RESET FORM

ACCELERATED LIFE BENEFIT FOR CHRONIC ILLNESS CLAIM FOR ASSOCIATION PLANS - MEMBER

ReliaStar Life Insurance Company, Minneapolis, MN
A member 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 Ave., Suite 900, Minneapolis, MN 55401

CLAIM CHECKLIST

Before completing this form, be sure to read and understand the information contained in the **Accelerated Life Benefit Rider for Terminal and Chronic Illness**. If you have any questions about the tax consequences associated with this benefit, you should seek the advice of a qualified tax advisor before submitting this form.

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

☐ All irrevocable beneficiaries, assignees and spouses *(community property only states)* must sign this form in Section 9.

☐ The **Attending Physician's Statement for Chronic Illness** form must be completed and signed by the attending physician and submitted with this form.

SECTION 1. GROUP INFORMATION *(This information is mandatory and can be obtained from the Administrator.)*

Association Name _____

Association Policy Number _____ Account Number _____

SECTION 2. MEMBER / INSURED INFORMATION

☐ Association Member / Insured ☐ Spouse

Select, if applicable.: ☐ International / Foreign Address

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

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Address _____

Address _____

City _____ Province / State _____ ZIP _____

Country _____ Email _____

Phone (_____) _____ International Phone _____

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

SECTION 3. IRREVOCABLE BENEFICIARY AND ASSIGNEE INFORMATION *(Complete if applicable. Include a separate page to provide additional irrevocable beneficiary or assignee information.)*

Irrevocable Beneficiary / Assignee Name _____ Role _____

Birth Date _____ SSN/TIN _____ Phone (_____) _____

Address _____

City _____ State _____ ZIP _____

SECTION 4. BENEFIT INFORMATION

Has any government agency required that the Policy Owner of the above policy(ies) exercise this option as a condition for obtaining or retaining a government benefit or entitlement? . . . . . ☐ Yes ☐ No

Has any creditor required that the Policy Owner of the above policy(ies) exercise the option? . . . . . ☐ Yes ☐ No

How would you like to receive your benefit payment? ☐ Annually ☐ Monthly **If you do not elect an option, we will pay benefits on a monthly basis.**

Order #174254 (e) 11/02/2022

Association Policy Number _____

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

SECTION 5. CHRONIC ILLNESS HISTORY

What are the diagnoses and symptoms that prevent the Insured from caring for himself or herself and which support eligibility for a chronic illness claim?

_____

_____

Has the Insured been confined to any type of facility (e.g., hospital, nursing home, rehabilitation center) for this condition? . . . . . ☐ Yes ☐ No

If "yes," list name, address and phone number of each facility and dates of confinement in the table.

Confinement Dates	Facility Name	Address *(Street, City, State, ZIP)*	Phone Number
			( )
			( )

List below any physicians that have treated the Insured for this chronic condition within the past 5 years.

Treatment Dates	Physician Name	Address *(Street, City, State, ZIP)*	Phone Number
			( )
			( )

SECTION 6. COGNITIVE IMPAIRMENT CLAIMS ONLY

When did you or the Insured's physician first conclude that the Insured, due to a severe cognitive impairment, requires substantial supervision to protect himself or herself from threats to health or safety? *(date)* _____

List the name, relationship, and phone number of the individual (including family members), agency, and/or facility that currently provide(s) this supervision.

Agency/Individual Name	Phone Number	Relationship	Date Supervision First Provided	Description of Assistance Provided and Frequency
	( )			
	( )			

SECTION 7. ACTIVITIES OF DAILY LIVING (ADL)

List the activities of daily living that the Insured needs assistance with below.

a. **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. . ☐ Yes ☐ No

b. **Continence** - the ability to maintain control of bowel or bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag. . . . . ☐ Yes ☐ No

c. **Dressing** – putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs. . . . . ☐ Yes ☐ No

d. **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. . . . . ☐ Yes ☐ No

e. **Toileting** - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene. . . . . ☐ Yes ☐ No

f. **Transferring** - moving into or out of a bed, chair, wheelchair. . . . . ☐ Yes ☐ No

If "yes" to any items above, provide the approximate date the Insured was first unable to perform the particular ADL. (month and year) _____

_____

_____

SECTION 8. U.S. TAXPAYER CERTIFICATIONS

Under penalties of perjury, I certify that:

1. The Taxpayer Identification Number that appears on this form is correct.

2. I am not subject to backup withholding due to failure to report interest and dividend income;

☐ **If I am subject to backup withholding, I have checked here.**

3. I am a U.S. person.

NON-RESIDENT ALIEN STATUS

If you are a Non-Resident Alien, check the box and provide your country of residence below.

☐ Under penalties of perjury, I certify that I am a Non-Resident Alien and my country of residence is: _____.

