RESET FORM

ATTENDING PHYSICIAN'S STATEMENT OF CRITICAL ILLNESS / SPECIFIED DISEASE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members 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

The patient is responsible for the completion of this form without expense to the insurance company.

CLAIM CHECKLIST

- ☐ SIGN and DATE this completed form, then submit using one of the above methods.
- ☐ The Employee / Insured / Member must complete Sections 1 and 2.
- ☐ Attach copies of all test results and operative reports.
- ☐ The Attending Physician must complete Sections 3 - 5.

SECTION 1. GROUP INFORMATION *(This information can be obtained from the Employer / Administrator.)*

Group / Association Name _____ Group / Association Policy Number _____

Claim Number *(if available)* _____ Member ID Number *(for Association only)* _____

SECTION 2. EMPLOYEE / INSURED / MEMBER INFORMATION

Select, if applicable.: ☐ International / Foreign Address

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

Patient Birth Date _____ Patient Phone (_____)_____ International Phone _____

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

Address _____

Address _____

City _____ Province / State _____ ZIP _____

Country _____

SECTION 3. HISTORY

When did the current symptoms first appear? _____ Confirmed Diagnosis Date _____

Has the patient ever had the same or a similar condition? *(If "yes," provide date and description.)* . . . . . ☐ Yes ☐ No

_____

_____

_____

_____

SECTION 4. CRITICAL ILLNESS / SPECIFIED DISEASE *(Only the conditions listed below may be covered. If the patient does not have one of the specific illnesses listed below, the claim may not be eligible.)*

Aneurysms:

☐ Abdominal Aortic Aneurysm
Has the patient been diagnosed with an enlargement of the abdominal aorta of 5 cm or more, or of 4 cm or greater and rapidly expanding in which surgical repair has been advised? *(Attach test results.)* . . . . . ☐ Yes ☐ No

☐ Ruptured or Dissecting Aneurysm *(Aneurysms of the arm or leg are not considered a Ruptured or Dissecting Aneurysm.)*
Has the patient been diagnosed with a balloon-like bulge in an artery that ruptures or dissects as confirmed by an ultrasound, CT scan, angiogram or MRI? *(Attach test results.)* . . . . . ☐ Yes ☐ No

☐ Thoracic Aortic Aneurysm
Has the patient been diagnosed with an enlargement of the thoracic aorta of 5.5 cm or more, or causing symptoms, or of 4.5 cm or greater and rapidly expanding in which surgical repair has been advised? *(Attach test results.)* . . . . . ☐ Yes ☐ No

Group / Association Policy Number _____

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

SECTION 4. CRITICAL ILLNESS / SPECIFIED DISEASE *(Continued)*

Cancers:

Initial Diagnosis Date _____ Any Subsequent Diagnosis Dates _____

☐ Benign Brain Tumor
Has a biopsy been performed to confirm diagnosis? . . . ☐ Yes ☐ No

Type of Tumor *(Attach test results.)* _____

☐ Bone Marrow Transplant
Has the patient undergone a bone marrow transplant? . . . ☐ Yes ☐ No

If the transplant has not been performed, is the patient on the Be the Match registry? . . . ☐ Yes ☐ No

☐ Cancer/Carcinoma in Situ
Cancer/Carcinoma in Situ was diagnosed using: ☐ Pathological Diagnosis *(Attach copy of report)* ☐ Clinical Diagnosis *(Provide reason for not obtaining pathological diagnosis and attach medical evidence that supports the diagnosis of cancer.)*

Stage of Cancer _____

☐ Skin Cancer
Indicate Skin Cancer Type *(Attach pathology report.)*: ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Melanoma

☐ Stem Cell Transplant
Has or will the patient undergo a surgical stem cell transplant? *(Attach test results.)* . . . ☐ Yes ☐ No

Endocrine Conditions:

☐ Addison's Disease
Diagnosis confirmed by *(Attach test results.)*: ☐ Blood test ☐ Urine test ☐ Medical imaging

☐ Type 1 Diabetes
Was diagnosis based on blood tests? *(Attach test results)* . . . ☐ Yes ☐ No

