RESET FORM

ATTENDING PHYSICIAN'S STATEMENT FOR CHRONIC ILLNESS

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya® family of companies
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

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 Member / Insured must complete Sections 1 and 2.
- ☐ The Attending Physician must complete Sections 3 - 8.

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

Association Name _____

Association Policy Number _____

SECTION 2. MEMBER / INSURED INFORMATION

Select, if applicable.: ☐ International / Foreign Address

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

Patient Birth Date _____

Member Name: if NOT Patient Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Address _____

Address _____

City _____ Province / State _____ ZIP _____

Country _____ Email _____

Phone (_____)_____ International Phone _____

SECTION 3. DIAGNOSIS AND PRESENT CONDITION OF CHRONIC ILLNESS

Insured's Primary Diagnosis _____

Insured's Secondary Diagnosis _____

When did the current symptoms first appear or accident happen? *(Month, Day, Year)* _____

Has the Insured ever had a similar condition? *(If "yes," state when & describe.)* . . . . . ☐ Yes ☐ No

Association Policy Number _____

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

SECTION 4. ACTIVITIES OF DAILY LIVING (ADL) CLAIMS ONLY

Has the Insured had a loss of functional capacity and been unable to perform for **at least 90 consecutive days** two or more of the following ADLs without substantial assistance? . . . . . ☐ Yes ☐ No

If "yes," is the condition expected to be permanent? . . . . . ☐ Yes ☐ No

If the Insured is unable to perform two or more ADLs without substantial assistance from another person, provide the approximate date the Insured was first unable to perform the particular ADL in the table below:

Activity of Daily Living	Assistance Required?	Date Assistance First Required
Bathing *(washing oneself)*		
a) By sponge bath	☐ Yes ☐ No	
b) In the tub or shower	☐ Yes ☐ No	
c) Getting in and out of the tub or shower	☐ Yes ☐ No	
Dressing *(putting on, taking off, fastening, unfastening)*		
a) Clothing	☐ Yes ☐ No	
b) Medically necessary braces, fasteners or artificial limbs	☐ Yes ☐ No	
Eating *(feeding oneself by getting food into the body)*		
a) Through the mouth	☐ Yes ☐ No	
b) By feeding tube or intravenously	☐ Yes ☐ No	
Toileting		
a) Getting to and from the toilet	☐ Yes ☐ No	
b) Getting on and off the toilet	☐ Yes ☐ No	
c) Performing associated personal hygiene	☐ Yes ☐ No	
Transferring		
a) Moving into or out of a bed	☐ Yes ☐ No	
b) Moving into or out of a chair	☐ Yes ☐ No	
c) Moving into or out of a wheelchair	☐ Yes ☐ No	
Continence		
a) Is the Insured able to control bladder function?	☐ Yes ☐ No	
b) Is the Insured able to control bowel function?	☐ Yes ☐ No	
c) Does the Insured need help performing associated personal hygiene?	☐ Yes ☐ No	
d) Does the Insured have a catheter or colostomy bag?	☐ Yes ☐ No	
e) Does the Insured need help caring for the catheter or colostomy bag?	☐ Yes ☐ No	

Provide results of any physical examination findings and diagnostic studies which support the patient's ADL dependencies identified above.

Association Policy Number _____

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

SECTION 5. COGNITIVE ABILITY

If the patient has a significant decline in cognitive ability, address the following questions based on the following definition of severe cognitive impairment and established using clinical evidence and standard tests. **Severe cognitive impairment means a loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning.**

Describe the patient's level of cognitive impairment based on clinical assessment and standardized screening tools. _____

_____

Standardized Screening Tool _____ Evaluation Date _____

Standardized Screening Tool _____ Evaluation Date _____

Does the patient require substantial supervision in order to protect himself/herself from threats to health and safety due to severe cognitive impairment? . . . . . ☐ Yes ☐ No

Is the condition expected to be permanent? . . . . . ☐ Yes ☐ No

SECTION 6. ADDITIONAL INFORMATION

Has the patient's driver's license been revoked? . . . . . ☐ Yes ☐ No

If "yes," provide approximate date of revocation. _____

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

Provide explanation. _____

_____

SECTION 7. REMARKS

_____

_____

SECTION 8. PHYSICIAN INFORMATION AND SIGNATURE

Attending Physician Name _____ Degree _____

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

Address _____

City _____ State _____ ZIP _____

Attending Physician Signature _____ Date _____