . ☐ Yes ☐ No

Has employment been terminated? . . . ☐ Yes ☐ No

If "yes," provide date and reason. _____

Has Employee returned to work? . . . ☐ Yes ☐ No

If "yes," provide date and select the status. _____ Status: ☐ Full Time ☐ Part Time

Is employee subject to FICA tax? . . . ☐ Yes ☐ No

If "yes," is employee subject to: ☐ Full FICA tax ☐ Medicare portion only

Percentage of employee/employer contribution to premium for this disability plan (as of policy year of disability):

Employee: ☐ 100% ☐ Other _____% Employer: ☐ 100% ☐ Other _____%

Is Employee Contribution: ☐ Pre-tax deduction ☐ After-tax deduction

Is Employee / Insured eligible for or receiving:			Benefits			Paid	
Yes	No		Amount	Date Began	Date Terminated	Weekly	Monthly
☐	☐	Sick Pay?	$			☐	☐
☐	☐	Salary Continuance Benefits?	$			☐	☐
☐	☐	Workers' Compensation?	$			☐	☐
☐	☐	Local, State or National Association or Society Disability Income Plan?	$			☐	☐
☐	☐	No Fault?	$			☐	☐
☐	☐	Unemployment Compensation Disability?	$			☐	☐
☐	☐	Social Security Benefits (Disability or Retirement)?	$			☐	☐
☐	☐	Retirement income (Normal, Early, or Disability)?	$			☐	☐
☐	☐	Other LTD/STD Benefits?	$			☐	☐
☐	☐	Veterans Benefits?	$			☐	☐
☐	☐	Vacation?	$			☐	☐
☐	☐	Paid Time Off?	$			☐	☐
☐	☐	Other? Describe.	$			☐	☐

Were deductions for this coverage taken on a pre-tax basis? . . . ☐ Yes ☐ No

SECTION 3: REMARKS

SECTION 4: APPROVED FMLA DATES

FMLA Begin Date _____ FMLA Approved Through Date _____

SECTION 5: WAIVER OF PREMIUM *(Complete this section ONLY if Life Insurance with Waiver of Premium is included in the Employee's Benefits Package. See certificate for age requirement to be eligible for waiver.)*

Group Name _____

Group Policy Number _____ Account Number _____ Labor Status: ☐ Union ☐ Non-Union

Amount of Employee's Insurance:

Basic Insurance Coverage $_____ Effective Date _____

Optional Insurance Coverage $_____ Effective Date _____

Supplemental Insurance Coverage $_____ Effective Date _____

Other Insurance Coverage $_____ Effective Date _____

Group Policy Number _____

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

SECTION 6: 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.

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.

Employer Name *(First)* _____

Title _____

Employer Address Line 1 _____

Employer Address Line 2 _____

City _____ State _____ ZIP _____

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

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.

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.