How long has patient been insulin dependent? _____

What is the start date of treatment? _____

Heart/Cardiac Conditions:

Procedure Date _____

☐ Coronary Angioplasty
Did or will the patient undergo a ☐ Coronary balloon angioplasty ☐ Angiojet clot removal ☐ Rotational and orbital atherectomy procedure *(Attach operative report.)*

☐ Coronary Artery Bypass
Did or will the patient undergo open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts? *(Attach operative report.)* . . . ☐ Yes ☐ No

☐ Heart Attack (*A sudden cardiac arrest is not in itself considered a Heart Attack.)*
Does the patient's condition meet all of the following criteria:

1. Are new and serial electrocardiographic (EKG) findings consistent with myocardial infarction? . . . ☐ Yes ☐ No
2. Were cardiac enzymes elevated above generally accepted laboratory levels of normal for creatine physphokinase (CPK) or elevated troponins? *(If "yes," attach confirmatory lab reports.)* . . . ☐ Yes ☐ No
3. Did diagnostic studies confirm a myocardial infarction and the occlusion of one or more coronary arteries? *(Attach copies of any applicable reports.)* . . . ☐ Yes ☐ No

☐ Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement
Has the patient undergone or been advised to undergo an initial placement of an implantable cardioverter-defibrillator (ICD)? *(Attach operative results.)* . . . ☐ Yes ☐ No

☐ Open Heart Surgery for Valve Replacement or Repair
Has the patient undergone or been advised to undergo open heart surgery to repair one or more valves due to severe valvular heart disease? *(Attach operative report.)* . . . ☐ Yes ☐ No

Group / Association Policy Number _____

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

SECTION 4. CRITICAL ILLNESS / SPECIFIED DISEASE *(Continued)*

☐ Pacemaker Placement

Has the patient undergone or been advised to undergo an initial placement of a permanent pacemaker? *(Attach operative report.)* . . . . . ☐ Yes ☐ No

☐ Sudden Cardiac Arrest

Has the patient had a sudden, unexpected loss of heart function, breathing, or consciousness due to an internal electrical disturbance of the heart? *(Attach test results.)* . . . . . ☐ Yes ☐ No

Did the sudden cardiac arrest result in death? *(Attach autopsy report or death certificate.)*. . . . . ☐ Yes ☐ No

☐ Transcatheter Heart Valve Replacement or Repair

Has the patient undergone or been advised to undergo a procedure performed through the blood vessels to replace or repair one or more heart valves? *(Attach operative report.)* . . . . . ☐ Yes ☐ No

Neurological Conditions:

☐ Advanced Dementia, including Alzheimer's Disease

The patient is UNABLE to perform 2 or more Activities of Daily Living *(see definitions below.)* . . . . . ☐ Yes ☐ No

ACTIVITIES OF DAILY LIVING: The basic human functional abilities required for the Insured to remain independent:

- Bathing: Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including catheter or colostomy bag).
- Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring: Moving into or out of bed, chair, or wheelchair.

Was the diagnosis clinically established by testing?. . . . . ☐ Yes ☐ No

If "yes," select testing method (Attach test results.): ☐ MRI ☐ CT

☐ Amyotrophic Lateral Sclerosis (ALS)

Diagnosis established by *(Attach test results.)*: ☐ MRI ☐ Nerve Biopsy ☐ EMG ☐ Neurological Exam

☐ Coma

Has patient experienced a continuous state of unconsciousness for 14 or more consecutive days? . . . . . ☐ Yes ☐ No

Did patient require intubation? . . . . . ☐ Yes ☐ No

Was there an absence of eye opening, verbal response and motor response? . . . . . ☐ Yes ☐ No

☐ Huntington's Disease (Huntington's Chorea)

Does the patient display symptoms of Huntington's Disease? *(Attach lab testing.)* . . . . . ☐ Yes ☐ No

☐ Multiple Sclerosis

Are symptoms persistent for 6 or more months? *(Attach MRI and spinal fluid analysis.)* . . . . . ☐ Yes ☐ No

☐ Muscular Dystrophy

Diagnosis established by *(Attach test results.)*: ☐ Muscle biopsy ☐ Increased creatine Phosphokinase (CpK3) ☐ Electromyography

