RESET FORM

DEATH CLAIM FOR GROUP LIFE PLANS

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)*
Phone: 888-238-4840; **Voya Life Claims:** PO Box 1548, Minneapolis, MN 55440
Overnight Address: 250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

CLAIM CHECKLIST

- ☐ SIGN and DATE this completed form, then submit using one of the above methods.
- ☐ Provide the appropriate **Proof of Death - Claimant's Statement** to the beneficiary(ies).
- ☐ Attach the enrollment documentation, any beneficiary change documentation and a death certificate indicating manner and cause of death.

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

Group Name _____

Group Policy Number _____ Insurance Policy Number _____

Claim Number _____ Account Number _____

SECTION 2. REPORTER'S INFORMATION *(Name and contact information for the person that reported the death to Employer.)*

Select, if applicable.: ☐ International / Foreign Address

First Name _____ Middle Initial _____ Last Name _____

Relationship to Policy Holder _____ If other, please mention: _____

Email Address _____

Phone (_____) _____ Country _____

Address _____ Unit / Apt. _____

City _____ Province / State _____ ZIP _____

SECTION 3. EMPLOYEE / INSURED INFORMATION

Select, if applicable.: ☐ International / Foreign Address

Employee 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

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

Job Category _____ If "Other" _____ Job Title _____

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

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

Employment Status at Death: ☐ Active ☐ Retired ☐ Disability Waiver of Premium ☐ FMLA (include FMLA documentation) ☐ Under Continuation

Reason for Stopping Work _____ If Other, Please Mention _____

Have premiums been paid to the date of death? ☐ Yes ☐ No If "no," to what date have premiums been paid? _____

Date of Death _____ Cause of Death _____

If death was caused by injuries, explain *(Attach newspaper clipping, if available.)* _____

Order #171880 (e) 01/29/2026

Group Policy Number _____

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

SECTION 3. EMPLOYEE / INSURED INFORMATION *(Continued.)*

If claim is for insurance on a dependent, complete the following information concerning dependent *(list amount below).*:

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

Effective Date This Dependent Was Insured _____ Dependent Phone (_____)_____

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 4. COVERAGE INFORMATION

Basic Life $_____ Effective Date _____

Additional Basic Life $_____ Effective Date _____

Basic AD&D $_____ Effective Date _____

Supplemental Life $_____ Effective Date _____

Supplemental Accidental Death $_____ Effective Date _____

Supplemental AD&D $_____ Effective Date _____

Lifetime Life $_____ Effective Date _____

Other $_____ Effective Date _____

Other Coverage Information _____

Status of Beneficiary Designation: ☐ Beneficiary Designation On File ☐ Beneficiary Designation Not On File

SECTION 5. EMPLOYER CERTIFICATION

The undersigned certifies that the above statements as to the insured are correct as reported on its records. This applies only to employers that utilize the Voya Personal Transition Account: The undersigned certifies that a Voya Personal Transition Account Supplemental Contract has been provided to each beneficiary.

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)* _____ *(Middle Initial)* _____ *(Last)* _____

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 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.