The amount paid to you will be subject to 30% withholding, unless you submit an IRS Form W-8, and are entitled to claim a reduced rate of withholding under the applicable U.S. tax treaty.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Association Policy Number _____

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

SECTION 9. AUTHORIZATIONS AND SIGNATURES

Authorizations: By signing this request, I make the following authorizations:

1. **Collection of Medical Record Information or Investigative Reports.** I authorize the Company and other insurance companies affiliated with the Company to collect medical record information and consumer or investigative consumer reports about me for the purposes described in this request.
2. **Release of Records.** I authorize any organization or medically related facility to release to the Company or its authorized representatives all requested information about me. I give my permission to the Company to send any information obtained to MIB, LLC, reinsurers, employees or contractors who process transactions regarding this insurance coverage. I understand that this authorization will be valid for 24 months from the date of signature on this application. I have the right to receive a copy of this authorization, and a photocopy will be as valid as the original.
3. **Investigative Consumer Reports.** If an investigative consumer report is prepared, I request to be interviewed. ☐ Yes

Statements of Understanding. I understand that this authorization will be valid for 24 months from the date of signature on this request. I have the right to receive a copy of this authorization, and a photocopy will be as valid as the original. I give my permission to the Company and other insurance companies affiliated with the company to collect medical record information and consumer or investigative consumer reports about me for the purposes described in this request. I authorize any organization or medically related facility to release to the Company or its authorized representatives all requested information about me. I give my permission to the Company to send any information obtained to MIB, LLC and reinsurers.

If the Insured is incapacitated and unable to sign the authorization, a legally appointed and duly qualified representative may execute the authorization on behalf of the Insured. Appropriate documentation establishing the representative's authority (i.e. Durable Power of Attorney, Letters of Conservatorship, etc.) must accompany the form. Depending on the circumstances, the Company may also require a court order expressly authorizing a Accelerated Life Benefit for Chronic Illness Claim. The Company will notify the Insured if such an order is needed.

By signing below, I certify that:

1. I have received, read and understand the Disclosure Statement Information Regarding Accelerated Benefits from the Company.
2. I understand that the payment of a Accelerated Life Benefit reduces the Life Insurance amount under the policy(ies) identified in Section 1.
3. I consent to the payment of a Accelerated Life Benefit to the Owner(s) under the policy(ies) identified in Section 1.
4. I certify that the information provided in this form is true and complete.
5. All irrevocable beneficiaries and assignees (if any) have signed this form.

Any person who knowingly and with intent to defraud, files a statement of claim containing any materially false or misleading information, commits a fraudulent act which is a crime.

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.

➥ Member / Insured Signature _____ Date _____

If the Insured is unable to sign, the Insured's representative may sign. Only those representatives who are court-appointed guardians or have a power of attorney specific to this type of claim may sign. Supporting documentation of the appointment must be submitted with this form.

➥ Insured's Representative _____ Date _____

Representative Address _____ Phone (_____)_____

Release by Irrevocable Beneficiary or Assignee, or by Spouse in a Community Property State

The undersigned acknowledges and consents to this Accelerated Life Benefit for Chronic Illness Claim and understands; that if approved, payment of the chronic illness accelerated life benefit shall be made to the owner or his/her legal representative; and in consideration of such payment the undersigned acknowledges and understands that the liability of the insurance company under the policy shall be discharged by the amount of the chronic illness accelerated life benefit paid.

Irrevocable Beneficiary Name _____ SSN/TIN _____

➥ Irrevocable Beneficiary Signature _____ Date _____

Assignee Name _____ SSN/TIN _____

➥ Assignee Signature _____ Date _____

Spouse Name *(if community property state)* _____ SSN/TIN _____

➥ Spouse Signature *(if community property state)* _____ 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.

CONSUMER NOTICES

Notice Regarding Collection of Information and Information Practices

In order to evaluate your application for life insurance, we must collect information about you and any minor children who are to be insured. The type of information that we may collect includes, but is not limited to, the following: any medical information regarding the diagnosis, treatment and prognosis of any physical or mental condition; prescription drug records and related information; any non-medical information about you or your minor children who are to be insured. Some of that information will come from you. Some will come from other sources.

The sources that we may contact for information include, but are not limited to, the following: physicians, medical practitioners, hospitals, clinics, medically related facilities, insurance or reinsuring companies, Medical Information Bureau ("MIB"), LLC, any consumer reporting agencies, and any other organizations. That information and any information collected by us later may, in certain circumstances, be disclosed to third parties without your specific permission.

You have a right to access and correct the information collected about you. This right does not extend to information that relates to a claim or civil or criminal proceeding. You have the right to receive, in writing, the reasons for any adverse underwriting decisions.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. The agency that makes the report will be one that is discreet and impartial. If you wish, the Company ("we") will send you the name, address, and phone number of any agency we ask to prepare a consumer report about you. You can request that the agency interview you. This may be indicated on the authorization form.

Consumer reports are used to help us decide if you are eligible for the insurance for which you have applied. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocations, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records or by contacting you, members of your family, business associates and employers, financial sources, and friends or others you know. This information will not be used to determine your sexual orientation. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with the Company unless you request otherwise.

The information may be kept by the consumer reporting agency. It may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; and your state's Insurance Information and Privacy Protection Act, if any. The agency will give you a copy of the report if you ask for one and provide the proper identification.

Notice Regarding MIB, LLC (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to the MIB, LLC, formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

We and our reinsurers may also release information in our files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

Federal Regulations - 42CFR Part 2

Your medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations - 42CFR Part 2. If information is protected by federal or state law, you may revoke this authorization at any time by mailing a written request to the Company. A written request, however, will not apply to any information collected before the date that we receive your request.

THIS PAGE MUST BE GIVEN TO THE INSURED AND OWNER.

CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures
For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices
Collecting Information
Your application or claim form is our main source of information. But we may:
- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, LLC., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, LLC." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports
Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use
We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure
We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, LLC, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information
If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, LLC.
We or our reinsurers may make brief reports to MIB, LLC (hereafter "MIB"). The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.