☐ Myasthenia Gravis

Diagnosis established by *(Attach test results.)*: ☐ Neurological exam ☐ Edrophonium test ☐ EMG ☐ CT Scan ☐ MRI ☐ Blood analysis ☐ Repetitive nerve stimulation

☐ Parkinson's Disease

Does the patient present any symptom or combination of 4 cardinal symptoms? *(Check all that apply.)*

☐ Rest Tremor ☐ Rigidity ☐ Bradykinesia ☐ Gait Disturbance

☐ Permanent Paralysis

Did the patient have total and permanent loss of use of 2 or more limbs due to accident or sickness for a continuous period of at least 60 days? . . . . . ☐ Yes ☐ No

Cause of Paralysis _____

Group / Association Policy Number _____

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

SECTION 4. CRITICAL ILLNESS / SPECIFIED DISEASE *(Continued)*

☐ Stroke

Did the patient have a stroke, meaning apoplexy, secondary to rupture or acute occlusion of a cerebral artery? Stroke does not include transient ischemic attacks, ischemic disorders or the vestibular system, brain injury related to trauma or infection, or brain injury associated with hypoxia/anoxia or hypotension. *(Attach confirmation test results.)* . . . . . ☐ Yes ☐ No

Did the patient experience any neurological impairment since discharged from the hospital? . . . . . ☐ Yes ☐ No

☐ Transient Ischemic Attacks (TIA)

Was the transient episode of neurologic dysfunction caused by focal brain, spinal cord or retinal ischemia, without acute infarction? *(Attach copies of any applicable reports.)* . . . . . ☐ Yes ☐ No

Rheumatologic Conditions:

☐ Systemic Lupus Erythematosus (SLE)

Diagnosis established by *(Attach test results.)*: ☐ Blood analysis ☐ Diagnostic criteria *(Provide reason for not obtaining laboratory tests and attach medical evidence that supports the diagnosis of SLE.)*

☐ Systemic Sclerosis (Scleroderma)

Was the patient diagnosed with an autoimmune disease that involves the hardening and tightening of the skin and connective tissues? *(Attach test results.)* . . . . . ☐ Yes ☐ No

Other Conditions:

☐ End Stage Renal (Kidney) Failure *(See Major Organ Transplant or Major Organ Failure below)*

☐ Infectious Disease

Was patient confined to a ☐ Hospital ☐ Transitional Care Facility

If "yes," how many consecutive days in the hospital or transitional care facility? _____

Define the type of infectious disease *(Attach lab test results.)* _____

☐ Loss of Hearing/Deafness

Is hearing loss profound, permanent and not correctable in both ears? *(Attach test results.)* . . . . . ☐ Yes ☐ No

☐ Loss of Sight/Blindness

What are the most recent visual acuity measurements?

With glasses *(in Snellen Notation)* O.D. _____ O.S. _____ Date _____

Without glasses *(in Snellen Notation)* O.D. _____ O.S. _____ Date _____

On what date was corrected vision irrecoverably reduced to 20/200 or less in the better eye? _____ ☐ O.D. ☐ O.S.

☐ Loss of Speech

Was patient diagnosed with total and permanent loss of the ability to speak? *(Attach copy of report.)*. . . . . ☐ Yes ☐ No

☐ Major Organ Transplant or Major Organ Failure

Did the patient undergo surgery to receive a human heart, liver, both lungs, both kidneys or pancreas? *(Attach a copy of the operative report.)* . . . . . ☐ Yes ☐ No

If operation has not been performed, is patient on United Network for Organ Sharing (UNOS) list for transplant?. . . . . ☐ Yes ☐ No

Date Added to the UNOS List _____ Date Diagnosed with Organ Failure _____

What condition caused the need for the major organ transplant? _____

If end stage renal (kidney) failure, does the patient's kidney failure necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly) or which results in kidney transplantation? . . . . . ☐ Yes ☐ No

On what date did dialysis treatments begin? _____

☐ Occupational Hepatitis B or C

Did the patient contract Hepatitis B or C at work and while performing normal occupational duties, from one of the following? *(Attach lab results.)*

☐ Accidental Needle Stick ☐ Other Accidental Sharp Injury ☐ Accidental Mucous Membrane Exposure to Blood or Bloodstained Bodily Fluid

☐ Occupational HIV

Did the patient contract HIV at work and while performing normal occupational duties, from one of the following? *(Attach lab results.)*

☐ Accidental Needle Stick ☐ Other Accidental Sharp Injury ☐ Accidental Mucous Membrane Exposure to Blood or Bloodstained Bodily Fluid

Group / Association Policy Number _____

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

SECTION 4. CRITICAL ILLNESS / SPECIFIED DISEASE *(Continued)*

☐ Severe Burns

Is the burn over more than 35 square inches? . . . ☐ Yes ☐ No

Is the burn full thickness or 3rd degree? *(Attach copies of any applicable reports.)* . . . ☐ Yes ☐ No

☐ Specified Conditions Rider: For Mental Illness and Neurodevelopmental Disorders

Define the Specified Condition type _____ Date of Initial Diagnosis _____

Was patient confined to a ☐ Hospital ☐ Rehabilitation Facility ☐ Transitional Care Facility

If "yes," what are the dates of confinement in the hospital, rehabilitation facility, or transitional care facility? _____

ADDITIONAL CHILDHOOD DISEASES

☐ Cerebral Palsy

Does the child have any of the following group of development/movement disorders?

☐ Delayed Motor Development ☐ Intellectual ☐ Seizures ☐ Speech ☐ Vision/Hearing ☐ Positive Neuroimaging Test ☐ Others (not listed)

☐ Congenital Birth Defects

Did the congenital birth defect result in the child being confined to a hospital for 30 days or more consecutively beginning within the first week after birth? . . . ☐ Yes ☐ No

If "yes," check all that apply.: ☐ Heart ☐ Lungs ☐ Spina Bifida ☐ Cleft Lip/Palate ☐ Limb Malformations ☐ Blindness ☐ Developmental Brain Disorders

☐ Cystic Fibrosis

Was a definite diagnosis established by one of the following?

Sweat Test? *If "yes," attach two independent positive tests.* . . . ☐ Yes ☐ No

Chest X-ray? . . . ☐ Yes ☐ No

Lung Function Testing? . . . ☐ Yes ☐ No

☐ Down Syndrome

Check the confirmed diagnosis: ☐ Trisomy 21 ☐ Translocation ☐ Mosaic

☐ Gaucher Disease, Type II or III

Was a definitive diagnosis confirmed through a blood test reviewing beta-glucosidase leukocyte (BGL)? *(Attach test results.)* . . . ☐ Yes ☐ No

☐ Infantile Tay Sachs

Was a definitive diagnosis confirmed through a blood test reviewing Hexosaminidase A levels? *(Attach test results.)* . . . ☐ Yes ☐ No

☐ Niemann-Pick Disease

Diagnosis established by *(Attach test results.)*: ☐ Blood test ☐ Genetic test

Classification: ☐ Type A ☐ Type B ☐ Type C

☐ Pompe Disease (Type II Glycogen Storage Disease)

Diagnosis established by *(Attach test results.)*: ☐ Enzyme Test ☐ Genetic test

☐ Sickle Cell Anemia

Was the diagnosis confirmed through a blood test? *(Attach test results.)* . . . ☐ Yes ☐ No

☐ Type 1 Diabetes *(See Endocrine Conditions section above)*

☐ Type IV Glycogen Storage Disease

Diagnosis established by *(Attach test results.)*: ☐ Enzyme Test ☐ Genetic test

☐ Zellweger Syndrome

Was a definitive diagnosis confirmed through genetic testing? *(Attach test results.)* . . . ☐ Yes ☐ No

Group / Association Policy Number _____

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

SECTION 5. PHYSICIAN INFORMATION AND SIGNATURE

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.

Attending Physician Name _____ Degree _____

TIN _____ Phone (_____)_____ Fax (_____)_____

Email _____

Address _____ City _____ State _____ ZIP _____

Attending Physician 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 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.